Montana Central Tumor Registry Abstracting Manual

For cases diagnosed 01/01/2018 and after

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Yellow highlights reflect changes from previous manual

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General Principles

Necessary Resources for 2018 Reporting

AJCC 8th Edition

https://cancerstaging.org/#s/default.aspx

NAACCR version 18 layout

https://www.naaccr.org/data-standards-data-dictionary/

New Histologic Terms

https://www.naaccr.org/implementation-guidelines/#ICDO3

https://seer.cancer.gov/icd-o-3/

SEER Summary Stage 2018

https://seer.cancer.gov/tools/ssm/

Site-Specific Data Indicators

https://apps.naaccr.org/ssdi/list/

Solid Tumor Rules (the 2007 Multiple Primary and Histology rules should be used for sites covered in Cutaneous melanoma and Other modules)

https://seer.cancer.gov/tools/solidtumor/

Hematopoietic Database

https://seer.cancer.gov/seertools/hemelymph/

Grade Manual

https://apps.naaccr.org/ssdi/list/

Radiation codes

https://www.naaccr.org/data-standards-data-dictionary/

SEER*Rx

https://seer.cancer.gov/seertools/seerrx/

CoC STORE Manual

https://www.facs.org/quality-programs/cancer/ncdb/registrymanuals/cocmanuals

SEER Registrar Staging Assistant (Cancer Schema List helpful for coding Site, Histology, Tumor Size, LN's, EOD, SS2018, Grade)

https://staging.seer.cancer.gov/eod_public/list/1.4/

PREFACE

Construction of this manual is developed with use from the **STORE** (STandards for Oncology Registry Entry 2018), **SEER** Program Coding and Staging Manual 2018, **CDC-NPCR** (Centers for Disease Control – National Program of Cancer Registries) Required Status Table 2018, and **NAACCR** (North American Association of Central Cancer Registries) version 18 Data Dictionary. Implementation of this manual will be required with cancer cases diagnosed on or after January 1, 2018. There are many revisions for reporting 2018 cancer cases:

- Implementation of AJCC TNM version 8 staging
- Transition from Multiple Primary and Histology Coding rules to Solid Tumor Coding Rules
- Transition from Summary Stage 2000 to Summary Stage 2018
- Transition from CS Site Specific Factors to Site-Specific Data Indicators (SSDI)
- Addition of new histologic terms
- Revision of site-specific Grade coding rules
- Revision of Radiation codes

Required fields are either required by the Montana Central Tumor Registry law (Duty to Report Tumors 50-15-703), Administrative Rules of Montana (37.8.1801 – 37.8.1808), Public Law 102-515 (Cancer Registries Amendment Act), or NPCR Required Status Table under cooperative agreement with the Centers for Disease Control and Prevention, National Program of Cancer Registries (cooperative agreement number DP17-1701).

CHANGES FROM 2016 MCTR REPORTING MANUAL TO THE 2018 MCTR REPORTING MANUAL

See Appendix C for list of changes and page numbers

Modified Fields:

- Consolidated Secondary Diagnosis 2-10 into one page
- Confidentiality section rewritten and referenced MCTR Data Release Policy
- List of website resources for 2018 reporting
- Multiple Primaries section rewritten and referenced SEER Solid Tumor Rules and Hematopoietic Database

Removed Fields:

- Collaborative Staging sections and related fields
- Comorbidities and Complications sections (use Secondary Diagnoses 1-10 for ICD-10-CM codes)
- Grade section and reference to the Grade Manual
- AJCC 7th edition TNM Clinical and Pathological sections to accommodate AJCC 8th edition
- SEER Summary Stage 2000 to accommodate SEER Summary Stage 2018
- CS Site Specific Factors to accommodate Site-Specific Data Indicators (SSDIs)
- Radiation fields to accommodate revised radiation fields

New Fields:

- AJCC TNM Clin T, N, M
- AJCC TNM Path T, N, M
- AJCC TNM Post Therapy T, N, M
- AJCC TNM Clin Stage Group
- AJCC TNM Path Stage Group OR AJCC TNM Post Therapy Stage Group
- AJCC TNM Clin T Suffix
- AJCC TNM Path T Suffix
- AJCC TNM Post Therapy T Suffix
- AJCC TNM Clin N Suffix
- AJCC TNM Path N Suffix
- AJCC TNM Post Therapy N Suffix
- Summary Stage 2018
- Clinical, Pathological, and Post Therapy Grade
- Site-Specific Data Items

- Date of Regional Lymph Node Dissection and Flag
- Date of Sentinel Lymph Node Biopsy and Flag (breast and melanoma)
- Sentinel Lymph Nodes Examined (breast and melanoma)
- Sentinel Lymph Nodes Positive (breast and melanoma)

- Radiation Primary Treatment Volume (Phase I, II, III) – converted from *Radiation Treatment Volume*
- Radiation to Draining Lymph Nodes (Phase I, II, III) – converted from *Radiation Treatment Volume*
- Radiation Treatment Modality (Phase I, II, III) – converted from *Regional Treatment Modality*
- Radiation External Beam Planning Technique (Phase I, II, III) – converted from *Regional Treatment Modality*
- Dose per Fraction (Phase I, II, III)
- Number of Fractions (Phase I, II, III) – 1-1 map from Regional Dose: cGy
- Total Dose (Phase I, II, III)
- Number of Phases of Radiation Treatment to this Volume
- Radiation Discontinued Early
- Total Dose

- Date of Last Cancer (tumor) Status and Flag

- Three new overrides to accommodate new staging variables

REQUIRED STATUS DEFINITIONS

Required – Field required by the Montana Administrative Rules 37.8.1801 – 37.8.1808 or Public Law 102-515.

Required by CoC – Field required to be collected by ACoS-CoC-approved facilities and transmitted to the MCTR. Recommended for all other reporting facilities.

Recommended – Field recommended to be collected, when available.

Optional – Field is not required but may be useful to the registry.

PURPOSE

Central cancer registries collect, store, analyze, and interpret cancer data on people who are diagnosed and/or treated for cancer in population-based areas. The primary objective of the MCTR is to analyze the incidence, mortality, survival, and the changing frequency of cancer in Montana residents. Analysis is possible with complete, timely and quality data reporting.

CASEFINDING

Casefinding is the method of locating all eligible cancer cases and retrieving the required information on all patients diagnosed with or treated for cancer who are to be included in the MCTR, inpatient or outpatient regardless of the type of service. Casefinding will identify both new cases and cases already entered. Active casefinding (involves the registrar retrieving all source documents) is recommended for identifying reportable cases. Reportable cases could easily be missed with passive casefinding as non-registry staff are not familiar with reporting criteria and terminology. For example, non-registry staff could miss the collection of cases with terms that may not sound cancerous (such as linitis plastica or Waldenstrom's macroglobulinemia).

A procedure for obtaining complete and relevant data on all cancer patients with a reportable tumor should be established. The following casefinding sources may identify possible cancer cases:

- Pathology reports (histology, cytology, autopsy, bone marrow, hematology, pathologic addenda and consultations)
    - Pathology-only cases must be reported even if the patient was not seen in your facility
- Medical Record Disease Indices (all services: inpatient, outpatient, clinics, inpatient hospice, etc.)
    - History and Physical
    - Consultation Notes
    - Progress Notes
    - Discharge Summary
- Daily admissions and discharges
- Notes from physician's offices
- Diagnostic Imaging reports (X-ray, MRI, CT, PET, mammogram)
- Surgery schedule
- Medical oncology logs
- Radiation oncology logs
- Infusion or Treatment Center
- Outpatient Departments (including cancer specialty clinics, chemotherapy clinics, infusion centers, day surgery, etc.)

These sources should be checked thoroughly and periodically to ensure that all cancer patients receiving inpatient or outpatient services from the hospital are included in the registry.

REFERENCE DATE

The reference date is the start date after which all eligible cases must be included in the tumor registry. The Montana Legislature established Montana's reference date as January 1, 1979.

REPORTABLE LIST

According to the Administrative Rules of Montana (37.8.1801), the following tumors are to be submitted for reporting. Reportable cancer cases should be submitted to the MCTR within six months after the patient's date of first contact. The list is based on those cases which are categorized as malignant, in-situ, or benign (for types listed below) by the International Classification of Diseases for Oncology. The MCTR requires non-analytic and pathology-only cases to be reported.

<table>
<tr><th>Type</th><th>Description</th></tr>
<tr><td>Reportable Diagnoses</td><td>1. All malignant neoplasms (including in-situ) (behavior code 2 or 3)

2. BCC and SCC of the labia, vagina, vulva, clitoris, penis, scrotum, prepuce, and anus

3. Cervix (CIN III), prostate (PIN III), vulva (VIN III), vagina (VAIN III), anus (AIN III), and (LIN III) larynx

4. All benign tumors of the brain (behavior code 0 or 1) INCLUDES: meninges, brain, spinal cord, cranial nerves, and other parts of the CNS, pituitary gland, craniopharyngeal duct, and pineal gland
NOTE: Juvenile astrocytoma, listed as 9421/1 in ICD-O-3, is required and should be recorded as 9421/3

5. All carcinoid tumors (malignant, benign, and NOS)
NOTE: Carcinoid tumors of the appendix must be coded to 8240/3 and must be reported with a behavior code 3

6. Gastro-intestinal stromal tumors (GIST) and thymomas are frequently non-malignant. However, they must be abstracted and assigned a behavior code of 3 if they are noted to have multiple foci, metastasis, or positive lymph nodes

7. LCIS (lobular carcinoma in situ of breast</td></tr>
<tr><td>Ambiguous Terminology Considered Diagnostic of Cancer</td><td>
<table>
<tr><td>Apparent(ly)</td><td>Most likely</td></tr>
<tr><td>Appears</td><td>Presumed</td></tr>
<tr><td>Comparable with</td><td>Probable</td></tr>
<tr><td>Compatible with</td><td>Suspect(ed)</td></tr>
<tr><td>Consistent with</td><td>Suspicious (for)</td></tr>
<tr><td>Favor</td><td>Typical (of)</td></tr>
<tr><td>Malignant appearing</td><td>Neoplasm or Tumor for C70.0-C72.9, C75.1-C75.3</td></tr>
</table>
Exception: If a cytology is identified only with an ambiguous term, do not interpret it as a diagnosis of cancer. Abstract the case only if a positive biopsy or a physician's clinical impression of cancer supports the cytology findings.

Do not substitute synonyms such as "supposed" for "presumed", "equal" for "comparable" or "likely" for "most likely".

<u>Examples of reportable ambiguous terms</u>:
• Chest x-ray states consistent with carcinoma of the right upper lobe of the lung. The patient refused further work-up or treatment. Consistent with carcinoma is indicative of cancer.
• CT of brain suspicious for neoplasm. Neoplasm is reportable for C70.0-C72.9, C75.1-C75.3.
• The pathology report states suspicious for malignancy. Suspicious for malignancy is indicative of cancer.
</td></tr>
</table>

Type	Description
Exceptions (not reportable)	1. Basal Cell Carcinoma (BCC) or Squamous Cell Carcinoma (SCC) of skin (C44._) with histologies 8000-8005, 8010-8046, 8050-8084, 8090-8110 2. Patients with a history of malignancy who are clinically free of disease when seen at your facility 3. Patients diagnosed with a probable carcinoma and subsequently ruled out (see list of Ambiguous Terms) Example: A patient was diagnosed with probable lung carcinoma in June 1995 and a biopsy performed in July 1995 revealed no evidence of cancer. 4. Patients who receive transient care to avoid interrupting a course of therapy started elsewhere Example: A patient who lives in Idaho is visiting and receives scheduled chemotherapy started in Idaho. 5. Out-of-state patients with a history of or evidence of cancer who are not receiving cancer treatment or are seen for an unrelated medical condition 6. Genetic findings in the absence of pathologic or clinical evidence of reportable disease are indicative of risk only and do not constitute a diagnosis
Ambiguous Terminology NOT Considered Diagnostic of Cancer	Cannot be ruled out — Questionable Equivocal — Rule out Possible — Worrisome Potentially malignant — Suggests Examples of non-reportable ambiguous terms: • Chest x-ray states *consistent with neoplasm* of left upper lobe of lung. The patient refused further work-up or treatment. *Consistent with neoplasm* is not indicative of cancer. While "consistent with" can indicate involvement, "neoplasm" without specification of malignancy is not diagnostic except for non-malignant primary intracranial and central nervous system tumors. • Mammogram notes p*ossible carcinoma* of the breast. "Possible" is not a diagnostic term for cancer. • Mammogram notes *suspicious* density. While "suspicious" can indicate a problem, "density" is not indicative of cancer.

Ambiguous Terminology Lists:

When abstracting, registrars are to use the Ambiguous Terms at Diagnosis list with respect to case reportability, and the Ambiguous Terms Describing Tumor Spread list with respect to tumor spread for staging purposes.

The first and foremost resource for the registrar for questionable cases is the physician who diagnosed and/or staged the tumor. The ideal way to approach abstracting situations when the medical record is not clear is to follow up with the physician. If the physician is not available, the medical record, and any other pertinent reports (e.g., pathology, etc.) should be read closely for the required information. The purpose of the Ambiguous Terminology lists is so that in the case where wording in the patient record is ambiguous with respect to re portability or tumor spread and no further information is available from any resource, registrars will make consistent decisions. When there is a clear statement of malignancy or tumor spread (i.e., the registrar can determine malignancy or tumor spread from the resources available), they should not refer to the Ambiguous Terminology lists. Registrars should only rely on these lists when the situation is not clear and the case cannot be discussed with the appropriate physician/pathologist.

The CoC recognizes that not every registrar has access to the physician who diagnosed and/or staged the tumor, as a result, the Ambiguous Terminology list delineated above must be used in Coe-accredited programs as "references of last resort."

Ambiguous Terms that Constitute a Diagnosis: apparent(ly), appears, comparable with, compatible with, consistent with, favors, malignant appearing, most likely, presumed, probable, suspect(ed), suspicious (for), typical of, tumor (for C70.0-C72.9, C75.1-C75.3), neoplasm (for C70.0-C72.9, C75.1-C75.3).

Ambiguous Terms that DO NOT constitute a diagnosis without additional information: cannot be ruled out, equivocal, possible, potentially malignant, questionable, rule out, suggests, worrisome.

Ambiguous Terms that Describe Tumor Spread: adherent, apparent, compatible with, consistent with, encroaching upon, fixation, fixed, induration, into, onto, out onto, probable, suspect, suspicious, to.

Ambiguous Terms that DO NOT Constitute tumor involvement or spread: approaching, equivocal, possible, questionable, suggests, very close to.

Reportable ICD-10-CM Codes

ICD-10-CM Code	Description
C00._ - C43._, C4A._, C45._ - C96._	Malignant neoplasms Includes: BCC and SCC of the labia (C51.0-C51.1), vagina (C52.9), vulva (C51.9), clitoris (C51.2), penis (C60.1-C60.9), scrotum (C63.2), prepuce (C60.0), and anus (C21.0)
C49.A-	Gastrointestinal Stromal Tumors
C7A._	Malignant carcinoid tumors
C84.A_	Cutaneous T-cell lymphoma
C84.Z_	Other mature T/NK-cell lymphoma
C91.A_	Mature B-cell leukemia Burkitt-type
C91.Z_	Other lymphoid leukemia
C92.A_	Acute myeloid leukemia with multi-lineage dysplasia
C92.Z_	Other myeloid leukemia
C93.Z_	Other monocytic leukemia
C96.2_	Malignant mast cell neoplasms
C96.A_	Histiocytic sarcoma
C96.Z_	Other specified malignant neoplasm of lymphoid, hematopoietic, and related tissue
D00._ - D09._	In situ neoplasms Note: Carcinoma in-situ of the cervix (CIS), intraepithelial neoplasia grade III (8077/2) of the cervix (CIN III), prostate (PIN III), vulva (VIN III), vagina (VAIN III), anus (AIN III), and (LIN III) larynx are reportable
D18.02	Hemangioma of intracranial structures and any site
D3Aa._	Carcinoid tumors (any behavior) and neuroendocrine tumor (malignant only)
D32._	Benign neoplasms of meninges (cerebral, spinal and unspecified)
D33._	Benign neoplasm of brain and other parts of central nervous system
D35.2 - D35.4	Benign neoplasm of pituitary gland, craniopharyngeal duct and pineal body
D42._, D43._	Neoplasm of uncertain or unknown behavior or meninges, brain, CNS
D44.3 - D44.5	Neoplasm of uncertain or unknown behavior of pituitary gland, craniopharyngeal duct and pineal gland
D45	Polycythemia vera (9950/3) Note: Excludes familial polycythemia (C75.0), secondary polycythemia (D75.1)
D46._	Myelodysplastic syndromes (9980, 9982/ 9983, 9985, 9986, 9989, 9991, 9992)
D47._	Myeloproliferative diseases (9931, 9740, 9741, 9742, 9960, 9961, 9962, 9963, 9965, 9966, 9967, 9970, 9971, 9975, 9987)
D47.Z1	Post-transplant lymphoproliferative disorder (PTLD)
D47.3	Essential (hemorrhagic) thrombocythemia (9962/3) Includes: essential thrombocytosis, idiopathic hemorrhagic thrombocythemia
D49.6, D49.7	Neoplasms of unspecified behavior of brain, endocrine glands and other CNS
J91.0	Malignant Pleural Effusion
R18.0	Malignant ascites
R85.614	Cytologic evidence of malignancy on smear of anus
R87.614	Cytologic evidence of malignancy on smear of cervix
R87.624	Cytologic evidence of malignancy on smear of vagina
Z51.0	Encounter for antineoplastic radiation therapy
Z51.1_	Encounter for antineoplastic chemotherapy and immunotherapy

QUALITY CONTROL

Accuracy and consistency are essential in tumor registry reporting. A computerized tumor registry should conduct minimal data quality checks. This includes visual review of abstracts and computerized edit checks on each abstract prior to submission to the MCTR. The MCTR will perform quality assurance tasks upon receipt of abstracts from each reporting institution. Review procedures may include visual review of abstracts, review of accession register and abstracts, and periodic re-abstracting of cases. The reporting facility will be required to resolve incomplete, incorrect, or inconsistent data upon MCTR query.

FOLLOW-UP

Annual follow-up of patients is an important cancer registry function. The MCTR conducts yearly lifetime follow-up on all reported cases. Follow-up is based on the date of last contact and is delinquent (lost) if no contact has been made within 15 months after the date of last follow-up information. Cases that are lost-to-follow-up (delinquent) should remain in the follow-up process until follow-up information is obtained.

Follow-up data must include the date(s) and type(s) of treatment for cancer, the site(s) of distant metastasis, date and type of recurrence, subsequent treatment for progressive disease or recurrence, the site and histology of any subsequent primary, the date of last contact, the patient's current physician, and the status of the patient and the cancer.

CONFIDENTIALITY

All data concerning cancer patients is held in strict confidence by the MCTR. Confidentiality is of paramount importance; the privacy of patients, physicians, and hospitals is strictly maintained. As it is elsewhere, confidentiality is an issue of increasing concern to cancer registries. The MCTR's Data Release Policy can be found on the website https://dphhs.mt.gov/publichealth/Cancer/TumorRegistry.

PROCEDURE MANUAL

Tumor registries should maintain a complete, up-to-date procedure manual that documents each phase of its operations. A procedure manual is a valuable and necessary tool used to organize and maintain an effective, efficient program. When adhered to, this manual will ensure a smooth operation with consistent and accurate abstracting, systematic and continuous follow-up, and complete and timely reporting.

The procedure manual should contain:

- The objectives of the cancer registry
- Job descriptions and specifications of registry positions
- Case eligibility criteria
- The reportable list
- Procedures for casefinding, maintaining and using a suspense file, and accessioning
- A description of the registry filing system
- Documentation of data collection methods, including principles of abstracting, detailed definitions for each data item, references used for coding systems, if applicable, and staging systems used
- Follow-up procedures
- Documentation of quality control procedures
- A description of reporting mechanisms
- Policy statements about confidentiality and release of information

UNIQUE PATIENT IDENTIFIERS

Accession Number and *Sequence Number* uniquely identify the patient and the tumor. Each cancer patient in a registry is assigned a unique accession number, and each primary diagnosed for that patient is assigned a sequence number. The accession number never changes.

- Accession numbers are never reassigned, even if a patient is removed from the registry.
- The sequence number is the sequence of all tumors over a lifetime of a patient and is counted throughout the patient's lifetime.
- Only tumors that would have been reportable at the time of diagnosis or by agreement with a central registry or the program's cancer committee are required to be counted when assigning sequence numbers. A registry may contain a single abstract for a patient with a sequence number of 02, because the first tumor had been either diagnosed and treated elsewhere or diagnosed and/or treated before the facility's reference date. Because of differences in requirements, however, it is still possible for two registries with dissimilar eligibility requirements (for example, a facility registry and a state central registry) to assign different sequence numbers to the same tumor, even though the sequence number codes and instructions applied are the same.

NATIONAL PROVIDER IDENTIFIER

The National Provider Identifier (NPI) is a unique identification number for health care providers that was implemented in 2007 and 2008 by the Centers for Medicare and Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008. Individual item descriptions in this manual should be reviewed for specific coding instructions.

MULTIPLE PRIMARIES

The 2018 **SEER Solid Tumor Rules** and **SEER Hematopoietic and Lymphoid Neoplasm Database** should be used to determine the number of primaries to be reported and for coding detailed histology and primary sites.

PAIRED ORGANS

A list of paired organ sites can be found earlier in this section with the coding instructions for *Laterality*. Refer to the **SEER Solid Tumor Rules** to determine whether involvement of paired sites should be coded as one or two primaries.

CODING DATES

Beginning in 2010, the way dates are transmitted between facility registries and central registries or the National Cancer DataBase (NCDB) was changed to improve the interoperability or communication of cancer registry data with other electronic record systems. Registry software may display dates in the traditional manner or in the interoperable format. Traditional dates are displayed in MMDDCCYY form, with 99 representing unknown day or month portions, and 99999999 representing a completely unknown date. In the traditional form, some dates also permit 88888888 or 00000000 for special meaning. Interoperable dates are displayed in CCYYMMDD form, with the unknown portions of the date filled with blank spaces. If the date is entirely blank, an associated date flag is used to explain the missing date. The following table illustrates the relationship among these items where each lower case 'b' represents a blank space. Flags are not used for software-generated dates.

Description	**Traditional Date** **Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999**	**Interoperable Date** **Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces);omit the date if the date is completely unknown**	**Date Flag**
Full date known	MMDDYYCC (example: 02182010)	CCYYMMDD (example: 20100218)	bb
Month and year known	MM99CCYY (example: 02992010)	CCYYMMbb (example: 201002bb)	bb
Year only known	9999CCYY (example: 99992010)	CCYYbbbb (example: 2010bbbb)	bb
Unknown if any surgery performed	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	10
No surgery performed, not applicable	00000000 (example: 00000000)	bbbbbbbb (example: bbbbbbbb	11
Date is unknown, surgery performed	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb	12
Surgery is planned, not yet begun	88888888 (example: 88888888)	bbbbbbbb (example: bbbbbbbb)	15

ESTIMATING DATES

Estimating the Month:

- Code "Spring" to April
- Code "Summer" or "middle of the year" to July
- Code "Fall" or "Autumn" to October
- For "Winter of", try to determine if the physician means the first of the year or the end of the year and code January or December as appropriate.
- Code "early in the year" to January
- Code "late in the year" to December
- Code the month of admission when there is no basis for estimation

Estimating the Year:

- Code "a couple years" to two years earlier
- Code "a few years" to three years earlier
- Use whatever information is available to calculate the year
- Code the year of admission when there is no basis for estimation

REVISING THE ORIGINAL DIAGNOSIS

Data are gathered from multiple sources using the most recent and complete information available. Over time, the patient's records may contain new information such as tests, scans, and consults. Change the primary site, laterality, histology, grade, and stage as the information becomes more complete. If the primary site is changed, it may also be necessary to revise site-specific staging and treatment codes. There is no time limit for making revisions that give better information about the original diagnosis or stage. However, if staging information is updated, it is important to adhere to the timing requirements for the respective staging system. Most cases that require revision are unknown primaries.

Examples:

1) The institution clinically diagnoses a patient with carcinomatosis. The registry enters the case as an unknown primary (C80.9), carcinoma, NOS (8010/3), stage of disease unknown. Nine months later, a paracentesis shows serous cystadenocarcinoma. The physician says that the patient has an ovarian primary. Change the primary site to ovary (C56.9), histology to serous cystadenocarcinoma (8441/3), and diagnostic confirmation to positive cytologic study, no positive histology (code 2). If enough information is available that meets the AJCC timing requirements for staging, change the stage from not applicable (88) to the appropriate staging basis, TNM elements, and stage group, or to unknown. Update the Collaborative Stage input items and rerun the derivation program. If first course surgery was performed, the surgery codes should be reviewed.

2) A physician may decide that a previously clinically diagnosed malignancy is a benign lesion. The patient is referred from a nursing home to the facility. The chest x-ray shows a cavitary lesion in the right lung. The family requests that the patient undergo no additional workup or treatment. Discharge diagnosis is "probable carcinoma of right lung". The registrar abstracts a lung primary (C34.9). Two years later a chest x-ray shows an unchanged lesion. The physician documents "lung cancer ruled out". Delete the case from the registry. Adjust the sequence number(s) of any other primaries the patient may have. Do not reuse the accession number.

OUTCOMES

The outcomes data items describe the known clinical and vital status of the patient. Follow-up information is obtained at least annually for all living patients included in a cancer registry's database. Recorded follow-up data should reflect the most recent information available to the registry that originates from reported patient hospitalizations, known patient readmissions, contact with the patient's physician, and/or direct contact with the patient.

Individual data item descriptions should be consulted for specific coding instructions. The paragraphs below describe the range of follow-up information that should be obtained.

Follow-up items that are required to be in the facility's database:

There may be times when first course treatment information is incomplete. Therefore, it is important to continue follow-up efforts to be certain the necessary treatment information is collected. This includes:

- Complete first course of treatment information when *Surgery of Primary Site* is delayed six months or more following the *Date of First Contact*.
- *Readmission to the Same Hospital Within 30 Days of Surgical Discharge* following the most definitive surgery.
- Radiation, chemotherapy, hormone therapy, immunotherapy, hematologic transplant and endocrine procedures, or other treatment that had been indicated as being planned as part of first course of treatment, but not been started or completed as of the most recent follow-up date. Use "reason for no" treatment codes of 88 or 8 as ticklers to identify incomplete treatment information.
- When all planned first course treatment has been recorded, first course treatment items no longer need to be followed.
- Follow-up for disease recurrence should be conducted until (a) evidence of disease recurrence is reported, or (b) the patient dies. If the *Type of First Recurrence* is coded 70 (never cancer free), when the patient was last seen, but treatment was still underway, then check at follow-up to see whether the patient subsequently became cancer-free. Occasionally, if first course treatment ends due to disease progression, it may be second course or subsequent treatment that results in a cancer-free status. If the *Type of First Recurrence* is coded 00 (became cancer-free and has had no recurrence), then continue to follow for recurrence and record the type and date when it occurs.

Once the first recurrence has been recorded, do not update recurrence items further.

While the patient is alive, be sure that contact information is kept current. Contact information includes:

Current Street Address	Current Zip Code
Current City	Telephone
Current State	Date of Last Contact

Follow-up for *Vital Status* and *Cancer Status* should be conducted annually for all cases in the cancer registry.

Once the patient's death has been recorded, no further follow-up is performed.

CASE ADMINISTRATION

Correct and timely management of case records in a registry data set are necessary to describe the nature of the data in the cancer record and to facilitate meaningful analysis of data, and it is necessary to understand each item's respective purpose to ensure their accuracy and how to use them in analysis.

Administrative Tracking

The following administrative tracking items are required to be in the facility's database:

- *Abstracted By*
- *Facility Number*

Abstracted By and *Hospital Number* identify the individual and facility responsible for compiling the record.

- In a registry with more than one abstractor or serving more than one facility, it will ordinarily be necessary to enter Abstracted By or Facility Number only when it changes.

The items, *Abstracted By* and *Facility Number*, should be autocoded by the registry software.

EDITS Overrides

The following override items are required to be in the facility's database:

- *Override Acsn/Class/Seq*
- *Override Age/Site/Morph*
- *Override CoC – Site/Type*
- *Override Site/Type*
- *Override Histology*
- *Override Leuk/Lymphoma*
- *Override Site/Behavior*
- *Override Site/Lat/Morph*
- *Override HospSeq/DxConf*
- *Override HospSeq/Site*
- *Override Site/TNM-StgGrp*
- *Override Surg/DxConf*
- *Override Seq/DxConf*
- *Override Site/Lat/Seq*
- *Override Report Source*
- *Override Ill-defined Site*

A series of override items designed to work with the EDITS package have been added with the publication of FORDS. Some of the edits identify rare, but possible, code combinations. For these edits, an override flag can be set if, upon review, the unusual combination is verified as being correct. Once set, the error message will not be repeated on subsequent EDITS passes.

- When no error message is generated by an edit that uses an override item, no action by the registrar is needed.
- If an error message is generated, the problem can often be resolved by checking the accuracy of the entry for each item that contributes to the edit and correcting any problems identified. If correction of data entry errors resolves the problem, no override entry is needed. If the codes reflect the information in the patient record, check for physician notes indicating the unusual combination of circumstances (for example, a colon adenocarcinoma in a child) has been confirmed.
- Enter the override code according to the instructions in the data item. If no comment regarding the unusual circumstances can be found in the record, it may be necessary to check with the managing physician or pathologist to determine whether it is appropriate to override the edit.

Patient Information

Reporting Hospital

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Hospital (Reporting Facility)	540	3	04/07, 01/12, 01/13	Required

Description

Identifies the facility reporting the case.

Rationale

Each facility's identification number is unique. The number is essential to monitor data submissions, ensuring the accuracy of data, and for identifying areas for special studies.

Coding Instructions

- Reporting Hospital is automatically coded by the software provider.

Montana Reporting Facilities

Number Hosp	NPI Number	ACoS Number	Facility Name	City
403	1568629764	6810010	Community Hospital of Anaconda	Anaconda
411	1316965346	6810013	Fallon Medical Complex	Baker
458	1730129305	6810005	Big Sandy Medical Center	Big Sandy
412	1265478291	6810020	Billings Clinic	Billings
413	1083655997	6810030	St. Vincent Healthcare	Billings
407	1720079619	6810040	Bozeman Health	Bozeman
400	1528037215	6810055	St. James Healthcare	Butte
414	1497754782	6810085	Liberty Medical Center	Chester
415	1083602205	6810095	Teton Medical Center	Choteau
409	1054388387	6810100	Stillwater Billings Clinic	Columbus
416	1467445049	6810110	Pondera Medical Center	Conrad
417	1598874232	6810123	Roosevelt Medical Center	Culbertson
418	1831143080	6810125	Northern Rockies Medical Center	Cut Bank
419	1275560617	6810129	Deer Lodge Medical Center	Deer Lodge
420	1326042078	6810135	Barrett Hospital and Healthcare	Dillon
421	1760531404	6810150	Dahl Memorial Healthcare	Ekalaka
405	1740223882	6810155	Madison Valley Medical Center	Ennis
422	1023066081	6810160	Rosebud Healthcare Center	Forsyth
423	1356332266	6810170	Missouri River Medical Center	Fort Benton
424	1689685323	6810190	Frances Mahon Deaconess Hospital	Glasgow
425	1376552893	6810220	Glendive Medical Center	Glendive
427	1881650737	6810245	Benefis/Sletten Cancer Institute	Great Falls
480	1801897780	10000701	Great Falls Clinic	Great Falls
429	1659475846	6810260	Marcus Daly Memorial Hospital	Hamilton
430	1891713533	6810272	Big Horn County Memorial Hospital	Hardin
431	1073687406	6810285	Wheatland Memorial Healthcare	Harlowton
432	1427059070	6810290	Northern Montana Healthcare	Havre
434	1710152277	6810330	St. Peter's Health	Helena
477	1417945627	6810360	Kalispell Regional Healthcare	Kalispell
438	1790798387	6810380	Central Montana Medical Center	Lewistown
439	1952312050	6810390	Cabinet Peaks Medical Center	Libby
408	1245222306	6810395	Livingston Healthcare	Livingston
440	1255476388	6810405	Phillips County Hospital	Malta
441	1548292220	6810410	Holy Rosary Healthcare	Miles City
443	1396711396	6810415	Community Medical Center	Missoula
445	1023032588	6810225	St. Patrick Hospital	Missoula
402	1922073907	6810440	Granite County Medical Center	Philipsburg
471	1265547939	6810445	Clark Fork Valley Hospital	Plains
446	1467452102	6810450	Sheridan Memorial Hospital	Plentywood

Number	NPI Number	ACoS Number	Facility Name	City
447	1821184888	6810460	Providence St. Joseph Medical Center	Polson
448	1396766903	6810465	Northeast Montana Health Services	Poplar
410	1336119338	6810477	Beartooth Billings Clinic	Red Lodge
467	1336213446	6810481	St. Luke Community Healthcare	Ronan
449	1386751196	6810485	Roundup Memorial Healthcare	Roundup
451	1346224391	6810505	Daniels Memorial Healthcare Center	Scobey
468	1497742415	6819070	Marias Medical Center	Shelby
469	1083710651	6819075	Ruby Valley Hospital	Sheridan
452	1285719161	6810510	Sidney Health Center	Sidney
470	1093809196	6819080	Mineral Community Hospital	Superior
404	1447245857	6810530	Broadwater Health Center	Townsend
454	1396710851	6810550	North Valley Hospital	Whitefish
457	1811102270	6819100	Mountainview Medical Center	White Sulphur Springs
455	1821016536	6810560	Northeast Montana Health Services	Wolf Point
VAMC				
463	1457546384	6810180	Montana VAMC	Fort Harrison
IHS				
478	1861409955	6810050	Blackfeet Indian Health Services	Browning
462	1235302142	6810120	Crow IHS Hospital	Crow Agency
464	1942367842	6810280	Fort Belknap IHS Hospital	Harlem
474	1972694602	9999999	Fort Peck IHS Poplar Health Services	Poplar

Abstracted By

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	570	3		Required

Description

Records the initials or assigned code of the individual abstracting the case.

Rationale

This item can be used for quality control and management in multi-staffed registries.

Coding Instructions

- Code the initials of the abstractor. Most software vendors automatically code this field when the user logs into the software.
- Do not record the initials of a data-entry person unless that person is also the abstractor.

Code	Definition
(fill spaces)	Initials or code of abstractor

Type of Reporting Source

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	500	1	09/06	Required

Description

Codes the source documents used to abstract the majority of information on the tumor being reported. This may not be the source of original case finding (for example, if a case is identified through a pathology laboratory report review and all source documents used to abstract the case are from the physician's office, code this item 4).

Rationale

The code in this field can be used to explain why information may be incomplete on a tumor. For example, death certificate only cases have unknown values for many data items, so one may want to exclude them from some analyses. The field also is used to monitor the success of non-hospital case reporting and follow-back mechanisms. All population-based registries should have some death certificate-only cases where no hospital admission was involved, but too high a percentage can imply both shortcomings in case-finding and that follow-back to uncover missed hospital reports was not complete.

Coding Instructions

- Code in the following priority order: 1, 2, 8, 4, 3, 5, 6, 7. The source facilities included in the previous code 1 are split between codes 1, 2, and 8.
- Field should not be left blank.

Code	Report Source	Priority
1	Hospital (inpatient or outpatient) Clinic (free standing) Managed health plans with comprehensive, unified medical records	1
2	Radiation Treatment Centers Medical Oncology Centers (hospital-affiliated or independent)	2
3	Laboratory (hospital-affiliated or private) Pathology reporting only	5
4	Physician's Office Private medical practitioner	4
5	Nursing Convalescent home Hospice	6
6	Autopsy only	7
7	Death certificate only (for MCTR use only)	8
8	Other hospital outpatient units Surgery centers	3

This data item is intended to indicate the completeness of information available to the abstractor. Reports from health plans (e.g., Kaiser, Veterans Administration, military facilities) in which all diagnostic and treatment information is maintained centrally and is available to the abstractor are expected to be at least as complete as reports for hospital inpatients, which is why these sources are grouped with inpatients and given the code with the highest priority.

Sources with code "2" usually have complete information on the cancer diagnosis, staging, and treatment.

Code 6, Autopsy only, means that the cancer was not diagnosed even as a clinical diagnosis while the patient was alive. Autopsy findings take precedence over death certificate information (i.e., Code 6 takes precedence over code 7). However, a clinical diagnosis of cancer at any of the sources coded 1 through 5 has priority over confirmation at autopsy.

Sources coded with "8" would include, but would not be limited to, outpatient surgery and nuclear medicine services. A physician's office that calls itself a surgery center should be coded as a physician's office. Surgery centers are equipped and staffed to perform surgical procedures under general anesthesia. If a physician's office calls itself a surgery center, but cannot perform surgical procedures under general anesthesia, code as a physician's office.

Suspense Case

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
		1		Optional

Description

Identifies a case that has not been completely abstracted.

Rationale

Registrars may desire to use the “suspense” code (1) when first abstracting a record with incomplete information and after completion then changing the record back to a non-suspense record (0). The “suspense” record is like flagging a record that has been started but not completed. Cases that are flagged suspense (1) are not submitted to the MCTR until the flag is changed to a 0.

Coding Instructions

Code	Description
(leave blank)	Not a suspense record (default code)
1	Suspense record

Accession Number

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	550	9	01/04, 01/10	Required

Description

Provides a unique identifier for the patient consisting of the year in which the patient was first seen at the reporting facility and the consecutive order in which the patient was abstracted.

Rationale

This data item protects the identity of the patient and allows cases to be identified on a local, state, and national level.

Coding Instructions

- Assign a unique accession number to each patient. The accession number identifies the patient even if multiple primaries exist. Use the same accession number for all subsequent primaries.
- When a patient is deleted from the database, do not reuse the accession number for another patient.
- The first four numbers specify the year (of first contact with cancer) and the last five numbers are the numeric order in which the patient was entered into the registry database.
- Numeric gaps are allowed in accession numbers.
- A patient's accession number is never reassigned.
- If a patient is first accessioned into the registry, then the registry later changes its reference date and the patient is subsequently accessioned into the registry with a new primary, use the original accession number associated with the patient and code the data item *Sequence Number* appropriately.

Code	Definition
(fill spaces)	Nine-digit number used to identify the year in which the patient was first seen at the reporting facility for the diagnosis and/or treatment of cancer

Examples:

Code	Reason
200300033	Patient enters the hospital in 2003 and is diagnosed with breast cancer. The patient is the 33rd patient accessioned in 2003.
200300033	A patient with the accession number 200300033 for a breast primary returns to the hospital with a subsequent colon primary in 2004. The accession number will remain the same. *Sequence Number* will reflect this primary.
200300010	Patient is diagnosed in November 2002, at another facility enters the reporting facility in January 2003, and is the tenth case accessioned in 2003.
200300012	Patient is diagnosed in staff physician office in December 2002 enters the reporting facility in January 2003 and is the 12th case accessioned in 2003.
199100067	Patient enters the hospital in 1991 and is diagnosed with prostate cancer. The registry later sets a new reference date of January 1, 1997. The same patient presents with a diagnosis of lymphoma in 2005. *Sequence Number* will distinguish this primary.
200300001	First patient diagnosed/treated and entered into the registry database for 2003.
200300999	999th patient diagnosed/treated and entered into the registry database for 2003.
200401504	1504th patient diagnosed/treated and entered into the registry database for 2004.

Sequence Number

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	560	2	04/07, 01/10, 01/12, 01/13	Required

Description

Indicates the sequence of reportable malignant and non-malignant neoplasms over the lifetime of the patient. Use the *Remarks Text* field to document information about prior tumors that support sequence number.

Rationale

This data item is used to distinguish among cases having the same accession numbers, to select patients with only one malignant primary tumor for certain follow-up studies, and to analyze factors involved in the development of multiple tumors.

Coding Instructions

- Codes 00-59 and 99 indicate neoplasms of malignant (in situ or invasive) (behavior code 2 or 3).
- Codes 60-88 indicate neoplasms of non-malignant behavior (behavior code 0 or 1) and malignant neoplasms that the MCTR has defined as reportable that the CoC does not require (carcinoma in-situ of the cervix (CIS), intraepithelial neoplasia grade III (8077/2) of the cervix (CIN III), prostate (PIN III), vulva (VIN III), vagina (VAIN III), larynx (LIN III), and anus (AIN III).
- Code 00 only if the patient has a single malignant primary. If the patient develops a subsequent invasive or in-situ primary tumor, change the code for the first tumor from 00 to 01, and number the subsequent tumors sequentially.
- Code 60 only if the patient has a single non-malignant primary or reportable neoplasm that the MCTR has defined as reportable that the CoC does not require (see list above). If the patient develops a subsequent non-malignant primary, change the code for the first tumor from 60 to 61, and assign codes to subsequent non-malignant primaries sequentially.
- If two or more invasive or in-situ neoplasms are diagnosed at the same time, assign the lowest sequence number to the diagnosis with the worst prognosis. If no difference in prognosis is evident, the decision is arbitrary.
- If two or more non-malignant neoplasms are diagnosed at the same time, assign the lowest sequence number to the diagnosis with the worst prognosis. If no difference in prognosis is evident, the decision is arbitrary.
- Any tumor in the patient's past which is reportable or reportable-by-agreement at the time the current tumor is diagnosed must be taken into account when sequencing subsequently accessioned tumors. However, do not reassign sequence numbers if one of those tumors becomes non-reportable later.
- Sequence numbers should be reassigned if the facility learns later of an unaccessioned tumor that would affect the sequence.

Malignant or In-situ

Code	Definition
00	One malignant or in-situ primary only in the patient's lifetime
01	First of two or more independent malignant or in-situ primaries
02	Second of two or more independent malignant or in-situ primaries
…	
…	(Actual sequence of this malignant or in-situ primary)
…	
59	Fifty-ninth of 59 or more independent malignant or in-situ primaries
99	Unknown number of malignant or in-situ primaries

Required by MCTR (see pages 12-15)

(CIS) carcinoma in-situ of the cervix
(CIN III) cervix
(PIN III) prostate
(VIN III) vulva
(VAIN III) vagina
(AIN III) anus
(LIN III) larynx
Benign tumors of brain and CNS
Uncertain carcinoid

Code	Definition
60	Only one non-malignant primary or in-situ case required by MCTR listed above
61	First of two or more independent non-malignant primaries or in-situ case required by MCTR listed above
62	Second of two or more independent non-malignant primaries or in-situ case required by MCTR listed above
…	
…	(Consecutive number of non-malignant primaries) or in-situ case required by MCTR listed above
…	
87	Twenty-seventh of twenty-seven independent non-malignant primaries or in-situ case required by MCTR listed above
88	Unspecified number of neoplasms in this category

Examples:

Code	Reason
00	A patient with no history of previous cancer is diagnosed with in-situ breast carcinoma June 13, 2003.
01	The sequence number is changed when the patient with an in-situ breast carcinoma diagnosed on June 13, 2003, is diagnosed with a subsequent melanoma on August 30, 2003.
02	Sequence number assigned to the melanoma diagnosed on August 30, 2003, following a breast cancer in-situ diagnosed on June 13, 2003.
04	A nursing home patient is admitted to a hospital for first course surgery for a colon adenocarcinoma. The patient has a prior history of three malignant cancers of the type the registry is required to accession, though the patient was not seen for these cancers at the hospital. No sequence numbers 01, 02, or 03 are accessioned for this patient.
60	The sequence number assigned to a benign brain tumor diagnosed on November 1, 2005, following a breast carcinoma diagnosed on June 13, 2003, and a melanoma diagnosed on August 30, 2003.
63	Carcinoma in-situ of the cervix (CIN III) is diagnosed by the facility in 2003 and accessioned as sequence 60. A benign brain tumor was diagnosed and treated elsewhere in 2002; patient comes to the facility with a second independent benign brain tumor in 2004. Unaccessioned earlier brain tumor is counted as sequence 61, CIN III is re-sequenced to 62, and second benign brain tumor is assigned sequence 63.

Last Name

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Name – Last	2230	40	01/10	Required

Description

Identifies the last name of the patient.

Rationale

This data item is used by hospitals as a patient identifier.

Coding Instructions

- Truncate name if more than 40 letters long. Blanks, spaces, hyphens, and apostrophes are allowed.
- Do not use other punctuation.
- Do not leave blank; code as unknown if the patient's last name is unknown.
- This field may be updated, if the last name changes.

Examples:

Code	Reason
Mc Donald	Recorded with space as Mc Donald
O'Hara	Recorded with apostrophe as O'Hara
Smith-Jones	Janet Smith marries Fred Jones and changes her name to Smith-Jones
UNKNOWN	Patient's last name is unknown, use UNKNOWN

First Name

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Name – First	2240	40	01/10, 01/11	Required

Description

Identifies the first name of the patient.

Rationale

This data item is used by hospitals to differentiate between patients with the same last name.

Coding Instructions

- Truncate name if more than 40 letters long. Blanks, spaces, hyphens, and apostrophes are allowed. Do not use other punctuation.
- This field may be updated if the name changes.

Examples:

Code	Reason
Michael	Patient is admitted as Michael David Hogan
(leave blank)	If patient's first name is not known, do not fill in the space

Middle Name

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Name – Middle	2250	40	01/10, 01/11	Required

Description

Identifies the middle name or middle initial of the patient.

Rationale

This data item helps distinguish between patients with identical first and last names.

Coding Instructions

- Truncate name if more than 40 letters long. Record the middle initial if the complete name is not provided. Blanks, spaces, hyphens, and apostrophes are allowed. Do not use other punctuation.
- This field may be updated if the name changes.

Examples:

Code	Reason
David	Patient's name is Michael David Hogan
D	Patient's name is Michael D. Hogan
(leave blank)	If patient's middle name is not known or there is none, do not fill in the space

Maiden Name

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Name – Maiden	2390	40	01/10, 01/12	Required

Description

Identifies the maiden name of the patient.

Rationale

Maiden name may be useful in matching multiple records for the same patient.

Coding Instructions

- Truncate the name if more than 40 letters long. Do not use punctuation.
- Leave blank if unknown or patient was never married.
- Record only the last name of the maiden name (i.e., MILLER).

Alias

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Name – Alias	2280	40	01/10	Required

Description

Identifies the alias or nickname of the patient.

Rationale

This item is useful for matching multiple records on the same patient.

Coding Instructions

- If the patient uses only a last name alias, record the last name alias followed by a blank space and the real first name.
- If the patient uses an alias for the first name, record the last name followed by a blank space and the alias name.
- If the patient uses an alias for the first and last name, record the last name alias followed by a blank space and the first name alias.
- Leave the field blank if the patient has no alias.

Examples:

Code	Reason
WILLIAMS BUD	Patient named Ralph Williams goes by Bud Williams
TWAIN MARK	Patient Samuel Clemens uses the name Mark Twain
BROWN JANICE	Patient named Janice Smith uses the name Janice Brown
(leave blank)	If patient's alias is unknown, do not fill in the space

Suffix

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Name – Suffix	2270	3		Optional

Description

Identifies the title that may follow a patient's name.

Rationale

Suffix is usually a generation identifier which helps to distinguish patients with the same name.

Coding Instructions

- Leave blank if the patient does not have a name suffix.
- If multiple suffixes are used, the generation specific suffix is to be recorded.
- Do not use punctuation.

Code	Description	Code	Description
FR	Father	DR	Doctor
SR	Senior	HON	Honorable
JR	Junior	I	First
REV	Reverend	II	Second
STR	Sister	III	Third
BR	Brother		

Date of First Contact

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Date First Seen	580	8	01/04, 09/06, 01/10, 01/11	Required

Description

Date of first contact with the reporting facility for diagnosis and/or treatment of this cancer.

Rationale

This data item can be used to measure the time between first contact and the date that the case was abstracted. It can also be used to measure the length of time between the first contact and treatment for quality of care reports.

Coding Instructions

- Record the date the patient first had contact with the facility as either an inpatient or outpatient for diagnosis and/or first course treatment of a reportable tumor. The date may be the date of an outpatient visit for a biopsy, X-ray, or laboratory test, or the date a pathology specimen was collected at the hospital.
- For analytic cases (Class of Case 00-22), the *Date of First Contact* is the date the patient became analytic. For non-analytic cases, it is the date the patient first qualified for the *Class of Case* that causes the case to be abstracted.
- If this is an autopsy-only or death certificate-only case, then use the date of death.
- If this is a path-only case, use the date the specimen was collected.
- When a patient is diagnosed in a staff physician's office, the date of first contact is the date the patient was physically first seen at the reporting facility.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date of First Contact* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of First Contact* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date. The *Date of Birth Flag* is used to explain why *Date of First Contact* is not a known date. See *Date of First Contact Flag* for an illustration of the relationships among these items.

Examples:

Code	Reason
02122008	A patient has an outpatient mammography that is suspicious for malignancy on February 12, 2008, and subsequently undergoes an excisional biopsy or radical surgical procedure on February 14, 2008
09142009	Patient undergoes a biopsy in a physician's office on September 8, 2009. The pathology specimen was sent to the reporting facility and was read as malignant melanoma. The patient enters that same reporting facility on September 14, 2009 for wide re-excision.
12072010	Patient has an MRI of the brain on December 7, 2010 for symptoms including severe headache and disorientation. The MRI findings are suspicious for astrocytoma. Surgery on December 19 removes all gross tumor.
04992003	If information is limited to the description "Spring, 2003".
07992003	If information is limited to the description "The middle of the year, 2003".
10992003	If information is limited to the description "Fall, 2003".
12992003 or 01992004	If information is limited to the description "Winter", try to determine if this means the beginning or the end of the year.

The *Date of First Contact* is the date of the facility's first inpatient or outpatient contact with the patient for diagnosis or treatment of the cancer. For analytic cases, the *Date of First Contact* is the date the patient qualifies as an analytic *Class of Case* 00-22. Usually, the *Date of First Contact* is the date of admission for diagnosis or for treatment. If the patient was admitted for non-cancer-related reasons, the *Date of First Contact* is the date the cancer was first suspected during the hospitalization. If the patient's diagnosis or treatment is as an outpatient of the facility, the *Date of First Contact* is the date the patient first appeared at the facility for that purpose.

If the patient was initially diagnosed at the facility and went elsewhere for treatment (*Class of Case* 00), but then returned for treatment that was initially expected to occur elsewhere, the *Class of Case* is updated to 13 or 14 but the *Date of First Contact* is not changed because it still represents the date the patient became analytic. If the *Class of Case* changes from non-analytic (for example, consult only, path-only, *Class of Case* 30) to analytic (for example, part of first course treatment administered at the facility, *Class of Case* 21), the *Date of First Contact* is updated to the date the case became analytic (the date the patient was admitted for treatment).

When a pathology specimen is collected off site and submitted to the facility to be read (and the specimen is positive for cancer), the case is required by the MCTR to be abstracted.

- If the patient subsequently receives first course treatment at the facility, the case becomes analytic. The *Date of First Contact* is the date the patient reported to the facility for the treatment; and the *Class of Case* is 11 or 12 if the diagnosing physician is a staff physician at the reporting facility or 20 or 21 for any other physician. A staff physician is one who is employed by the facility, is under contract with it, or has routine admitting privileges there.

When a staff physician performs a biopsy off site and the specimen is not submitted to the facility to be read, the case is not required to be abstracted unless the patient receives some first course care at the facility.

- If the patient subsequently receives first course treatment at the facility, the case is analytic and must be abstracted and followed. The *Date of First Contact* is the date the patient reported to the facility for the treatment and the *Class of Case* is 11 or 12.

For non-analytic cases, the *Date of First Contact* is the date the patient's non-analytic status begins with respect to the cancer. For example, for a patient diagnosed and treated entirely in a staff physician's office (*Class of Case* 40), the date the physician initially diagnosed the cancer is the *Date of First Contact*. For autopsy only cases, the *Date of First Contact* is the date of death.

If the state or regional registry requires pathology-only cases to be abstracted and reported, the *Date of First Contact* is the date the specimen was collected, and the *Class of Case* is 43. If a patient whose tumor was originally abstracted as a *Class of Case* 43 receives first course treatment subsequently as an inpatient or outpatient at the facility, update both *Class of Case* and *Date of First Contact* to reflect the patient's first in-person contact with the facility.

Date of First Contact Flag

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	581	2	New 01/10	Required

Description

This flag explains why there is no appropriate value in the corresponding date field, *Date of First Contact*.

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

- Leave this item blank if *Date of First Contact* has a full or partial date recorded.
- Code 12 if the *Date of First Contact* cannot be determined at all.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Definition
12	A proper value is applicable but not known (for example, date of first contact is unknown)
(Blank)	A valid date is provided in item *Date of First Contact*

Medical Record Number

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Chart Number	2300	11	01/11	Required

Description

Records the medical record number usually assigned by the reporting facility's health information management (HIM) department.

Rationale

This number identifies the patient within a reporting facility. It can be used to reference a patient record and it helps to identify multiple reports on the same patient.

Coding Instructions

- Record the medical record number.

Examples:

Code	Reason
_ _ _ _ _ _ _NNNN	If the medical record number is fewer than 11 characters, right justify the characters and allow leading blanks
_ _ _ _ _NNNNRT (Radiology) _ _ _ _ _ _ _NNSU (Surgery clinic)	Record standard abbreviations for departments that do not use HIM medical record numbers
_ _ _ _ _ _ _ _UNK	The medical record is unknown

Social Security Number

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2320	9		Required

Description

Records the patient's Social Security number.

Rationale

This data item can be used to identify patients with similar names.

Coding Instructions

- Code the patient's Social Security number.
- A patient's Medicare claim number may not always be identical to the person's Social Security number.
- Code Social Security numbers that end with a "B" or "D" as 999999999. The patient receives benefits under the spouse's number and this is the spouse's Social Security number.
- If only the last 4 or 5 digits are recorded in the patient's medical record, record with preceding 9's.

Code	Definition
(fill spaces)	Record the patient's Social Security number (SSN) without dashes
999999999	When the patient does not have a Social Security Number or the information is not available
999994578	Record the last four digits of the social security number with preceding 9's

Sex

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Gender	220	1	01/13, 01/15, 01/16	Required

Description

Identifies the sex of the patient.

Rationale

This data item is used to compare cancer rates and outcomes by site. The same sex code should appear in each medical record for a patient with multiple tumors.

Coding Instructions

- Record the patient's sex as indicated in the medical record.
- Assign code 3 for intersexed (persons with sex chromosome abnormalities.
- Assign code 4 for transgendered.
- Natality for transsexuals was added for use in 2015 but may be applied for earlier diagnoses.
- The definition of code 3 was updated to "Other (intersex, disorders of sexual development/DSD)" in 2016.

Code	Label
1	Male
2	Female
3	Other (intersex, disorders of sexual development/DSD)
4	Transsexual, transgendered, NOS
5	Transsexual, natal male
6	Transsexual, natal female
9	Not stated in patient record, unknown

Definitions

Transsexual: Surgically altered gender

Transgendered: A person who identifies with or expresses a gender identify that differs from one which corresponds to the person's sex at birth.

Date of Birth

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Birthdate	240	8	01/10	Required

Description

Identifies the date of birth of the patient.

Rationale

This data item is useful for patient identification. It is also useful when analyzing tumors according to age cohort.

Coding Instructions

- Record the patient's date of birth as indicated in the patient record. For single-digit day or month, record with a lead 0 (for example, September is 09). Use the full four-digit year for year.
- For *in utero* diagnosis and treatment, record the actual date of birth. It will follow one or both dates for those events.
- If only the patient age is available, calculate the year of birth from age and the year of diagnosis and leave day and month of birth unknown (for example, a 60-year-old patient diagnosed in 2010 is calculated to have been born in 1950).
- If month is unknown, the day is coded unknown. If the year cannot be determined, the day and month are both coded unknown.
- If the date of birth cannot be determined at all, record the reason in *Date of Birth Flag*.
- Beginning in 2010, the way dates are transmitted has changed. In order that the registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date of Birth* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of Birth* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date. The *Date of Birth Flag* is used to explain why *Date of Birth* is not a known date. See *Date of Birth Flag* for an illustration of the relationships among these items.

Date of Birth Flag

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	241	2	New 01/10	Required

Description

This flag explains why there is no appropriate value in the corresponding date field, *Date of Birth*.

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

- Leave this item blank if *Date of Birth* has a full or partial date recorded.
- Code 12 if the *Date of Birth* cannot be determined at all.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Definition
12	A proper value is applicable but not known (for example, birth date is unknown)
(Blank)	A valid date is provided in item *Date of Birth*

Age at Diagnosis

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	230	3		Required

Description

Records the age of the patient at his or her birthday before diagnosis.

Rationale

This data item is useful for patient identification. It may also be useful when analyzing tumors according to specific patient age.

Coding Instructions

- If the patient has multiple primaries, then the age at diagnosis may be different for subsequent primaries.

Code	Definition
000	Less than one year old
001	One year old, but less than two years old
002	Two years old
…	Show actual age in years
120	One hundred twenty years old
999	Unknown age

Place of Birth - State

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	252	3	New 01/13	Required

Description

Records the patient's state of birth. If the patient has multiple primaries, the state of birth is the same for each tumor.

Rationale

This data item is used to evaluate medical care delivery to special populations and to identify populations at special risk for certain cancers.

Coding Instructions

- Use the most specific code.
- This item corresponds to *Birthplace - Country*.
- See Appendix B for a list of state codes and their respective country codes.
- This item was first defined for use in 2013; cases diagnosed before that date should be converted automatically by the registry's software from the former *Place of Birth* field.

Examples:

Code	Definition
IL	If the state in which the patient was born is Illinois, then use the USPS code for the state of Illinois
XX	Born in a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country is *known* (code the country in *Birthplace – Country*)
YY	Born in a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country is *unknown*
US	Born in the U.S. (including its territories, commonwealths, or possessions) and the state is *unknown*
CD	Born in Canada and the province is *unknown*
ZZ	Place of birth is unknown, not mentioned in patient record

Place of Birth - Country

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	254	3	New 01/13	Required

Description

Identifies the country where the patient was born. The codes are based on International Organization for Standardization (ISO) 3166-1 alpha-3 country codes, with some custom codes. If the patient has multiple tumors, all records should contain the same code.

Rationale

The country code is part of the patient's demographic data and has multiple uses. It may be useful for understanding risk factors, assessment of patient prognosis, and chances for survival.

Coding Instructions

- This item corresponds to *Birthplace – State*.
- See Appendix B for a list of country codes and their respective state codes.
- This item was first defined for use in 2013; cases diagnosed before that date should be converted automatically by the registry's software.

Examples:

Code	Definition
USA	United States
CAN	Canada
ZZU	Place of birth is unknown, not mentioned in patient record

Patient Address

Patient Address and Residency Rules

The patient's address at diagnosis is the patient's place of residence at the time of original diagnosis. It does not change if the patient moves. If the patient has more than one primary tumor, the address at diagnosis may be different for each primary.

The current address initially is the patient's residence at the time the patient was first seen at the accessioning facility for this primary. The current address is updated if the patient moves. If the patient has more than one primary tumor, the current address should be the same for each primary.

Normally a residence is the home named by the patient. Legal status and citizenship are not factors in residency decisions. Rules of residency are identical to or comparable with the rules of the Census Bureau whenever possible. The registry can resolve residency questions by using the Census Bureau's definition, "the place where he or she lives and sleeps most of the time or the place the person considers to be his or her usual home". Vital statistic rules may differ from Census rules. Do not record residence from the death certificate. Review each case carefully.

A post office box is not a reliable source to identify the residency at diagnosis. Post office box addresses do not provide accurate geographical information for analyzing cancer incidence. Use the post office box address only if no street address information is available.

Rules for Persons with Ambiguous Residences

Persons with More Than One Residence (summer and winter homes): Code the residence where the patient spends the majority of time (usual residence). If the usual residence is not known or the information is not available, code the residence the patient specifies at the time of diagnosis.

- The above rules should be followed for "snowbirds" who live in the south for the winter months, "sunbirds" who live in the north during the summer months, and people with vacation residences that they occupy for a portion of the year.

Persons with No Usual Residence (transients, homeless): Use the address of the place the patient was staying when the cancer was diagnosed. This could be a shelter or the diagnosing facility.

Persons Away at School: College students are residents of the school area. Boarding school students below the college level are residents of their parents' homes.

Persons in Institutions: The Census Bureau states, "Persons under formally authorized, supervised care or custody", are residents of the institution. This includes the following:

- Incarcerated persons
- Persons in nursing, convalescent, and rest homes
- Persons in homes, schools, hospitals, or wards for the physically disabled, mentally retarded, or mentally ill.
- Long-term residents of other hospitals, such as Veterans Affairs (VA) hospitals.

Persons in the Armed Forces and on Maritime Ships: Members of the armed forces are residents of the installation area. Use the stated address for military personnel and their families. Military personnel may use the installation address or the surrounding community's address. The Census Bureau has detailed residency rules for Navy personnel, Coast Guard, and maritime ships. Refer to Census Bureau publications for the detailed rules.

Street Address at DX

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Addr at DX – No & Street	2330	60	01/10, 01/12	Required

Description

Identifies the patient's address (number and street) at the time of diagnosis.

Rationale

The address is part of the patient's demographic data and has multiple uses. It indicates referral patterns and allows for the analysis of cancer clusters or environmental studies. Physical address allows a central registry to assign latitude and longitude to patient addresses and gives the ability to map each location. Accurate geographic information allows a central registry to monitor cancer trends to watch for possible patterns that could be the first hint of an environmental or other geographic focus of increased cancer risk.

Coding Instructions

- Record the physical address (number and street address or the rural mailing address) of the patient's usual residence when the tumor was diagnosed.
- The address should be fully spelled out with standardized use of abbreviations and punctuation per U.S. Postal Service postal addressing standards. The USPS Postal Addressing Standards, Pub 28, November 2000 can be found on the Internet at *http://pe.usps.gov/cpim/ftp/pubs/pub28/pub28.pdf*.
- Abbreviations should be limited to those recognized by the Postal Service standard abbreviations. They include, but are not limited to:

  - AVE (avenue)
  - BLVD (boulevard)
  - CIR (circle)
  - CT (court)
  - DR (drive)
  - PLZ (plaza)
  - PARK (park)
  - PKWY (parkway)
  - RD (road)
  - SQ (square)
  - ST (street)
  - APT (apartment)
  - BLDG (building)
  - FL (floor)
  - STE (suite)
  - UNIT (unit)
  - RM (room)
  - DEPT (department)
  - N (north)
  - NE (northeast)
  - NW (northwest)
  - S (south)
  - SE (southeast)
  - SW (southwest)
  - E (east)
  - W (west

  A complete list of recognized street abbreviations is provided in *Appendix C of USPS Pub 28*.

- Punctuation marks should be avoided, except when punctuation is necessary to convey the meaning. Punctuation normally is limited to periods when the period carries meaning (e.g., 39.2 RD), slashes for fractional addresses (e.g., 101 1/2 Main St), and hyphens when the hyphen carries meaning (e.g., 289-01 Montgomery Ave). Use of the pound sign (#) to designate address units should be avoided whenever possible. The preferred notation is as follows: 102 Main St Apt 101. If a pound sign is used, there must be a space between the pound sign and the secondary number (e.g., 425 Flower Blvd # 72).
- If the patient has multiple tumors, the address may be different for subsequent primaries.
- Do not update this data item if the patient's address changes.
- See "Residency Rules" on page 48 for further instructions.

Examples:

Code	Definition
103 FIRST AVE SW APT 102	The use of capital letters is preferred by the USPS; use recognized USPS standardized abbreviations; do not use punctuation unless absolutely necessary to clarify an address; leave blanks between numbers and words
UNKNOWN	If the patient's address is unknown, enter UNKNOWN

Supplemental Address at DX

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Addr at DX – Supplemental	2335	60	09/06, 01/10, 01/12	Required

Description

Provides the ability to store additional address information such as the name of a place or facility (i.e., a nursing home or name of an apartment complex) at the time of diagnosis.

Rationale

A registry may receive the name of a facility instead of a proper street address containing the street number, name, direction, and other elements necessary to locate an address on a street file for the purpose of geocoding.

Coding Instructions

- Record the place or facility (i.e., a nursing home or name of an apartment complex) of the patient's usual residence when the tumor was diagnosed.
- If the patient has multiple tumors, the address may be different for subsequent primaries.
- Do not use this data item to record the number and street address of the patient.
- Do not update this data item if the patient's address changes.
- See "Residency Rules" on page 48 for further instructions.

Examples:

Code	Definition
VALLEYVIEW NURSING HOME	The use of capital letters is preferred by the USPS; use recognized USPS standardized abbreviations; do not use punctuation unless absolutely necessary to clarify an address; leave blanks between numbers and words
(leave blank)	If this address space is not needed, then leave blank

City at DX

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Addr at DX – City or Town	70	50	01/10	Required

Description

Identifies the name of the city or town in which the patient resides at the time the tumor is diagnosed and treated.

Rationale

The city or town is part of the patient's demographic data and has multiple uses. It indicates referral patterns and allows for the analysis of cancer clusters or environmental studies.

Coding Instructions

- If the patient resides in a rural area, record the name of the city or town used in his or her mailing address.
- If the patient has multiple malignancies, the city or town may be different for subsequent primaries.
- Do not update this data item if the patient's city or town of residence changes.
- See "Residency Rules" on page 48 for further instructions.

Code	Definition
CITY NAME	Do not use punctuation, special characters, or numbers. The use of capital letters is preferred by the USPS; it also guarantees consistent results in queries and reporting. Abbreviate where necessary
UNKNOWN	If the patient's city or town is unknown

State at DX

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Addr at DX – State	80	2	01/04, 09/06, 01/10, 01/12	Required

Description

Identifies the patient's state of residence at the time of diagnosis.

Rationale

The state of residence is part of the patient's demographic data and has multiple uses. It indicates referral patterns and allows for the analysis of cancer clusters or environmental studies.

Coding Instructions

- Use U.S. Postal Service abbreviation for the state, territory, commonwealth, U.S. possession, or Canadian province or territory in which the patient resides at the time the tumor is diagnosed and treated.
- If the patient has multiple tumors, the state of residence may be different for subsequent primaries.
- If the patient is a foreign resident, then code either XX or YY depending on the circumstance.
- Do not update this data item if the patient's state of residence changes.

Code	Definition
MT	If the state in which the patient resides at the time of diagnosis and treatment is Montana, then use the USPS code for the state of Montana
XX	Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country is *known*
YY	Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country is *unknown*
US	Resident of the U.S. (including its territories, commonwealths, or possessions) and the state is *unknown*
CD	Resident of Canada and the province is *unknown*
ZZ	Residence unknown

Common abbreviations

United States State and Territory Abbreviations (refer to the Zip Code directory for further listings)

State	Abbrev	State	Abbrev	State	Abbrev
Alabama	AL	Massachusetts	MA	Tennessee	TN
Alaska	AK	Michigan	MI	Texas	TX
Arizona	AZ	Minnesota	MN	Utah	UT
Arkansas	AR	Mississippi	MS	Vermont	VT
California	CA	Missouri	MO	Virginia	VA
Colorado	CO	Montana	MT	Washington	WA
Connecticut	CT	Nebraska	NE	West Virginia	VW
Delaware	DE	Nevada	NV	Wisconsin	WI
District of Columbia	DC	New Hampshire	NH	Wyoming	WY
Florida	FL	New Jersey	NJ	United States, state unk	US
Georgia	GA	New Mexico	NM	American Samoa	AS
Hawaii	HI	New York	NY	Guam	GU
Idaho	ID	North Carolina	NC	Puerto Rico	PR
Illinois	IL	North Dakota	ND	Virgin Islands	VI
Indiana	IN	Ohio	OH	Palau	PW
Iowa	IA	Oklahoma	OK	Micronesia	FM
Kansas	KS	Oregon	OR	Marshall Islands	MH
Kentucky	KY	Pennsylvania	PA	Outlying Islands	UM
Louisiana	LA	Rhode Island	RI	APO/FPO Armed Services America	AA
Maine	ME	South Carolina	SC	APO/FPO Armed Services Europe	AE
Maryland	MD	South Dakota	SD	APO/FPO Armed Services Pacific	AP

Canadian Provinces and Territory Abbreviations

Provide/Territory	Abbrev	Province/Territory	Abbrev
Alberta	AB	Nunavut	NU
British Columbia	BC	Ontario	ON
Manitoba	MB	Prince Edward Island	PE
New Brunswick	NB	Quebec	QC
Newfoundland and Labrador	NL	Saskatchewan	SK
Northwest Territories	NT	Yukon	YT
Nova Scotia	NS	Canada, province unknown	CD

Zip Code at DX

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Addr at DX – Postal (Zip) Code	100	9	01/04	Required

Description

Identifies the postal code of the patient's address at diagnosis.

Rationale

The postal code is part of the patient's demographic data and has multiple uses. It will provide a referral pattern report and allow analysis of cancer clusters or environmental studies.

Coding Instructions

- For U.S. residents, record the patient's nine-digit extended postal code at the time of diagnosis and treatment.
- For Canadian residents, record the six-character postal code.
- When available, record the postal code for other countries.
- If the patient has multiple malignancies, the postal code may be different for subsequent primaries.
- Do not update this data item if the patient's postal code changes.
- See "Residency Rules" on page 48 for further instructions.

Code	Definition
(fill spaces)	The patient's nine-digit U.S. extended postal code. Do not record hyphens.
59666_ _ _ _	When the nine-digit extended U.S. Zip Code is not available, record the five-digit postal code, left justified, followed by four blanks.
M6G2S8_ _ _	The patient's six-character Canadian postal code left justified, followed by three blanks.
88888_ _ _ _ or 888888888	Permanent address in a country other than Canada, United States, or U.S. possessions **and** postal code is unknown.
99999_ _ _ _ or 999999999	Permanent address in Canada, United States, or U.S. possession **and** postal code is unknown.

Montana Zip Codes:

City	County	Zip	City	County	Zip
Absarokee	Stillwater	59001	Acton	Yellowstone	59002
Alberton	Mineral	59820	Alder	Madison	59710
Alzada	Carter	59311	Anaconda	Deer Lodge	59711
Angela	Rosebud	59312	Antelope	Sheridan	59211
Arlee	Lake	59821	Ashland	Rosebud	59003
Augusta	Lewis & Clark	59410	Avon	Powell	59713
Babb	Glacier	59411	Bainville	Roosevelt	59212
Baker	Fallon	59313	Ballantine	Yellowstone	59006
Basin	Jefferson	59631	Bearcreek	Carbon	59007
Belfry	Carbon	59008	Belgrade	Gallatin	59714
Belt	Cascade	59412	Biddle	Powder River	59314
Big Arm	Lake	59910	Bigfork	Flathead	59911
Bighorn	Treasure	59010	Big Sandy	Chouteau	59520
Big Sky	Gallatin	59716	Big Timber	Sweet Grass	59011
Billings	Yellowstone	59101	Billings	Yellowstone	59102
Billings	Yellowstone	59103	Billings	Yellowstone	59104
Billings	Yellowstone	59105	Billings	Yellowstone	59106
Billings	Yellowstone	59107	Billings	Yellowstone	59108
Birney	Rosebud	59012	Black Eagle	Cascade	59414
Bloomfield	Dawson	59315	Bonner	Missoula	59823
Boulder	Jefferson	59632	Box Elder	Hill	59521
Boyd	Carbon	59013	Boyes	Carter	59316
Bozeman	Gallatin	59715	MSU Bozeman	Gallatin	59717
Bozeman	Gallatin	59718	Bozeman	Gallatin	59719
Bozeman	Gallatin	59771	Bozeman	Gallatin	59772
Bozeman	Gallatin	59773	Brady	Pondera	59416
Bridger	Carbon	59014	Broadus	Powder River	59317
Broadview	Yellowstone	59015	Brockton	Roosevelt	59213
Brockway	McCone	59214	Browning	Glacier	59417
Brusett	Garfield	59318	Buffalo	Fergus	59418
Busby	Big Horn	59016	Butte	Silver Bow	59701
Butte	Silver Bow	59702	Butte	Silver Bow	59703
Butte	Silver Bow	59750	Bynum	Teton	59419
Cameron	Madison	59720	Canyon Creek	Lewis & Clark	59633
Capitol	Carter	59319	Cardwell	Jefferson	59721
Carter	Chouteau	59420	Cascade	Cascade	59421
Cat Creek	Petroleum	59087	Charlo	Lake	59824
Chester	Liberty	59522	Chinook	Blaine	59523
Choteau	Teton	59422	Circle	McCone	59215
Clancy	Jefferson	59634	Clinton	Missoula	59825
Clyde Park	Park	59018	Coffee Creek	Fergus	59424
Cohagen	Garfield	59322	Colstrip	Rosebud	59323
Columbia Falls	Flathead	59912	Columbus	Stillwater	59019
Condon	Missoula	59826	Conner	Ravalli	59827
Conrad	Pondera	59425	Cooke City	Park	59020
Coram	Flathead	59913	Corvallis	Ravalli	59828
Corwin Springs	Park	59030	Craig	Lewis & Clark	59648
Crane	Richland	59217	Creston	Flathead	59902
Crow Agency	Big Horn	59022	Culbertson	Roosevelt	59218
Custer	Yellowstone	59024	Cut Bank	Glacier	59427
Dagmar	Sheridan	59219	Darby	Ravalli	59829
Dayton	Lake	59914	De Borgia	Mineral	59830

City	County	Zip	City	County	Zip
Decker	Big Horn	59025	Deer Lodge	Powell	59722
Dell	Beaverhead	59724	Denton	Fergus	59430
Dillon	Beaverhead	59725	Divide	Silver Bow	59727
Dixon	Sanders	59831	Dodson	Phillips	59524
Drummond	Granite	59832	Dupuyer	Pondera	59432
Dutton	Teton	59433	East Glacier	Glacier	59434
East Helena	Lewis & Clark	59635	Edgar	Carbon	59026
Ekalaka	Carter	59324	Elliston	Powell	59728
Elmo	Lake	59915	Emigrant	Park	59027
Ennis	Madison	59729	Essex	Flathead	59916
Ethridge	Toole	59435	Eureka	Lincoln	59917
Evergreen	Flathead	59901	Fairfield	Teton	59436
Fairview	Richland	59221	Fallon	Prairie	59326
Fishtail	Stillwater	59028	Flaxville	Daniels	59222
Florence	Ravalli	59833	Floweree	Chouteau	59440
Forestgrove	Fergus	59441	Forsyth	Rosebud	59327
Fort Benton	Chouteau	59442	Fort Harrison	Lewis & Clark	59636
Fort Peck	Valley	59223	Fort Shaw	Cascade	59443
Fort Smith	Big Horn	59035	Fortine	Lincoln	59918
Four Buttes	Daniels	59263	Frazer	Valley	59225
Frenchtown	Missoula	59834	Froid	Roosevelt	59226
Fromberg	Carbon	59029	Galata	Toole	59444
Gallatin Gateway	Gallatin	59730	Gardiner	Park	59030
Garneill	Fergus	59445	Garrison	Powell	59731
Garryowen	Big Horn	59031	Geraldine	Chouteau	59446
Geyser	Judith Basin	59447	Gildford	Hill	59525
Glasgow	Valley	59230	Glen	Beaverhead	59732
Glendive	Dawson	59330	Glentana	Valley	59240
Gold Creek	Powell	59733	Grantsdale	Ravalli	59835
Grass Range	Fergus	59032	Great Falls	Cascade	59401
Great Falls	Cascade	59402	Great Falls	Cascade	59403
Great Falls	Cascade	59404	Great Falls	Cascade	59405
Great Falls	Cascade	59406	Greenough	Missoula	59836
Greycliff	Sweet Grass	59033	Hall	Granite	59837
Hamilton	Ravalli	59840	Hammond	Carter	59332
Hardin	Big Horn	59034	Harlem	Blaine	59526
Harlowton	Wheatland	59036	Harrison	Madison	59735
Hathaway	Rosebud	59333	Haugan	Mineral	59842
Havre	Hill	59501	Hays	Blaine	59527
Heart Butte	Pondera	59448	Helena	Lewis & Clark	59601
Helena	Lewis & Clark	59602	Helena	Lewis & Clark	59604
Helena	Lewis & Clark	59620	Helena	Lewis & Clark	59624
Helena	Lewis & Clark	59626	Helmville	Powell	59843
Heron	Sanders	59844	Highwood	Chouteau	59450
Hilger	Fergus	59451	Hingham	Hill	59528
Hinsdale	Valley	59241	Hobson	Judith Basin	59452
Hogeland	Blaine	59529	Homestead	Roosevelt	59242
Hot Springs	Sanders	59845	Hungry Horse	Flathead	59919
Huntley	Yellowstone	59037	Huson	Missoula	59846
Hysham	Treasure	59038	Ingomar	Rosebud	59039
Inverness	Hill	59530	Ismay	Custer	59336
Jackson	Beaverhead	59736	Jefferson City	Jefferson	59638
Joliet	Carbon	59041	Joplin	Liberty	59531

City	County	Zip	City	County	Zip
Jordan	Garfield	59337	Judith Gap	Wheatland	59453
Kalispell	Flathead	59901	Kalispell	Flathead	59902
Kalispell	Flathead	59903	Kalispell	Flathead	59904
Kevin	Toole	59454	Kila	Flathead	59920
Kinsey	Custer	59338	Kremlin	Hill	59532
Lake McDonald	Flathead	59921	Lakeside	Flathead	59922
Lambert	Richland	59243	Lame Deer	Rosebud	59043
Larslan	Valley	59244	Laurel	Yellowstone	59044
Lavina	Golden Valley	59046	Ledger	Pondera	59456
Lewistown	Fergus	59457	Libby	Lincoln	59923
Lima	Beaverhead	59739	Lincoln	Lewis & Clark	59639
Lindsay	Dawson	59339	Livingston	Park	59047
Lloyd	Blaine	59535	Lodge Grass	Big Horn	59050
Lolo	Missoula	59847	Loma	Chouteau	59460
Lonepine	Sanders	59848	Loring	Phillips	59537
Lothair	Liberty	59461	Lothair	Toole	59474
Lustre	Valley	59225	Luther	Carbon	59068
Malmstrom AFB	Cascade	59402	Malta	Phillips	59538
Manhattan	Gallatin	59741	Marion	Flathead	59925
Martin City	Flathead	59926	Martinsdale	Meagher	59053
Marysville	Lewis & Clark	59640	McAllister	Madison	59740
McCabe	Roosevelt	59245	McLeod	Sweet Grass	59052
Medicine Lake	Sheridan	59247	Melrose	Silver Bow	59743
Melstone	Musselshell	59054	Melville	Sweet Grass	59055
Mildred	Prairie	59341	Miles City	Custer	59301
Mill Iron	Carter	59324	Milltown	Missoula	59851
Missoula	Missoula	59801	Missoula	Missoula	59802
Missoula	Missoula	59803	Missoula	Missoula	59804
Missoula	Missoula	59806	Missoula	Missoula	59807
Missoula	Missoula	59808	Moccasin	Judith Basin	59462
Moiese	Lake	59824	Molt	Stillwater	59057
Monarch	Cascade	59463	Montana City	Jefferson	59634
Moore	Fergus	59464	Mosby	Garfield	59058
Musselshell	Musselshell	59059	Nashua	Valley	59248
Neihart	Cascade	59465	Niarada	Sanders	59845
Norris	Madison	59745	Noxon	Sanders	59853
Nye	Stillwater	59061	Oilmont	Toole	59466
Olive	Powder River	59343	Olney	Flathead	59927
Opheim	Valley	59250	Otter	Powder River	59062
Outlook	Sheridan	59252	Ovando	Powell	59854
Pablo	Lake	59855	Paradise	Sanders	59856
Park City	Stillwater	59063	Peerless	Daniels	59253
Pendroy	Teton	59467	Phillipsburg	Granite	59858
Pinesdale	Ravalli	59841	Plains	Sanders	59859
Plentywood	Sheridan	59254	Plevna	Fallon	59344
Polaris	Beaverhead	59746	Polebridge	Flathead	59928
Polson	Lake	59860	Pompeys Pillar	Yellowstone	59064
Pony	Madison	59747	Poplar	Roosevelt	59255
Powderville	Powder River	59345	Power	Teton	59468
Pray	Park	59065	Proctor	Lake	59914
Proctor	Lake	59929	Pryor	Big Horn	59066
Radersburg	Broadwater	59641	Ramsay	Silver Bow	59748
Rapelje	Stillwater	59067	Ravalli	Lake	59863

City	County	Zip	City	County	Zip
Raymond	Sheridan	59256	Raynesford	Judith Basin	59469
Red Lodge	Carbon	59068	Redstone	Sheridan	59257
Reedpoint	Stillwater	59069	Reserve	Sheridan	59258
Rexford	Lincoln	59930	Richey	Dawson	59259
Richland	Valley	59260	Ringling	Meagher	59642
Roberts	Carbon	59070	Rollins	Lake	59931
Ronan	Lake	59864	Roscoe	Carbon	59071
Rosebud	Rosebud	59347	Roundup	Musselshell	59072
Roy	Fergus	59471	Rudyard	Hill	59540
Ryegate	Golden Valley	59074	Saco	Phillips	59261
Saint Ignatius	Lake	59865	Saint Marie	Valley	59231
Saint Mary	Glacier	59417	Saint Regis	Mineral	59866
Saint Xavier	Big Horn	59075	Saltese	Mineral	59867
Sand Coulee	Cascade	59472	Sand Springs	Garfield	59077
Sanders	Treasure	59076	Sanders	Treasure	59038
Santa Rita	Glacier	59473	Savage	Richland	59262
Scobey	Daniels	59263	Seeley Lake	Missoula	59868
Shawmut	Wheatland	59078	Shelby	Toole	59474
Shepherd	Yellowstone	59079	Sheridan	Madison	59749
Shonkin	Chouteau	59450	Sidney	Richland	59270
Silesia	Carbon	59041	Silver Gate	Park	59081
Silver Star	Madison	59751	Simms	Cascade	59477
Somers	Flathead	59932	Sonnette	Powder River	59348
Springdale	Park	59082	Stanford	Judith Basin	59479
Stevensville	Ravalli	59870	Stockett	Cascade	59480
Stryker	Lincoln	59933	Sula	Ravalli	59871
Sumatra	Rosebud	59083	Sun River	Cascade	59483
Sunburst	Toole	59482	Superior	Mineral	59872
Swan Lake	Flathead	59911	Sweetgrass	Toole	59484
Teigen	Petroleum	59084	Terry	Prairie	59349
Thompson Falls	Sanders	59873	Three Forks	Gallatin	59752
Toston	Broadwater	59643	Townsend	Broadwater	59644
Trego	Lincoln	59934	Trout Creek	Sanders	59874
Troy	Lincoln	59935	Turner	Blaine	59542
Twin Bridges	Madison	59754	Twodot	Wheatland	59085
Ulm	Cascade	59485	Valier	Pondera	59486
Vandalia	Valley	59273	Vaughn	Cascade	59487
Victor	Ravalli	59875	Vida	McCone	59274
Virginia City	Madison	59755	Volborg	Custer	59351
Walkerville	Silver Bow	59701	Warmsprings	Deer Lodge	59756
Westby	Sheridan	59275	West Glacier	Flathead	59936
West Yellowstone	Gallatin	59758	Whitefish	Flathead	59937
Whitehall	Jefferson	59759	Wht Sulphur Spr	Meagher	59645
Whitetail	Daniels	59276	Whitlash	Liberty	59545
Wibaux	Wibaux	59353	Willard	Fallon	59354
Willow Creek	Gallatin	59760	Wilsall	Park	59086
Winifred	Fergus	59489	Winnett	Petroleum	59087
Winston	Broadwater	59647	Wisdom	Beaverhead	59761
Wise River	Beaverhead	59762	Wolf Creek	Lewis & Clark	59648
Wolf Point	Roosevelt	59201	Worden	Yellowstone	59088
Wyola	Big Horn	59089	Yellowtail	Big Horn	59035
Zortman	Phillips	59546	Zurich	Blaine	59547

County at Diagnosis Reported

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
County at Diagnosis	90	3	09/06, 01/10, 01/15, 01/18	Required

Description

Identifies the county of the patient's residence at the time the reportable tumor is diagnosed.

Rationale

This data item may be used for epidemiological purposes. For example, to measure the cancer incidence in a particular geographic area.

Coding Instructions

- This field is intended to store address information for the patient's physical, residential address. All efforts should be made to find the patient's true street address and postal code, including reviewing relevant sources outside the medical record if available. The county for a PO Box mailing address should only be recorded when no other address information is available in the medical record and no other information sources are available.
- If the patient has multiple tumors, the county codes may be different for each tumor.
- If the patient is a non-U.S. resident, use code 999.
- Do not update this data item if the patient's county of residence changes. Store updated address information in the affiliated current address data items. Only update based on improved information on the residential address at time of diagnosis. For instance, it is appropriate to correct county during a consolidation process.

Code	Label	Definition
001-997	County at Diagnosis	Valid FIPS code
998	Outside state/county code unknown	Known town, city, state, or country of residence, but county code not known **and** a resident outside of the state of the reporting institution (must meet all criteria)
999	County unknown	The county of the patient is unknown or the patient is not a United States resident. County is not documented in the patient's medical record

Montana County Codes:

Code	Label	Code	Label	Code	Label
001	Beaverhead	039	Granite	077	Powell
003	Big Horn	041	Hill	079	Prairie
005	Blaine	043	Jefferson	081	Ravalli
007	Broadwater	045	Judith Basin	083	Richland
009	Carbon	047	Lake	085	Roosevelt
011	Carter	049	Lewis & Clark	087	Rosebud
013	Cascade	051	Liberty	089	Sanders
015	Chouteau	053	Lincoln	091	Sheridan
017	Custer	055	McCone	093	Silver Bow
019	Daniels	057	Madison	095	Stillwater
021	Dawson	059	Meagher	097	Sweetgrass
023	Deer Lodge	061	Mineral	099	Teton
025	Fallon	063	Missoula	101	Toole
027	Fergus	065	Musselshell	103	Treasure
029	Flathead	067	Park	105	Valley
031	Gallatin	069	Petroleum	107	Wheatland
033	Garfield	071	Phillips	109	Wibaux
035	Glacier	073	Pondera	111	Yellowstone
037	Golden Valley	075	Powder River		

Address at DX - Country

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	102	3	New 01/13	Required

Description

Identifies the country of the patient's residence at the time of diagnosis. The codes are based on International Organization for Standardization (ISO) 3166-1 alpha-3 country codes, with some custom codes.

Rationale

The country code is part of the patient's demographic data and has multiple uses. It may be useful for understanding risk factors, assessment of patient prognosis, and chances for survival.

Coding Instructions

- This item corresponds to the other *Address at DX* items (state, postal code).
- Do not change if the patient moves to another country. Patients with more than one tumor may have different countries at diagnosis, however.
- See Appendix B for a list of country codes and their respective state codes.
- This item was first defined for use in 2013; cases diagnosed before that date should be converted automatically by the registry's software.

Examples:

Code	Country
USA	United States
CAN	Canada

Current Street Address

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Addr Current – No & Street	2350	60	09/04, 01/10, 01/12	Required

Description

Identifies the patient's current address (number and street).

Rationale

This data item provides a current address used for follow-up purposes. It is different from *Patient Address at Diagnosis*.

Coding Instructions

- Record the number and street address or the rural mailing address of the patient's current usual residence.
- The address should be fully spelled out with standardized
- use of abbreviations and punctuation per U.S. Postal Service postal addressing standards. The USPS Postal Addressing Standards, Pub 28, November 2000 can be found on the Internet at *http://pe.usps.gov/cpim/ftp/pubs/pub28/pub28.pdf*.
- Abbreviations should be limited to those recognized by the Postal Service standard abbreviations. They include, but are not limited to:

  - AVE (avenue)
  - BLVD (boulevard)
  - CIR (circle)
  - CT (court)
  - DR (drive)
  - PLZ (plaza)
  - PARK (park)
  - PKWY (parkway)
  - RD (road)
  - SQ (square)
  - ST (street)
  - APT (apartment)
  - BLDG (building)
  - FL (floor)
  - STE (suite)
  - UNIT (unit)
  - RM (room)
  - DEPT (department)
  - N (north)
  - NE (northeast)
  - NW (northwest)
  - S (south)
  - SE (southeast)
  - SW (southwest)
  - E (east)
  - W (west)

  A complete list of recognized street abbreviations is provided in *Appendix C of USPS Pub 28*.

- Punctuation marks should be avoided, except when punctuation is necessary to convey the meaning. Punctuation normally is limited to periods when the period carries meaning (e.g., 39.2 RD), slashes for fractional addresses (e.g., 101 1/2 Main St), and hyphens when the hyphen carries meaning (e.g., 289-01 Montgomery Ave). Use of the pound sign (#) to designate address units should be avoided whenever possible. The preferred notation is as follows: 102 Main St Apt 101. If a pound sign is used, there must be a space between the pound sign and the secondary number (e.g., 425 Flower Blvd # 72).
- If the patient has multiple tumors, the current street address should be the same for all tumors.
- Update this data item if the patient's address changes.
- Do not change this item when the patient dies.
- See "Residency Rules" on page 48 for further instructions.

Examples:

Code	Definition
103 FIRST AVE SW APT 102	The use of capital letters is preferred by the USPS; use recognized USPS standardized abbreviations; do not use punctuation unless absolutely necessary to clarify an address; leave blanks between numbers and words.
UNKNOWN	The patient's street address is unknown.

Current Supplemental Address

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Addr Current – Supplemental	2355	60	09/04, 09/06, 01/10, 01/12	Required

Description

Provides the ability to store additional address information such as the name of a place or facility (i.e., a nursing home or name of an apartment complex).

Rationale

A registry may receive the name of a facility instead of a proper street address containing the street number, name, direction, and other elements necessary to locate an address on a street file for the purpose of geocoding.

Coding Instructions

- Record the place or facility (i.e., a nursing home or name of an apartment complex) of the patient's current usual residence.
- If the patient has multiple tumors, the current address should be the same for all tumors.
- Update this data item if a patient's address changes.
- Do not use this data item to record the number and street address of the patient.
- Do not change this item when the patient dies.
- See "Residency Rules" on page 48 for further instructions.

Examples:

Code	Definition
VALLEYVIEW NURSING HOME	The use of capital letters is preferred by the USPS; use recognized USPS standardized abbreviations; do not use punctuation unless absolutely necessary to clarify an address; leave blanks between numbers and words.
(leave blank)	If this address space is not needed, then leave blank.

Current City

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Addr Current – City/Town	1810	50	09/04, 01/10	Required

Description

Identifies the name of the city or town of the patient's current usual residence.

Rationale

This data item provides a current city/town used for follow-up purposes. It is different from *City/Town at Diagnosis*.

Coding Instructions

- If the patient resides in a rural area, record the name of the city or town used in his or her mailing address.
- If the patient has multiple tumors, the current city or town should be the same for all tumors.
- Update this data item if the patient's city/town of residence changes.
- Do not change this item when the patient dies.
- See "Residency Rules" on page 48 for further instructions.

Code	Definition
CITY NAME	Do not use punctuation, special characters, or numbers. The use of capital letters is preferred by the USPS; it also guarantees consistent results in queries and reporting. Abbreviate where necessary.
UNKNOWN	The city in which the patient resides in unknown.

Current State

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Addr Current – State	1820	2	09/04, 09/06, 01/12	Required

Description

Identifies the patient's current state of residence.

Rationale

This item provides a current state of residence used for follow-up purposes. It is different from *State at Diagnosis*.

Coding Instructions

- U.S. Postal Service abbreviation for the state, territory, commonwealth, U.S. possession, or Canadian province/territory of the patient's current usual residence.
- If the patient has multiple tumors, the current state of residence should be the same for all tumors.
- If the patient is a foreign resident, then code either XX or YY depending on the circumstance.
- Update this data item if the patient's state of residence changes.
- Do not change this item when the patient dies.

Code	Definition
MT	If the state in which the patient resides at the time of diagnosis and treatment is Montana, then use the USPS code for the state of Montana.
XX	Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country is *known*.
YY	Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country is *unknown*.
US	Resident of the U.S. (including its territories, commonwealths, or possessions) and the state is *unknown*.
CD	Resident of Canada and the province is *unknown*.
ZZ	Residence unknown.

Common abbreviations

United States State and Territory Abbreviations (refer to the Zip Code Directory for further listings)

State	Abbrev	State	Abbrev	State	Abbrev
Alabama	AL	Massachusetts	MA	Tennessee	TN
Alaska	AK	Michigan	MI	Texas	TX
Arizona	AZ	Minnesota	MN	Utah	UT
Arkansas	AR	Mississippi	MS	Vermont	VT
California	CA	Missouri	MO	Virginia	VA
Colorado	CO	Montana	MT	Washington	WA
Connecticut	CT	Nebraska	NE	West Virginia	VW
Delaware	DE	Nevada	NV	Wisconsin	WI
District of Columbia	DC	New Hampshire	NH	Wyoming	WY
Florida	FL	New Jersey	NJ	United States, state unk	US
Georgia	GA	New Mexico	NM	American Samoa	AS
Hawaii	HI	New York	NY	Guam	GU
Idaho	ID	North Carolina	NC	Puerto Rico	PR
Illinois	IL	North Dakota	ND	Virgin Islands	VI
Indiana	IN	Ohio	OH	Palau	PW
Iowa	IA	Oklahoma	OK	Micronesia	FM
Kansas	KS	Oregon	OR	Marshall Islands	MH
Kentucky	KY	Pennsylvania	PA	Outlying Islands	UM
Louisiana	LA	Rhode Island	RI	APO/FPO Armed Services America	AA
Maine	ME	South Carolina	SC	APO/FPO Armed Services Europe	AE
Maryland	MD	South Dakota	SD	APO/FPO Armed Services Pacific	AP

Canadian Provinces and Territory Abbreviations

Province/Territory	Abbrev	Province/Territory	Abbrev
Alberta	AB	Nunavut	NU
British Columbia	BC	Ontario	ON
Manitoba	MB	Prince Edward Island	PE
New Brunswick	NB	Quebec	QC
Newfoundland and Labrador	NL	Saskatchewan	SK
Northwest Territories	NT	Yukon	YT
Nova Scotia	NS	Canada, province unknown	CD

Current Zip Code

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Addr Current – Postal (Zip) Code	1830	9	01/04	Required

Description

Identifies the postal code of the patient's current address.

Rationale

This data item provides a current postal code for follow-up purposes and should be updated. It is different from *Postal Code at Diagnosis*.

Coding Instructions

- For U.S. residents, record the nine-digit extended postal code for the patient's current usual residence.
- For Canadian residents, record the six-character postal code.
- When available, record the postal code for other countries.
- If the patient has multiple tumors, the postal code should be the same for both tumors.
- Update this data item if the patient's postal code changes.

Code	Definition
(fill spaces)	The patient's nine-digit U.S. extended postal code. Do not record hyphens.
59666_ _ _ _	When the nine-digit extended U.S. Zip Code is not available, record the five-digit postal code, left justified, followed by four blanks.
M6G2S8_ _ _	The patient's six-character Canadian postal code left justified, followed by three blanks.
88888_ _ _ _ or 888888888	Permanent address in a country other than Canada, United States, or U.S. possessions **and** postal code is unknown.
99999_ _ _ _ or 999999999	Permanent address in Canada, United States, or U.S. possession **and** postal code is unknown.

Montana Zip Codes:

See pages 55-58 for Montana Zip codes and associated Counties.

Current Address – Country

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1832	3	New 01/13	Required

Description

Identifies the country of the patient's current residence. The codes are based on International Organization for Standardization (ISO) 3166-1 alpha-3 country codes, with some custom codes.

Rationale

The country code is part of the patient's demographic data and has multiple uses. It may be useful for understanding risk factors, assessment of patient prognosis, and chances for survival.

Coding Instructions

- This item corresponds to the other *Current State*.
- See Appendix B for a list of country codes and their respective state codes.
- This item was first defined for use in 2013; cases diagnosed before that date should be converted automatically by the registry's software.

Examples:

Code	Country
USA	United States
CAN	Canada

Telephone and Type

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2360	11		Required

Description

Records the current telephone number with area code for the patient and describes who the phone number belongs to.

Rationale

This data item may be used by the hospital registry to contact the patient for follow-up.

Coding Instructions

- The telephone number should be the current number with area code of the patient.
- Update this data item if the patient's telephone number changes.

Phone Number:

Code	Definition
(fill spaces)	Number is entered without dashes.
00000000000	Patient does not have a telephone.
99999999999	Telephone number is unavailable or unknown.

Type:

Type	Description
0	Parent
1	Patient
2	Son or daughter
3	Relative, NOS
9	Unknown whose phone number

Class of Case

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	610	2	01/10, 01/11, 01/12, 01/15	Required

Description

Class of Case divides cases into two groups. Analytic cases (codes 00-22) are grouped according to the location of diagnosis and first course of treatment. Non-analytic cases (codes 30-49 and 99) may be abstracted by the facility to meet central registry requirements or in response to a request by the facility's cancer program. Non-analytic cases are grouped according to the reason a patient who received care at the facility is non-analytic, or the reason a patient who never received care at the facility may have been abstracted.

Rationale

Class of Case reflects the facility's role in managing the cancer, whether the cancer is required to be reported by CoC, and whether the case was diagnosed after the program's Reference Date.

Coding Instructions

- Code the *Class of Case* that most precisely describes the patient's relationship to the facility.
- Code 00 applies only when it is known the patient went elsewhere for treatment. If it is not known that the patient actually went somewhere else, code *Class of Case* 10.
- It is possible that information for coding *Class of Case* will change during the patient's first course of care. If that occurs, change the code accordingly.
- Document *NPI-Facility Referred To* or the applicable physician NPI for patients coded 00 to establish that the patient went elsewhere for treatment.
- Code 34 or 36 if the diagnosis benign or borderline (*Behavior* 0 or 1) for any site diagnosed before 2004 or for any site other than meninges (C70._), brain (C71._), spinal cord, cranial nerves, and other parts of the central nervous system (C72._), pituitary gland (C75.1), craniopharyngeal duct (C75.2) and pineal gland (C75.3) that were diagnosed in 2004 or later.
- Code 34 or 36 for carcinoma in situ of the cervix (CIS) and intraepithelial neoplasia grade III (8077/2 or 8148/2) of the cervix (CIN III), prostate (PIN III), vulva (VIN III), vagina (VAIN III), and anus (AIN III).
- Physicians who are not employed by the reporting facility but are under contract with it or have routine admitting privileges there are described in codes 10-12 and 41 as physicians with admitting privileges. Treatment provided in the office of a physician with admitting privileges is provided "elsewhere". That is because care given in the physician's office is not within the hospital's realm of responsibility.
- If the hospital purchases a physician practice, it will be necessary to determine whether the practice is now legally considered part of the hospital (their activity is coded as the hospital's) or not. If the practice is not legally part of the hospital, it will be necessary to determine whether the physicians involved have routine admitting privileges or not, as with any other physician.
- "In-transit" care is care given to a patient who is temporarily away from the patient's usual practitioner for continuity of care. If these cases are abstracted, they are *Class of Case* 31. Monitoring of oral medication started elsewhere is coded Class of Case 31. If a patient begins first course radiation or chemotherapy elsewhere and continues at the reporting facility, and the care is not in-transit, then the case is analytic (*Class of Case* 21).

Analytic Cases

Code	Definition	Reportable by MCTR
	Initial diagnosis at reporting facility or in a staff physician's office	
00	Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done elsewhere	√
10	Initial diagnosis at the reporting facility or in an office of a physician with admitting privileges AND part or all of the first course treatment or a decision not to treat was at the reporting facility, NOS	√
11	Initial diagnosis in an office of a physician with admitting privileges AND part of first course treatment was done at the reporting facility	√
12	Initial diagnosis in an office of a physician with admitting privileges AND all first course treatment or a decision not to treat was done at the reporting facility	√
13	Initial diagnosis at the reporting facility AND part of first course treatment was done at the reporting facility; part of first course treatment was done elsewhere	√
14	Initial diagnosis at the reporting facility AND all first course treatment or a decision not to treat was done at the reporting facility	√
	Initial diagnosis elsewhere, facility involved in first course treatment	
20	Initial diagnosis elsewhere AND part or all of first course treatment was done at the reporting facility, NOS	√
21	Initial diagnosis elsewhere AND part of first course treatment was done at the reporting facility; part of first course treatment was done elsewhere	√
22	Initial diagnosis elsewhere AND all first course treatment or a decision not to treat was done at the reporting facility	√

Non-Analytic Cases

Code	Definition	Reportable by MCTR
	Patient appears in person at reporting facility; both initial diagnosis and treatment elsewhere	
30	Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in diagnostic workup (for example, consult only, treatment plan only, staging workup after initial diagnosis elsewhere)	√
31	Initial diagnosis and all first course treatment elsewhere AND reporting facility provided in-transit care; or hospital provided care that facilitated treatment elsewhere (for example, stent placement)	
32	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease recurrence or persistence (active disease)	√
33	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease history only (disease not active)	
34	Type of case not required to be accessioned by the CoC but required by MCTR (for example, CIN III, PIN III, etc.) AND initial diagnosis AND part or all of first course treatment by reporting facility	√
35	Case diagnosed before program's Reference Date but after MCTR's reference date AND initial diagnosis AND part or all of first course treatment by reporting facility	√
36	Type of case not required to be accessioned by the CoC but required by MCTR (for example, CIN III, PIN III, etc.) AND initial diagnosis elsewhere AND all or part of first course treatment by reporting facility	√
37	Case diagnosed before program's Reference Date AND initial diagnosis elsewhere AND all or part of first course treatment by facility	√
38	Initial diagnosis established by autopsy at reporting facility, cancer not suspected prior to death	√
	Patient does not appear in person at reporting facility	
40	Diagnosis AND all first course treatment given at the same staff physician's office	√
41	Diagnosis and all first course treatment given in two or more different offices of physicians with admitting privileges	√
42	Non-staff physician or non-CoC accredited clinic or other facility, not part of reporting facility, accessioned by reporting facility for diagnosis and/or treatment by that entity (for example, hospital abstracts cases from an independent radiation facility)	

Code	Definition	Reportable
43	Pathology or other lab specimens only	√
49	Death certificate only	
	Unknown relationship to reporting facility	
99	Non-analytic case of unknown relationship to facility (not for use by CoC accredited cancer programs for analytic cases); unknown	

Examples:

Code	Reason
00	Leukemia was diagnosed at the facility, and all care was given in an office of a physician with practice privileges. The treatment may be abstracted if the cancer committee desires, but the case is *Class of Case* 00.
13	Breast cancer was diagnosed at the reporting hospital and surgery performed there. Radiation was given at the hospital across the street with which the reporting hospital has an agreement.
10	Reporting hospital found cancer in a biopsy but was unable to discover whether the homeless patient actually received any treatment elsewhere.
32	After treatment failure, the patient was admitted to the facility for supportive care.
11	Patient was diagnosed by a physician with practice privileges, received neoadjuvant radiation therapy at another facility, then underwent surgical resection at the reporting facility.
42	Patients from an unaffiliated, free-standing clinic across the street that hospital voluntarily abstracts with its cases because many physicians work both at the clinic and at the hospital
31	Patient received chemotherapy while attending daughter's wedding in the reporting hospital's city, then returned to the originating hospital for subsequent treatments.

Analytic Cases

- Cases diagnosed and/or administered any of the first course of treatment at the accessioning facility after the registry's reference date are analytic (*Class of Case* 00-22). A network clinic or outpatient center belonging to the facility is part of the facility.
- Analytic cases, *Class of Case* 10-22, are included in treatment and survival analysis.
- Analytic cases, *Class of Case* 00, diagnosed on or after January 1, 2006 are not required to be staged or followed. *Class of Case* 00 is reserved for patients who are originally diagnosed by the reporting facility and receive all of their treatment elsewhere or a decision not to treat is made elsewhere. If the patient receives no treatment, either because the patient refuses recommended treatment, or a decision is made not to treat, the *Class of Case* is 14. If there is no information about whether or where the patient was treated, the *Class of Case* is 10.

Non-analytic Cases

Non-analytic cases (*Class of Case* 30-99) are not usually included in routine treatment or survival statistics. The MCTR requires them to be reported.

Primary Payer at Diagnosis

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	630	2	07/06, 01/10	Required

Description

Identifies the patient's primary payer/insurance carrier at the time of initial diagnosis and/or treatment.

Rationale

This item is used in financial analysis and as an indicator for quality and outcome analyses. Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires the patient admission page to document the type of insurance or payment structure that will cover the patient while being cared for at the hospital.

Coding Instructions

- If the patient is diagnosed at the reporting facility, record the payer at the time of diagnosis.
- If the patient is diagnosed elsewhere or the payer at the time of diagnosis is not known, record the payer when the patient is initially admitted for treatment.
- Record the type of insurance reported on the patient's admission page.
- Codes 21 and 65-68 are to be used for patients diagnosed on or after January 1, 2006.
- If more than one payer or insurance carrier is listed on the patient's admission page, record the first.
- If the patient's payer or insurance carrier changes, do not change the initially recorded code.

Code	Label	Definition
01	Not insured	Patient has no insurance and is declared a charity write-off
02	Not insured, self-pay	Patient has no insurance and is declared responsible for charges
10	Insurance, NOS	Type of insurance unknown or other than the types listed in codes 20, 21, 31, 35, 60-68
20	Private Insurance: Managed Care, HMO, or PPO	An organized system of prepaid care for a group of enrollees usually within a defined geographic area. Generally formed as one of four types: a group model, an independent physician association (IPA), a network, or a staff model. "Gate-keeper model" is another term for describing this type of insurance
21	Private Insurance: Fee-for-Service	An insurance plan that does not have negotiated fee structure with the participating hospital. Type of insurance plan not coded as 20
31	Medicaid	State government administered insurance for persons who are uninsured, below the poverty level, or covered under entitlement programs Medicaid other than those described in 35
35	Medicaid -Administered through a Managed Care plan	Patient is enrolled in Medicaid through a Managed Care program (e.g., HMO or PPO). The managed care plan pays for all incurred costs
60	Medicare without supplement, Medicare, NOS	Federal government funded insurance for persons who are 62 years of age or older or are chronically disabled (social security insurance eligible). Not described in codes 61, 62, or 63
61	Medicare with supplement, NOS	Patient has Medicare and another type of unspecified insurance to pay costs not covered by Medicare
62	Medicare-Administered through a Managed Care plan	Patient is enrolled in Medicare through a Managed Care plan (e.g., HMO or PPO). The Managed Care plan pays for all incurred costs
63	Medicare with private supplement	Patient has Medicare and private insurance to pay costs not covered by Medicare
64	Medicare with Medicaid eligibility	Federal government Medicare insurance with State Medicaid administered supplement

Code	Label	Definition
65	TRICARE	Department of Defense program providing supplementary civilian-sector hospital and medical services beyond a military treatment facility to military dependents, retirees, and their dependents Formerly CHAMPUS (Civilian Health and Medical Program of the Uniformed Services)
66	Military	Military personnel or their dependents who are treated at a military facility
67	Veterans Affairs	Veterans who are treated in Veterans Affairs facilities
68	Indian/Public Health Service	Patient who receives care at an Indian Health Service facility or at another facility, and the medical costs are reimbursed by the Indian Health Service Patient receives care at Public Health Service facility or at another facility, and medical costs are reimbursed by the Public Health Service
99	Insurance status unknown	It is unknown from the patient's medical record whether or not the patient is insured

Examples:

Code	Reason
01	An indigent patient is admitted with no insurance coverage.
20	A patient is admitted for treatment and the patient admission page states the primary insurance carrier is an HMO.
62	A 65-year old male patient is admitted for treatment and the patient admission page states the patient is covered by Medicare with additional insurance coverage from a PPO.

Race 1

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	160	2	01/09, 01/10, 01/12, 01/13	Required

Description

Identifies the primary race of the person.

Rationale

Racial origin captures information used in research and cancer control activities comparing stage at diagnosis and/or treatment by race. The full coding system should be used to allow for an accurate national comparison.

Coding Instructions

- Additional races reported by the person should be coded in *Race 2, Race 3, Race 4*, and *Race 5*.
- *Race 1* is the field used to compare with race data on cases diagnosed prior to January 1, 2000.
- "Race" is analyzed with *Spanish/Hispanic Origin*. Both items must be recorded.
- All tumors for the same patient should have the same race code.
- If the patient is multiracial, then code all races using *Race 2* through *Race 5* and code all remaining *race* items 88.
- If the person is multiracial and one of the races is white, code the other race(s) first with white in the next race field.
- If the person is multiracial and one of the races is Hawaiian, code Hawaiian as *Race 1*, followed by the other race(s).
- A known race code (other than blank or 99) must not occur more than once. For example, do not code "Black" in *Race 1* for one parent and "Black" in *Race 2* for the other parent.
- If *Race 1* is coded 99, then *Race 2* through *Race 5* must all be coded 99.
- Codes 08-13 became effective with diagnoses on or after January 1, 1988.
- Code 14 became effective with diagnoses on or after January 1, 1994.
- In 2010, code 09 was converted to the new code 15, and codes 16 and 17 were added.
- Codes 20-97 became effective with diagnoses on or after January 1, 1991.
- If a patient diagnosed prior to January 1, 2000, develops a subsequent primary after that date, then *Race 2* through *Race 5* that do not have specific race recorded must be coded 88.

Code	Description	Code	Description
01	White	20	Micronesian, NOS
02	Black	21	Chamorro/Chamoru
03	American Indian, Aleutian, or Eskimo	22	Guamanian, NOS
04	Chinese	25	Polynesian, NOS
05	Japanese	26	Tahitian
06	Filipino	27	Samoan
07	Hawaiian	28	Tongan
08	Korean	30	Melanesian, NOS
10	Vietnamese	31	Fiji Islander
11	Laotian	32	New Guinean
12	Hmong	96	Other Asian, including Asian, NOS and Oriental, NOS
13	Kampuchean (Cambodian)	97	Pacific Islander, NOS
14	Thai	98	Other
15	Asian Indian or Pakistani, NOS	99	Unknown
16	Asian Indian		
17	Pakistani		

Examples:

Code	Reason
01	A patient was born in Mexico of Mexican parentage. *Code also Spanish/Hispanic Origin*.
02	A black female patient.
05	A patient has a Japanese father and a Caucasian mother. (Caucasian will be coded to *Race 2*).
01	Patient is stated to be German-Irish.
08	Patient is described as Asian-American with Korean parents. Code 08 (Korean) because it's more specific than 96 (Asian).

Priority:

Code 07 (Hawaiian) takes priority over all over codes.

Codes 02-98 take priority over code 01.

Code only the specific race when both a specific race code and a non-specific race code apply:

codes 04-17 take priority over code 96;

codes 16-17 take priority over code 15;

codes 20-32 take priority over code 97;

codes 02-32 and 96-97 take priority over code 98;

code 98 takes priority over code 99.

Instructions:

Code 01 (white) when there is a statement that the patient is Hispanic or Latino(a) and no further information is available. Do not code 98 (other). Persons of Spanish or Hispanic origin may be of any race, although persons of Mexican, Central American, South American, Puerto Rican, or Cuban origin are usually White.

Code the race based on birthplace information when the race is recorded as Oriental, Mongolian, or Asian and the place of birth is recorded as China, Japan, the Philippines, or another Asian nation.

Race 2

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	161	2	01/01, 01/09, 01/10, 01/12	Required

Description

Identifies the patient's race.

Rationale

Racial origin captures information used in research and cancer control activities comparing stage at diagnosis and/or treatment by race. The full coding system should be used to allow for an accurate national comparison.

Coding Instructions

- "Race" is analyzed with *Spanish/Hispanic Origin*. Both items must be recorded.
- If *Race 1* is coded 99, then *Race 2* must be coded 99.
- All tumors for the same patient should have the same race code.
- Codes 08-13 became effective with diagnoses on or after January 1, 1988.
- Code 14 became effective with diagnoses on or after January 1, 1994.
- In 2010, code 09 was converted to the new code 15, and codes 16 and 17 were added.
- Codes 20-97 became effective with diagnoses on or after January 1, 1991.
- See the instructions for *Race 1* for coding sequences for entering multiple races.

Code	Description	Code	Description
01	White	20	Micronesian, NOS
02	Black	21	Chamorro/Chamoru
03	American Indian, Aleutian, or Eskimo	22	Guamanian, NOS
04	Chinese	25	Polynesian, NOS
05	Japanese	26	Tahitian
06	Filipino	27	Samoan
07	Hawaiian	28	Tongan
08	Korean	30	Melanesian, NOS
10	Vietnamese	31	Fiji Islander
11	Laotian	32	New Guinean
12	Hmong	96	Other Asian, including Asian, NOS and Oriental, NOS
13	Kampuchean (Cambodian)	97	Pacific Islander, NOS
14	Thai	98	Other
15	Asian Indian or Pakistani, NOS	99	Unknown
16	Asian Indian		
17	Pakistani		

Race 3

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	162	2	01/04, 01/09, 01/10, 01/12	Required

Description

Identifies the patient's race.

Rationale

Racial origin captures information used in research and cancer control activities comparing stage at diagnosis and/or treatment by race. The full coding system should be used to allow for an accurate national comparison.

Coding Instructions

- "Race" is analyzed with *Spanish/Hispanic Origin*. Both items must be recorded.
- If *Race 2* is coded 88 or 99, then *Race 3* must be coded with the same value.
- All tumors for the same patient should have the same race code.
- Codes 08-13 became effective with diagnoses on or after January 1, 1988.
- Code 14 became effective with diagnoses on or after January 1, 1994.
- In 2010, code 09 was converted to the new code 15, and codes 16 and 17 were added.
- Codes 20-97 became effective with diagnoses on or after January 1, 1991.
- See the instructions for *Race 1* for coding sequences for entering multiple races.

Code	Description	Code	Description
01	White	20	Micronesian, NOS
02	Black	21	Chamorro/Chamoru
03	American Indian, Aleutian, or Eskimo	22	Guamanian, NOS
04	Chinese	25	Polynesian, NOS
05	Japanese	26	Tahitian
06	Filipino	27	Samoan
07	Hawaiian	28	Tongan
08	Korean	30	Melanesian, NOS
10	Vietnamese	31	Fiji Islander
11	Laotian	32	New Guinean
12	Hmong	96	Other Asian, including Asian, NOS and Oriental, NOS
13	Kampuchean (Cambodian)	97	Pacific Islander, NOS
14	Thai	98	Other
15	Asian Indian or Pakistani, NOS	99	Unknown
16	Asian Indian		
17	Pakistani		

Race 4

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	163	2	01/04, 01/09, 01/10, 01/12	Required

Description

Identifies the patient's race.

Rationale

Racial origin captures information used in research and cancer control activities comparing stage at diagnosis and/or treatment by race. The full coding system should be used to allow for an accurate national comparison.

Coding Instructions

- "Race" is analyzed with *Spanish/Hispanic Origin*. Both items must be recorded.
- If *Race 3* is coded 88 or 99, then *Race 4* must be coded with the same value.
- All tumors for the same patient should have the same race code.
- Codes 08-13 became effective with diagnoses on or after January 1, 1988.
- Code 14 became effective with diagnoses on or after January 1, 1994.
- In 2010, code 09 was converted to the new code 15, and codes 16 and 17 were added.
- Codes 20-97 became effective with diagnoses on or after January 1, 1991.
- See the instructions for *Race 1* for coding sequences for entering multiple races.

Code	Description	Code	Description
01	White	20	Micronesian, NOS
02	Black	21	Chamorro/Chamoru
03	American Indian, Aleutian, or Eskimo	22	Guamanian, NOS
04	Chinese	25	Polynesian, NOS
05	Japanese	26	Tahitian
06	Filipino	27	Samoan
07	Hawaiian	28	Tongan
08	Korean	30	Melanesian, NOS
10	Vietnamese	31	Fiji Islander
11	Laotian	32	New Guinean
12	Hmong	96	Other Asian, including Asian, NOS and Oriental, NOS
13	Kampuchean (Cambodian)	97	Pacific Islander, NOS
14	Thai	98	Other
15	Asian Indian or Pakistani, NOS	99	Unknown
16	Asian Indian		
17	Pakistani		

Race 5

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	164	2	01/04, 01/09, 01/10, 01/12	Required

Description

Identifies the patient's race.

Rationale

Racial origin captures information used in research and cancer control activities comparing stage at diagnosis and/or treatment by race. The full coding system should be used to allow for an accurate national comparison.

Coding Instructions

- "Race" is analyzed with *Spanish/Hispanic Origin*. Both items must be recorded.
- If *Race 4* is coded 88 or 99, then *Race 5* must be coded with the same value.
- All tumors for the same patient should have the same race code.
- Codes 08-13 became effective with diagnoses on or after January 1, 1988.
- Code 14 became effective with diagnoses on or after January 1, 1994.
- In 2010, code 09 was converted to the new code 15, and codes 16 and 17 were added.
- Codes 20-97 became effective with diagnoses on or after January 1, 1991.
- See the instructions for *Race 1* for coding sequences for entering multiple races.

Code	Description	Code	Description
01	White	20	Micronesian, NOS
02	Black	21	Chamorro/Chamoru
03	American Indian, Aleutian, or Eskimo	22	Guamanian, NOS
04	Chinese	25	Polynesian, NOS
05	Japanese	26	Tahitian
06	Filipino	27	Samoan
07	Hawaiian	28	Tongan
08	Korean	30	Melanesian, NOS
10	Vietnamese	31	Fiji Islander
11	Laotian	32	New Guinean
12	Hmong	96	Other Asian, including Asian, NOS and Oriental, NOS
13	Kampuchean (Cambodian)	97	Pacific Islander, NOS
14	Thai	98	Other
15	Asian Indian or Pakistani, NOS	99	Unknown
16	Asian Indian		
17	Pakistani		

Spanish/Hispanic Origin

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Ethnicity	190	1	09/04	Required

Description

Identifies persons of Spanish or Hispanic origin.

Rationale

This code is used by hospitals and central registries to identify whether or not the person should be classified as "Hispanic" for purposes of calculating cancer rates. Hispanic populations have different patterns of occurrence of cancer from other populations that may be included in the 01 (White category) or *Race 1* through *Race 5*.

Coding Instructions

- Persons of Spanish or Hispanic origin may be of any race, but these categories are generally not used for Native Americans, Filipinos, or others who may have Spanish names.
- Code 0 (Non-Spanish; non-Hispanic) for Portuguese and Brazilian persons.
- If the patient has multiple tumors, all records should have the same code.

Code	Label
0	Non-Spanish; non-Hispanic
1	Mexican (includes Chicano)
2	Puerto Rican
3	Cuban
4	South or Central American (except Brazil)
5	Other specified Spanish/Hispanic origin (includes European; excludes Dominican Republic)
6	Spanish, NOS; Hispanic, NOS; Latino, NOS (There is evidence other than surname or maiden name that the person is Hispanic, but he/she cannot be assigned to any other category of 1-5)
7	Spanish surname only (The only evidence of the person's Hispanic origin is surname or maiden name, and there is no contrary evidence that the person is not Hispanic)
8	Dominican Republic (for use with patients who were diagnosed with cancer on January 1, 2005, or later)
9	Unknown whether Spanish or not; not stated in patient record

Usual Occupation

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Text – Usual Occupation	310	100	01/10, 01/12	Required

Description

Text area for information about the patient's usual occupation, also known as usual type of job or work.

Rationale

Used to identify new work-related health hazards; serves as an additional measure of socioeconomic status; identifies occupational groups in which cancer screening or prevention activities may be beneficial. This data item applies only to patients who are age 14 years or older at the time of diagnosis.

Coding Instructions

- Record the patient's usual occupation (i.e., the kind of work performed during most of the patient's working life before diagnosis of this tumor). Do not record "retired". **Example**: record "teacher" rather than "retired teacher".
- If usual occupation is not available or is unknown, record the patient's current or most recent occupation, or any known occupation.
- Update this field if better information is obtained as to the usual occupation of the patient. However, it is not the responsibility of the registrar to update abstracts with information provided on death certificates.
- If the patient was a housewife/househusband and also worked outside the home most of his/her adult life, record the usual occupation outside of the home. If the patient was a housewife/househusband and did not work outside the home for most of his/her adult life, record "housewife" or "househusband".
- If the patient was not a student or housewife and never worked, record "never worked" as the usual occupation.
- If no information is available, record "unknown".
- Spell out acronyms of occupations; do not just record the acronym. For example, spell out Registered Nurse rather than RN.

Usual Industry

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Text – Usual Industry	320	100	01/10, 01/12	Required

Description

Text area for information about the patient's usual industry; also known as usual kind of business/industry.

Rationale

Used to identify new work-related health hazards, serves as an additional measure of socioeconomic status; identifies industrial groups or worksite-related groups in which cancer screening or prevention activities may be beneficial. This data item applies only to patients who are age 14 years or older at the time of diagnosis.

Coding Instructions

- Record the primary type of activity carried on by the business/industry where the patient was employed for the most number of years before diagnosis of this tumor. Do not record "retired". **Example**: record "elementary school" rather than "retired from elementary school".
- Be sure to distinguish among "manufacturing", "wholesale", "retail", and "service" components of an industry which performs more than one of these components.
- If the primary activity carried on at the location where the patient worked is unknown, it may be sufficient to record the name of the company (with city or town) for which the patient performed his/her usual occupation. In these situations, if resources permit, a central registry may be able to use the employer name and city/town to determine the type of activity conducted at that location
- If current or most recent occupation, rather than usual occupation was recorded, record the patient's current or most recent business/industry.
- Update this field if better information is obtained as to the usual industry of the patient. However, it is not the responsibility of the registrar to update abstracts with industry information provided on death certificates.
- There should be an entry for "usual industry" if any occupation is recorded. If no information is available regarding industry in which the reported occupation was carried out, record "unknown".
- Spell out acronyms of industry/company; do not just record the acronym. For example, spell out "Department of Public Health and Human Services" rather than "DPHHS".
- Describe the company if the name of the company is not in itself descriptive. For example, describe "Sam's" as "Sam's Exxon Gas Station".

Tobacco History

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Smoking History	340	1	01/09	Required

Description

Identifies the patient's past or current use of tobacco.

Rationale

This data item is used to evaluate if previous or present tobacco use may have caused a higher risk of cancer.

Coding Instructions

Code	Definition
0	Never used
1	Cigarette smoker, current
2	Cigar/pipe smoker, current
3	Snuff/chew/smokeless, current
4	Combination use, current
5	Previous use
9	Unknown

Alcohol History

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	350	1	01/09	Required

Description

Indicates the patient's past or current consumption of alcoholic beverages.

Rationale

This data item is used to evaluate if previous or present alcohol use have caused a higher risk of cancer.

Coding Instructions

Code	Definition
0	No history of alcohol use
1	Current use of alcohol
2	Past history of alcohol use, does not currently use
9	Alcohol usage unknown

Marital Status at DX

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	150	1	01/12, 01/13	Required

Description

Identifies the patient's marital status at diagnosis.

Rationale

This data item is used to evaluate marital status and identify those at risk for certain cancers. Marital status for both men and women is correlated with mortality, stage at diagnosis, tumor size at diagnosis, cancer screening, cancer treatment delay, and other healthcare seeking behaviors. It is an important factor to consider when reporting disparities in diagnosis and survival.

Coding Instructions

- Code the patient's marital status at diagnosis for each primary tumor.
- If the patient has more than one primary tumor, the marital status may be different for each.
- Marital status should not be modified or updated if the patient's marital status changes after diagnosis.
- If a patient is under 15 years of age, assume he/she is single and code 1.
- Code 6 is applicable for cases diagnosed on or after January 1, 2011.

Code	Definition
1	Single (never married)
2	Married (including common law)
3	Separated
4	Divorced
5	Widowed
6	Unmarried or domestic partner (same sex or opposite sex, registered or unregistered)
9	Unknown

Spouse/Parent Name

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Name – Spouse/Parent	2290	60	01/10	Required

Description

Identifies the patient's spouse or parent.

Rationale

This data item is used to confirm marital status and to aid in follow-up of the patient.

Coding Instructions

- Record the patient's spouse's name if the patient is married.
- Record the patient's parent's name if the patient is unmarried or is still a child.

Secondary Diagnosis 1

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	3780	7	New 01/13	Required by CoC

Description

Records the patient's preexisting medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-10-CM values.

Rationale

Pre-existing medical conditions, factors influencing health status, and/or complications may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care.

Coding Instructions

- Use this item to record ICD-10-CM codes.
- Only the actual ICD-10-CM code is to be entered for *Secondary Diagnosis* fields, leaving blanks beyond those characters.
- Omit the decimal points when coding.
- Secondary diagnoses are found on the discharge abstract. Information from the billing department at your facility may be consulted when a discharge abstract is not available.
- Code the secondary diagnoses in the sequence in which they appear on the discharge abstract or are recorded by the billing department at your facility.
- Report the secondary diagnoses for this cancer using the following priority rules:
  - Surgically treated patients:
    a) following the most definitive surgery of the primary site
    b) following other non-primary site surgeries
  - Non-surgically treated patients:
    following the first treatment encounter/episode
  - In cases of non-treatment:
    following the last diagnostic/evaluative encounter
- If the data item *Readmission to the Same Hospital Within 30 Days of Surgical Discharge* is coded 1, 2, or 3, report *Secondary Diagnosis* ICD-10-CM codes appearing on the "readmission" discharge abstract.
- If no ICD-10-CM secondary diagnoses were documented, then code 0000000 in this data item, and leave the remaining *Secondary Diagnosis* data items blank.
- If fewer than 10 ICD-10-CM secondary diagnoses are listed, then code the diagnoses listed, and leave the remaining *Secondary Diagnosis* data items blank.

Examples:

Code	Reason (ICD-10-CM)
J449	Chronic obstructive pulmonary disease, unspecified (ICD-10-CM code J44.9)
E119	Type 2 diabetes mellitus without complications (ICD-10-CM code E11.9)
Y632	The patient was inadvertently exposed to an overdose of radiation during a medical procedure (ICD-10-CM code Y63.2)
T360X5	During hospitalization, the patient has an adverse reaction to Ampicillin, a semisynthetic form of penicillin (ICD-10-CM code T36.0X5)
Z853	The patient has a personal history of breast cancer (ICD-10-CM code Z85.3)
0000000	No applicable ICD-10-CM codes are recorded in this patient's record

Secondary Diagnosis 2-10

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	3782-1798	7	New 01/13, 01/15	Required by CoC

Description

Records the patient's preexisting medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-10-CM values.

Rationale

Pre-existing medical conditions, factors influencing health status, and/or complications may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care.

Coding Instructions

- Use this item to record ICD-10-CM codes.
- Only the actual ICD-10-CM code is to be entered for *Secondary Diagnosis* fields, leaving blanks beyond those characters.
- Omit the decimal points when coding.
- Secondary diagnoses are found on the discharge abstract. Information from the billing department at your facility may be consulted when a discharge abstract is not available.
- Code the secondary diagnoses in the sequence in which they appear on the discharge abstract or are recorded by the billing department at your facility.
- Report the secondary diagnoses for this cancer using the following priority rules:
  - Surgically treated patients:
    a) following the most definitive surgery of the primary site
    b) following other non-primary site surgeries
  - Non-surgically treated patients:
    following the first treatment encounter/episode
  - In cases of non-treatment:
    following the last diagnostic/evaluative encounter
- If the data item *Readmission to the Same Hospital Within 30 Days of Surgical Discharge* is coded 1, 2, or 3, report *Secondary Diagnosis* ICD-10-CM codes appearing on the "readmission" discharge abstract.
- If fewer than 10 ICD-10-CM secondary diagnoses are listed, then code the diagnoses listed, and leave the remaining *Secondary Diagnosis* data items blank.

Examples:

Code	Reason (ICD-10-CM)
J449	Chronic obstructive pulmonary disease, unspecified (ICD-10-CM code J44.9)
E119	Type 2 diabetes mellitus without complications (ICD-10-CM code E11.9)
Y632	The patient was inadvertently exposed to an overdose of radiation during a medical procedure (ICD-10-CM code Y63.2)
T360X5	During hospitalization, the patient has an adverse reaction to Ampicillin, a semisynthetic form of penicillin (ICD-10-CM code T36.0X5)
Z853	The patient has a personal history of breast cancer (ICD-10-CM code Z85.3)
blank	No applicable ICD-10-CM codes are recorded in this patient's record

Facility Referred From

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Institution Referred From	2410	10	01/09	Optional

Description

Identifies the facility that referred the patient to the reporting facility.

Rationale

Each facility's identification number (FIN) is unique. This number is used to document and monitor referral patterns.

Coding Instructions

- For facilities with seven-digit FINs in the range of 6020009-6953290 that were assigned by the CoC before January 1, 2001, the coded FIN will consist of three leading zeros followed by the full seven-digit number.
- For facilities with eight-digit FINs greater than or equal to 10000000 that were assigned by the CoC after January 1, 2001, the coded FIN will consist of two leading zeroes followed by the full eight-digit number.
- A complete list of FINs is available on the American College of Surgeons Website at https://www.facs.org/quality-programs/cancer/accredited/info/fin. NPI numbers are available through the facility's billing or accounting department or at https://nppescms.hhs.gov/NPPES/Welcome.do.

Code	Definition
(fill spaces)	Seven or eight-digit FIN
0000000000	If the patient was not referred to the reporting facility from another facility
0099999999	If the patient was referred, but the referring facility's ID number is unknown

Examples:

Code	Reason
0006439999	6439999, General Hospital, Anytown, Montana
0010000099	10000099, Anytown Medical Center, Anytown, Montana

Facility Referred To

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Institution Referred To	2420	10	01/09	Optional

Description

Identifies the facility to which the patient was referred for further care after discharge from the reporting facility.

Rationale

Each facility's identification number (FIN) is unique. This number is used to document and monitor referral patterns.

Coding Instructions

- For facilities with seven-digit FINs in the range of 6020009-6953290 that were assigned by the CoC before January 1, 2001, the coded FIN will consist of three leading zeros followed by the full seven-digit number.
- For facilities with eight-digit FINs greater than or equal to 10000000 that were assigned by the CoC after January 1, 2001, the coded FIN will consist of two leading zeroes followed by the full eight-digit number.
- A complete list of FINs is available on the American College of Surgeons Website at https://www.facs.org/quality-programs/cancer/accredited/info/fin. NPI numbers are available through the facility's billing or accounting department or at https://nppescms.hhs.gov/NPPES/Welcome.do.

Code	Definition
(fill spaces)	Eight-digit facility ID number
0000000000	If the patient was not referred to another facility
0099999999	If the patient was referred, but the facility's ID number is unknown

Examples:

Code	Reason
0006439999	6439999, General Hospital, Anytown, Montana
0010000099	10000099, Anytown Medical Center, Anytown, Montana

NPI-Facility Referred From

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
NPI Institution Referred From	2415	10	01/09	Required by CoC

Description

Identifies the facility that referred the patient to the reporting facility.

Rationale

Each facility's NPI is unique. This number is used to document and monitor referral patterns.

NPI–Institution Referred From is the NPI equivalent of *Facility Referred From*. Both are required during a period of transition.

Coding Instructions

- Record the 10-digit NPI for the referring facility.
- NPI should be recorded as available for cases diagnosed during 2007 and is required to be recorded for all cases diagnosed January 1, 2008, and later.
- NPI may be blank for cases diagnosed on or before December 31, 2006.
- Check with the registry, billing, or health information departments of the facility to determine its NPI or search at https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.

Code	Definition
(fill spaces)	10-digit NPI number for the facility
(leave blank)	NPI for the referring facility is unknown or not available
(leave blank)	If the patient was not referred to the reporting facility from another facility

NPI-Facility Referred To

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
NPI Institution Referred To	2425	10	01/09	Required by CoC

Description

Identifies the facility to which the patient was referred for further care after discharge from the reporting facility.

Rationale

Each facility's NPI is unique. This number is used to document and monitor referral patterns.

NPI–Institution Referred To is the NPI equivalent of *Facility Referred To*. Both are required during a period of transition.

Coding Instructions

- Record the 10-digit NPI for the facility to which the patient was referred.
- NPI should be recorded as available for cases diagnosed during 2007 and is required to be recorded for all cases diagnosed January 1, 2008, and later.
- NPI may be blank for cases diagnosed on or before December 31, 2006.
- Check with the registry, billing, or health information departments of the facility to determine its NPI or search at https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.

Code	Definition
(fill spaces)	10-digit NPI number for the facility
(leave blank)	NPI for the facility referred to is unknown or not available
(leave blank)	If the patient was not referred to the reporting facility from another facility

Casefinding Source

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	501	2	01/15	Required

Description

This variable codes the earliest source of identifying information. For cases identified by a source other than reporting facilities (such as through death clearance or as a result of an audit), this variable codes the type of source through which the tumor was first identified. This data item cannot be used by itself as a data quality indicator. The timing of the casefinding processes (e.g., death linkage) varies from registry to registry, and the coded value of this variable is a function of that timing.

Rationale

This data item will help reporting facilities as well as regional and central registries in prioritizing their casefinding activities. It will identify reportable tumors that were first found through death clearance or sources other than traditional reporting facilities. It provides more detail than “Type of Reporting Source”.

Coding Instructions

- Code the source that first identified the tumor. Determine where the case was first identified and enter the appropriate code.
- At the regional or central level, if a hospital and a non-hospital source identified the case independently of each other, enter the code for the non-hospital source (i.e., codes 30-95 have priority over codes 10-29).
- If the case was first identified at a reporting facility (codes 10-29), code the earliest source (based on patient or specimen contact at the facility) of identifying information.
- If a death certificate, independent pathology laboratory report, consultation-only report from a hospital, or other report was used to identify a case that was then abstracted from a different source, enter the code for the source that first identified the case, not the source from which it was subsequently abstracted.
- If a regional or central registry identifies a case and asks a reporting facility to abstract it, enter the code that corresponds to the initial source, not the code that corresponds to the eventual reporting facility.

Codes

Cases first identified at a reporting facility

Code	Definition
10	Reporting hospital, NOS
20	Pathology department review (surgical pathology reports, autopsies, or cytology reports)
21	Daily discharge review (daily screening of charts of discharged patients in the medical records department)
22	Disease index review (review of disease index in the medical records department)
23	Radiation therapy department/center
24	Laboratory reports (other than pathology reports, code 20)
25	Outpatient chemotherapy
26	Diagnostic imaging/radiology (other than radiation therapy, code 23; includes nuclear medicine)
27	Tumor board
28	Hospital rehabilitation service or clinic
29	Other hospital source (including clinic, NOS or outpatient department, NOS)

Cases first identified by source other than a reporting facility covered in the codes above

Code	Definition
30	Physician-initiated case
40	Consultation-only or pathology-only report (not abstracted by reporting hospital
50	Independent (non-hospital) pathology-Laboratory report
60	Nursing home-initiated case
70	Coroner's office records review
75	Managed care organization (MCO) or insurance records
80	Death certificate (case identified through death clearance)
85	Out-of-state case sharing
90	Other non-reporting hospital source
95	Quality control review (case initially identified through quality control activities such as casefinding audit of a regional or central registry)
99	Unknown

Cancer Information

Place of Diagnosis Text

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Text – Place of Diagnosis	2690	60	01/10, 01/12	Required

Description

Text area for manual documentation of the facility, physician office, city, state, or county where the diagnosis was made.

Rationale

Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted with coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values.

Coding Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR or MCTR-approved abbreviations should be utilized (see website www.cancer.mt.gov for lists).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including *Remarks*. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Suggestions for text:

- The complete name of the hospital or physician office where diagnosis occurred. The initials of a hospital are not adequate.
- For out-of-state residents and facilities, include the city and the state where the medical facility is located.

Data Item(s) to be verified/validated using the text entered in this field include the *Reporting Hospital*, *Type of Reporting Source*, *Class of Case*, *Facility Referred From*, and *Facility Referred To* fields. After manual entry of the text field, ensure that the text entered on both agrees with the coded values and clearly justifies the selected codes.

Date of Diagnosis

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Diagnosis Date	390	8	01/09, 01/10, 01/11, 01/13	Required

Description

Records the date of initial diagnosis by a physician for the tumor being reported.

Rationale

The timing for staging and treatment of cancer begins with the date of initial diagnosis for cancer.

Coding Instructions

- Use the first date of diagnosis whether clinically or histologically confirmed.
- If the physician states that in retrospect the patient had cancer at an earlier date, use the earlier date as the date of diagnosis.
- Refer to the list of "Ambiguous Terms" for language that represents a diagnosis of cancer.
- Use the date treatment was started as the date of diagnosis if the patient receives a first course of treatment before a diagnosis is documented.
- The date of death is the date of diagnosis for a *Class of Case* 38 (diagnosed at autopsy) or 49 (death certificate only).
- Use the actual date of diagnosis for an *in utero* diagnosis, for cases diagnosed on January 1, 2009 or later. For cases diagnosed before January 1, 2009, assign the date of birth.
- If the year of diagnosis cannot be identified, it must be approximated. In that instance, the month and day are unknown.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date of Initial Diagnosis* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of Initial Diagnosis* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date.

Examples:

Date	Reason
July 2, 2010	Cytology "suspicious" for cancer June 12, 2010; pathology positive July 2, 2010. Do not consider cytology with ambiguous terms to be diagnostic.
May 17, 2010	Pathology "suspicious" for cancer May 17, 2010; confirmed positive May 22, 2010.
April 2010	Physician's referral notes dated July 5, 2010 indicate the patient was diagnosed with cancer spring of 2010. Use April for "spring", July for "summer" or "mid-year", October for "fall" or "autumn". In winter, attempt to determine whether the diagnosis was "late in the year" (use December with the applicable year) or "early in year" (use January with the respective year).

Estimating the year of diagnosis

Code "a couple of years" to two years earlier

Code "a few years" to three years earlier

Use whatever information is available to calculate the year of diagnosis

Code year of admission (date of first contact) when there is no basis for estimation

Date of Diagnosis Flag

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	391	2	New 01/10, 01/11	Required

Description

This flag explains why there is no appropriate value in the corresponding date field, *Date of Initial Diagnosis*.

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

- *Date of Diagnosis Flag* should never be used because of the rule that specifies that the *Date of Diagnosis* should never be unknown; the year should be estimated.
- Leave this item blank if *Date of Initial Diagnosis* has a full or partial date recorded.
- Code 12 if the *Date of Initial Diagnosis* cannot be determined at all.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Definition
12	A proper value is applicable but not known (for example, date of initial diagnosis is unknown)
(Blank)	A valid date is provided in item *Date of Initial Diagnosis*

Primary Site Title

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Text – Primary Site Title	2580	100	01/10, 01/12	Required

Description

Text area for manual documentation of information regarding the primary site and laterality of the tumor being reported.

Rationale

Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted with coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and **should not be generated electronically from coded values**.

Coding Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR or MCTR-approved abbreviations should be utilized (see website www.cancer.mt.gov for lists).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including *Remarks Text*. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Suggestions for text:

- State the specific location of the primary site, including subsite
- Include available information on tumor laterality

Data Item(s) to be verified/validated using the text entered in this field include the *Primary Site* and the *Laterality* fields. After manual entry of the text field, ensure that the text entered on both agrees with the coded values and clearly justifies the selected codes.

CANCER IDENTIFICATION

Follow the instructions in the ICD-O-3 section, "Coding Guidelines for Topography and Morphology" (ICD-O-3 pp. 19-42) to code *Primary Site*, *Histology*, *Behavior Code*, and *Grade/Differentiation*.

Primary Site

The Coding Instructions primary site are found in the "Topography" section of the ICD-O-3 "Coding Guidelines for Topography and Morphology" (ICD-O-3 pages 23-26). The following guidelines should be followed for consistent analysis of primary sites for particular histologies.

Hematopoietic and Lymphoid Cancers

Beginning with cases diagnosed in 2010, the **Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual** is to be used for coding primary site, histology, and grade of hematopoietic tumors (M-9590-9992) and to determine whether multiple conditions represent one or more tumors to be abstracted.

Kaposi Sarcoma

- Code Kaposi sarcoma to the site in which it arises.
- Code to Skin (C44.9) if Kaposi sarcoma arises simultaneously in the skin and another site or the primary site is not identified.

Melanoma

- Code to Skin, NOS (C44.9) if a patient is diagnosed with metastatic melanoma and the primary site is not identified.

Specific Tissues with Ill-Defined Sites

- If any of the following histologies appears only with an ill-defined site description (e.g., "abdominal" or "arm"), code it to the tissue in which such tumors arise rather than the ill-defined region (C76._) of the body, which contains multiple tissues. Use the alphabetic index in **ICD-O-3** to assign the most specific site if only a general location is specified in the record.

Histology	Description	Code to This Site
8720-8790	Melanoma	C44._, Skin
8800-8811, 8813-8830, 8840-8921, 9040-9044	Sarcoma except periosteal fibrosarcoma and dermatofibrosarcoma	C49._, Connective, Subcutaneous and Other Soft Tissues
8990-8991	Mesenchymoma	C49._, Connective, Subcutaneous and Other Soft Tissues
9120-9170	Blood vessel tumors, lymphatic vessel tumors	C49._, Connective, Subcutaneous and Other Soft Tissues
9580-9582	Granular cell tumor and alveolar soft part sarcoma	C49._, Connective, Subcutaneous and Other Soft Tissues
9240-9252	Mesenchymal chrondrosarcoma and giant cell tumors	C40._, C41,_ for Bone and Cartilage C49._, Connective, Subcutaneous and Other Soft Tissues
8940-8941	Mixed tumor, salivary gland type	C07._ for Parotid Gland C08._ for Other and Unspecified Major Salivary Glands

Primary Site

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	400	4	01/04, 01/09, 01/10	Required

Description

Identifies the primary site.

Rationale

Primary Site is a basis for staging and determination of treatment options. If also affects the prognosis and course of the disease.

Coding Instructions

- Record the ICD-O-3 topography code for the site of origin.
- Consult the physician advisor to identify the primary site or the most definitive site code if the medical record does not contain that information.
- Topography codes are indicated by a "C" preceding the three-digit code number. Do not record the decimal point.
- Follow the Coding Instructions in ICD-O-3, pages 20-40 and in the current *SEER Multiple Primary and Histology Coding Rules or 2018 Solid Tumor Rules* to assign site for solid tumors.
- Follow the instructions in *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* and the Hematopoietic and Lymphoid Neoplasms Database (hematopoietic DB) for assigning site for lymphomas, leukemia and other hematopoietic neoplasms.
- Use subcategory 8 for single tumors that overlap the boundaries of two or more sub-sites and the point of origin is not known.
- Use subcategory 9 for multiple tumors that originate in one organ.

Examples:

Code	Reason
C108	Overlapping lesion of oropharynx. Code overlapping lesion when a large tumor involves both the lateral wall of the oropharynx (C10.2) and the posterior wall of the oropharynx (C10.3) and the point of origin is not stated.
C678	Overlapping lesion of bladder. Code overlapping lesion of the bladder when a single lesion involves the dome (C67.1) and the lateral wall (C67.2) and the point of origin is not stated.
C189	Colon, NOS. Familial polyposis with carcinoma and carcinoma in-situ throughout the transverse (C18.4) and descending colon (C18.6) would be one primary and coded to colon, NOS (C18.9). For a full explanation see the *SEER Multiple Primary and Histology Coding Rules or 2018 Solid Tumor Coding Rules*.
C16_	Stomach (sub-site as identified). An extranodal lymphoma of the stomach would be coded to C16._ (sub-site as identified).

Laterality

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Paired Organ	410	1	01/04, 01/10, 01/11, 01/13	Required

Description

Identifies the side of a paired organ or the side of the body on which the reportable tumor originated. This applies to the primary site only.

Rationale

Laterality supplements staging and extent of disease information and defines the number of primaries involved.

Coding Instructions

- Code laterality for all paired sites (see list of paired organs on the following page).
- Do not code metastatic sites as bilateral involvement.
- If both lungs have nodules or tumors and the lung of origin is not known, assign code 4.
- Where the right and left sides of paired sites are contiguous (come into contact) and the lesion is at the point of contact of the right and left sides, use code 5, midline. Note that "midline of the right breast" is coded 1, right; midline in this usage indicates the primary site is C50.8 (overlapping sites).
- Non-paired sites may be coded right or left, if appropriate. Otherwise, code non-paired sites 0.

Code	Definition
0	Organ is not a paired site
1	Origin of primary is right
2	Origin of primary is left
3	Only one side involved, right or left origin not specified
4	Bilateral involvement at time of diagnosis, lateral origin unknown for a single primary; or both ovaries involved simultaneously with a single histology; bilateral retinoblastomas; bilateral Wilms tumors
5	Paired site: midline tumor
9	Paired site, but no information concerning laterality

Laterality must be recorded for the following paired organs as 1-5 or 9. Organs that are not paired, unless they are recorded "right" or "left" laterality, are coded 0. Midline origins are coded 5. "Midline" in this context refers to the point where the "right" and "left" sides of paired organs come into direct contact and a tumor forms at that point. Most paired sites cannot develop midline tumors. For example, skin of the trunk can have a midline tumor, but the breasts cannot.

Paired Organ Sites

ICD-O-3	Site
C07.9	Parotid gland
C08.0	Submandibular gland
C08.1	Sublingual gland
C09.0	Tonsillar fossa
C09.1	Tonsillar pillar
C09.8	Overlapping lesion of tonsil
C09.9	Tonsil, NOS
C30.0	Nasal cavity (excluding nasal cartilage and nasal septum)
C30.1	Middle ear
C31.0	Maxillary sinus
C31.2	Frontal sinus
C34.0	Main bronchus (excluding carina)
C34.1-C34.9	Lung
C38.4	Pleura
C40.0	Long bones of upper limb and scapula
C40.1	Short bones of upper limb
C40.2	Long bones of lower limb
C40.3	Short bones of lower limb
C41.3	Rib and clavicle (excluding sternum)
C41.4	Pelvic bones (excluding sacrum, coccyx, and symphysis pubis)
C44.1	Skin of eyelid
C44.2	Skin of external ear
C44.3	Skin of other and unspecified parts of face
C44.5	Skin of trunk
C44.6	Skin of upper limb and shoulder
C44.7	Skin of lower limb and hip
C47.1	Peripheral nerves and autonomic nervous system of upper limb and shoulder
C47.2	Peripheral nerves and autonomic nervous system of lower limb and hip
C49.1	Connective, subcutaneous, and other soft tissues of upper limb and shoulder
C49.2	Connective, subcutaneous, and other soft tissues of lower limb and hip
C50.0-C50.9	Breast
C56.9	Ovary
C57.0	Fallopian tube
C62.0-C62.9	Testis
C63.0	Epididymis
C63.1	Spermatic cord
C64.9	Kidney, NOS
C65.9	Renal pelvis
C66.9	Ureter
C69.0-C69.9	Eye and lacrimal gland
C70.0	Cerebral meninges, NOS
C71.0 – C71.1	Cerebrum and Frontal lobe
C71.2 – C71.4	Temporal, Parietal, and Occipital lobes
C72.2 – C72.5	Olfactory, Optic, Acoustic, and Cranial nerves, NOS
C74.0-C74.9	Adrenal gland
C75.4	Carotid body

Diagnostic Confirmation

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	490	1	01/10, 01/11, 01/12, 01/13	Required

Description

Records the best method of diagnostic confirmation of the cancer being reported at any time in the patient's history. The rules for coding differ between solid tumors and hematopoietic and lymphoid neoplasms.

Rationale

This item is an indicator of the precision of diagnosis. The percentage of solid tumors that are clinically diagnosed only is an indication of whether casefinding includes sources beyond pathology reports. Complete casefinding must include both clinically and pathologically confirmed cases.

Coding Instructions Solid Tumors (all tumors except M9590-9992)

- These instructions apply to "Codes for Solid Tumors" below. See the section following this one for "Coding Hematopoietic or Lymphoid Tumors (9590-9992)".
- The codes are in **priority order**; code 1 as the highest priority. Always code the procedure with the lower numeric value when presence of cancer is confirmed with multiple diagnostic methods. This data item must be changed to the lower (higher priority) code if a more definitive method confirms the diagnosis *at any time during* the course of the disease.
- Assign code 1 when the microscopic diagnosis is based on tissue specimens from biopsy, frozen section, surgery, autopsy, or D & C or from aspiration of biopsy of bone marrow specimens.
- Assign code 2 when the microscopic diagnosis is based on cytologic examination of *cells* such as sputum smears, bronchial brushings, bronchial washings, prostatic secretions, breast secretions, gastric fluid, spinal fluid, peritoneal fluid, pleural fluid, urinary sediment, cervical smears and vaginal smears, or from paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid. Cases that contain ambiguous terminology regarding a cytologic diagnosis are not required.
- Code 5 when the diagnosis of cancer is based on laboratory tests or marker studies which are clinically diagnostic for that specific cancer.
- Code 6 when the diagnosis is based only on the surgeon's operative report from a surgical exploration or endoscopy or from gross autopsy findings in the absence of tissue or cytological findings.
- Assign code 8 when the case was diagnosed by any clinical method not mentioned in preceding codes. A number of hematopoietic and lymphoid neoplasms are diagnosed by tests of exclusion where the tests for the disease are equivocal and the physician makes a clinical diagnosis based on the information from the equivocal tests and the patient's clinical presentation.

Codes for Solid Tumors

Code	Label	Definition
1	Positive histology	Histologic confirmation (tissue microscopically examined)
2	Positive cytology	Cytologic confirmation (no tissue microscopically examined; fluid cells microscopically examined)
4	Positive microscopic confirmation, method not specified	Microscopic confirmation is all that is known. It is unknown if the cells were from histology or cytology
5	Positive laboratory test/marker study	A clinical diagnosis of cancer is based on laboratory tests/marker studies which are clinically diagnostic for cancer. This includes alpha-fetoprotein for liver primaries. Elevated PSA is not diagnostic of cancer. However, if the physician uses PSA as a basis for diagnosing prostate cancer with no other workup, record as code 5
6	Direct visualization without microscopic confirmation	The tumor was visualized during a surgical or endoscopic procedure only with no tissue resected for microscopic examination
7	Radiography and other imaging techniques without microscopic confirmation	The malignancy was reported by the physician from an imaging technique report only
8	Clinical diagnosis only other than 5, 6, or 7	The malignancy was reported by the physician in the medical record
9	Unknown whether or not microscopically confirmed	A statement of malignancy was reported in the medical record, but there is no statement of how the cancer was diagnosed (usually non-analytic)

Coding Instructions Hematopoietic or Lymphoid Tumors (9590-9992)

- These instructions apply to "Codes for hematopoietic and Lymphoid Neoplasms" below. See the preceding section for instructions "Coding Solid Tumors".
- There is no priority hierarchy for coding *Diagnostic Confirmation* for hematopoietic and lymphoid tumors. Most commonly, the specific histologic type is diagnosed by immunophenotyping or genetic testing. See the *Hematopoietic Database (DB)* for information on the definitive diagnostic confirmation for specific types of tumors.
- Code 1 when the microscopic diagnosis is based on tissue specimens from biopsy, frozen section, surgery, or autopsy or bone marrow specimens from aspiration or biopsy.
- For leukemia only, code 1 when the diagnosis is based only on the complete blood count (CBC), white blood count (WBC) or peripheral blood smear. Do not use code 1 if the diagnosis was based on immunophenotyping or genetic testing using tissue, bone marrow, or blood.
- Use code 2 when the microscopic diagnosis is based on cytologic examination of *cells* (rather than tissue) including but not limited to spinal fluid, peritoneal fluid, pleural fluid, urinary sediment, cervical smears and vaginal smears, or from paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid. These methods are rarely used for hematopoietic or lymphoid tumors.
- Assign code 3 when there is a histology positive for cancer AND positive immunophenotyping and/or positive genetic testing results. Do not use code 3 for neoplasms diagnosed prior to January 1, 2010.
- Assign code 5 when the diagnosis of cancer is based on laboratory tests or marker studies which are clinically diagnostic for that specific cancer, but no positive histologic confirmation.
- Assign code 6 when the diagnosis is based only on the surgeon's report from a surgical exploration or endoscopy or from gross autopsy findings without tissue or cytological findings.
- Assign code 8 when the case was diagnosed by any clinical method not mentioned in preceding codes. A number of hematopoietic and lymphoid neoplasms are diagnosed by tests of exclusion where the tests for the disease are equivocal and the physician makes a clinical diagnosis based on the information from the equivocal tests and the patient's clinical presentation.

Codes for Hematopoietic or Lymphoid Tumors

Code	Label	Definition
1	Positive histology	Histologic confirmation (tissue microscopically examined)
2	Positive cytology	Cytologic confirmation (no tissue microscopically examined; fluid cells microscopically examined)
3	Positive histology PLUS • Positive immunophenotyping AND/OR • Positive genetic studies	Histology is positive for cancer, and there are also positive immunophenotyping and/or genetic test results. For example, bone marrow examination is positive for acute myeloid leukemia (9861/3). Genetic testing shows AML with inv(16)(p13.1q22) (9871/3)
4	Positive microscopic confirmation, method not specified	Microscopic confirmation is all that is known. It is unknown if the cells were from histology or cytology
5	Positive laboratory test/marker study	A clinical diagnosis of cancer is based on laboratory tests/marker studies which are clinically diagnostic for cancer
6	Direct visualization without microscopic confirmation	The tumor was visualized during a surgical or endoscopic procedure only with no tissue resected for microscopic examination
7	Radiography and other imaging techniques without microscopic confirmation	The malignancy was reported by the physician from an imaging technique report only
8	Clinical diagnosis only (other than 5, 6, or 7)	The malignancy was reported by the physician in the medical record
9	Unknown whether or not microscopically confirmed	A statement of malignancy was reported in the medical record, but there is no statement of how the cancer was diagnosed (usually non-analytic)

Note: Code 3 (used only for hematopoietic and lymphoid neoplasms 9590-9992) was adopted for use effective with 2010 diagnoses.

Pathology Text

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Text – DX Proc – Path	2570	1,000	01/10, 01/12, 01/15	Required

Description

Text area for manual documentation of information from cytology and histopathology reports.

In RMCDS, click on the box "T" on the left of the text line to open entire text box.

Rationale

Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted with coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values.**

Coding Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
    - NAACCR or MCTR-approved abbreviations should be utilized (see website http://dphhs.mt.gov/publichealth/Cancer/TumorRegistry.aspx for lists).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including *Remarks Text*. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Suggestions for text:

- Date(s) of procedure(s)
- Anatomic source of specimen
- Type of tissue specimen(s)
- Tumor type and grade (include all modifying adjectives (i.e., predominantly, with features of, with foci of, elements of, etc.)
- Gross tumor size
- Extent of tumor spread
- Involvement of resection margins
- Number and description of lymph nodes involved and examined
- Record both positive and negative findings; record positive test results first
- Note if pathology report is a slide review or a second opinion from an outside source (i.e., AFIP, Mayo, etc.)
- Record any additional comments from the pathologist, including differential diagnoses considered and any ruled out or favored

Data Item(s) to be verified/validated using the text entered in this field include the *Date of Diagnosis*, *Primary Site*, *Laterality*, *Histologic Type*, *Grade*, *Collaborative Stage variables, Surgery of Primary Site, Scope of Regional LN Surgery, Surgery of Other Regional/Distant Sites, SEER Summary Stage, Regional LN's positive and examined, Date of Surgery, Reason for No Surgery*, and *Diagnostic Confirmation* fields. After manual entry of the text field, ensure that the text entered on both agrees with the coded values and clearly justifies the selected codes.

Histology Title

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Text – Histology Title	2590	100	01/10, 01/12	Required

Description

Text area for manual documentation of information regarding the histologic type, behavior, and grade (differentiation) of the tumor being reported.

Rationale

Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted with coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Coding Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR or MCTR-approved abbreviations should be utilized (see website www.cancer.mt.gov for lists).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including *Remarks Text*. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Suggestions for text:

- Information on histologic type and behavior
- Information on differentiation from scoring systems such as Gleason's Score, Bloom Richardson Grade, etc.

Data Item(s) to be verified/validated using the text entered in this field include the *Histology*, *Behavior*, and *Grade* fields. After manual entry of the text field, ensure that the text entered on both agrees with the coded values and clearly justifies the selected codes.

Histology

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Morphology	522	4	09/06, 01/10, 01/11, 01/15	Required

Description

Identifies the microscopic anatomy of cells.

Rationale

Histology is a basis for staging and the determination of treatment options. It also affects the prognosis and course of the disease.

Coding Instructions

- ICD-O-3 identifies the morphology codes with an "M" preceding the code number. Do not record the "M".
- Record histology using the ICD-O-3 codes in the Numeric Lists/Morphology section (ICD-O-3, pages 69-104) and in the Alphabetic Index (ICD-O-3, pages 105-218).
- Follow the coding rules outlined on pages 20 through 40 of ICD-O-3.
- Use the current *Solid Tumor Rules* when coding the histology for all reportable solid tumors. These rules are effective for cases diagnosed January 1, 2007, or later. Do not use these rules to abstract cases diagnosed prior to January 1, 2007.
- Review all pathology reports.
- Code the **final** pathologic diagnosis for solid tumors.
- For lymphomas, leukemias, and other hematopoietic tumors, follow the instructions in *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* and the Hematopoietic and Lymphoid Neoplasms Database (Hematopoietic DB).
- The codes for cancer, NOS (8000) and carcinoma, NOS (8010) are **not** interchangeable. If the physician says that the patient has carcinoma, then code carcinoma, NOS (8010).

Examples:

Code	Label	Definition
8140	Adenocarcinoma	Final pathologic diagnosis is carcinoma, NOS (8010) of the prostate. Microscopic diagnosis specifies adenocarcinoma (8140) of the prostate.
9680	Diffuse large B-cell lymphoma	Diffuse large B-cell lymphoma, per the WHO Classification of Hematopoietic and Lymphoid Neoplasms.

The Coding Instructions histology and behavior are found in the "Morphology" section of the ICD-O-3 "Coding Guidelines for Topography and Morphology" (ICD-O-3 pages 27-30).

To code multiple or mixed histologies present in one primary, the most recent *SEER 2007 Multiple Primary and Histology Coding Rules* (http://seer.cancer.gov/tools/mphrules/) or 2018 Solid Tumor Rules replaces all previous multiple histology rules, effective for cases diagnosed January 1, 2007; do not use them to abstract cases diagnosed before January 1, 2007.

Use the *SEER Hematopoietic and Lymphoid Neoplasm Coding Manual* and Database at http://seer.cancer.gov/tools/heme/ to code hematopoietic and lymphoid histologies.

Behavior

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	523	1	01/10, 01/12, 01/13, 01/15	Required

Description

Records the behavior of the tumor being reported. The fifth digit of the morphology code is the behavior code.

Rationale

The behavior code is used by pathologists to describe whether the tissue samples are benign (0), borderline (1), in situ (2), or invasive (3).

Coding Instructions

- Code 3 if any *malignant* invasion is present, no matter how limited.
- Code 3 if any *malignant* metastasis to nodes or tissue beyond the primary is present.
- If the specimen is from a metastatic site, code the histology of the metastatic site and code 3 for behavior.

  ***Note*:** The ICD-O-3 behavior code for juvenile astrocytoma (9421/1) is coded as 3 (9421/3) by agreement of North American registry standard-setters. Gastrointestinal stromal tumors (GIST) and thymomas are frequently non-malignant. However, they must be abstracted and assigned a *Behavior Code* 3 if they are noted to have multiple foci, metastasis or positive lymph nodes.

  Note: Effective in 2015, code 8240/1 for Carcinoid tumor, NOS, of appendix (C18.1) becomes obsolete. Carcinoid tumors of the appendix (C18.1) must be coded to 8240/3, effective with 2015. This is required and must be coded with a behavior 3. Prior appendix primaries coded 8240/1 are converted to 8240/3 by the implementation conversions for 2015.

Code	Label	Definition
0	Benign	Benign
1	Borderline	Uncertain whether benign or malignant Borderline malignancy Low malignant potential Uncertain malignant potential
2	In-situ and synonymous with in-situ	AIN III (C21.1) Adenocarcinoma in an adenomatous polyp with no invasion of stalk Bowen disease (not reportable for C44._) CIN III (C53.9) Clark level 1 for melanoma (limited to epithelium) Comedocarcinoma, noninfiltrating (C50.-) Confined to epithelium Hutchinson melanotic freckle, NOS (C44.-) Intracystic, non-infiltrating (carcinoma) Intraductal (carcinoma) Intraepidermal, NOS (carcinoma) Intraepithelial, NOS (carcinoma) Involvement up to, but not including the basement membrane Lentigo maligna (C44.-) Lobular neoplasia (C50.-) Lobular, non-infiltrating (C50.-) (carcinoma) Non-infiltrating (carcinoma) Noninvasive (carcinoma only) No stromal invasion or involvement Papillary, non-infiltrating or intraductal (carcinoma) PIN III (C61.9) Precancerous melanosis (C44.-) Queyrat erythroplasia (C60.-) Stage 0 (except Paget's disease (8540/3) of breast and color or rectal tumors confined to the lamina propria VAIN III (C52.9) VIN III (C51._)
3	Invasive	Invasive or microinvasive

Examples:

Code	Reason
3	Intraductal carcinoma (8500/2) with focal areas of invasion
3	Atypical thymoma (8585/1) with malignant metastasis in one lymph node
1	Atypical meningioma (9539/1) invading bone of skull (the meninges, which line the skull, are capable of invading into the bone without being malignant; do not code as malignant unless it is specifically mentioned)
1	GIST (with no mention of whether malignant or benign)
3	Malignant GIST

Grade Clinical

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	3843	1	New 01/18	Required

Description

This data item records the grade of a solid primary tumor before any treatment (surgical resection or initiation of any treatment including neoadjuvant).

For cases diagnosed January 1, 2018 and later, this data item, along with *Grade Pathological* and *Grade Post-Therapy*, replaces *Grade/Differentiation* as well as CS Site Specific Factors for cancer sites with alternative grading systems (e.g. breast (Bloom-Richardson), prostate (Gleason).

Rationale

Grade is a measure of the aggressiveness of the tumor. Grade and cell type are important prognostic indicators for many cancers. For some sites, grade is required to assign the clinical stage group.

For those cases that are eligible for AJCC staging, the recommended grading system is specified in the AJCC 8th Edition chapter. The AJCC 8th Edition chapter-specific grading systems (codes 1-5, L, H, M, S) take priority over the generic grade definitions (codes A-E, 8, 9). For those cases that are not eligible for AJCC staging, if the recommended grading system is not documented, the generic grade definitions would apply.

Coding Instructions

- Please see the following URL for detailed coding instructions and site-specific coding rules: https://www.naaccr.org/SSDI/Grade-Manual.pdf.

Grade Pathological

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	3844	1	New 01/18	Required

Description

This data item records the grade of a solid primary tumor that has been resected and for which no neoadjuvant therapy was administered. If AJCC staging is being assigned, the tumor must have met the surgical resection requirements in the AJCC manual. This may include the grade from the clinical workup since all clinical information is used in pathological staging. Record the highest grade documented from any microscopic specimen of the primary site whether from the clinical workup or the surgical resection.

For cases diagnosed January 1, 2018 and later, this data item, along with *Grade Clinical* and *Grade Post-Therapy*, replaces *Grade/Differentiation* as well as CS Site Specific Factors for cancer sites with alternative grading systems (e.g. breast (Bloom-Richardson), prostate (Gleason).

Rationale

Grade is a measure of the aggressiveness of the tumor. Grade and cell type are important prognostic indicators for many cancers. For some sites, grade is required to assign the pathological stage group.

For those cases that are eligible for AJCC staging, the recommended grading system is specified in the AJCC 8th Edition chapter. The AJCC 8th Edition chapter-specific grading systems (codes 1-5, L, H, M, S) take priority over the generic grade definitions (codes A-E, 8, 9). For those cases that are not eligible for AJCC staging, if the recommended grading system is not documented, the generic grade definitions would apply.

Coding Instructions

- Please see the following URL for detailed coding instructions and site-specific coding rules: https://www.naaccr.org/SSDI/Grade-Manual.pdf.

Grade Post Therapy

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	3845	1	New 01/18	Required

Description

This data item records the grade of a solid primary tumor that has been resected following neoadjuvant therapy. If AJCC staging is being assigned, the tumor must have met the surgical resection requirements in the AJCC manual. Record the highest grade documented from the surgical treatment resection specimen of the primary site following neoadjuvant therapy.

For cases diagnosed January 1, 2018 and later, this data item, along with *Grade Clinical* and *Grade Pathological*, replaces *Grade/Differentiation* as well as CS Site Specific Factors for cancer sites with alternative grading systems (e.g. breast (Bloom-Richardson), prostate (Gleason).

Rationale

Grade is a measure of the aggressiveness of the tumor. Grade and cell type are important prognostic indicators for many cancers. For some sites, grade is required to assign the pathological stage group.

For those cases that are eligible for AJCC staging, the recommended grading system is specified in the AJCC 8th Edition chapter. The AJCC 8th Edition chapter-specific grading systems (codes 1-5, L, H, M, S) take priority over the generic grade definitions (codes A-E, 8, 9). For those cases that are not eligible for AJCC staging, if the recommended grading system is not documented, the generic grade definitions would apply.

Coding Instructions

- Please see the following URL for detailed coding instructions and site-specific coding rules: https://www.naaccr.org/SSDI/Grade-Manual.pdf.

Staging Text

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Text – Staging	2600	1,000	01/10, 01/12	Required

Description

Text area for manual documentation of information about staging decisions that haven't been described in other text fields. Document any unresolved discrepancies between physician and registry staging decisions.

In RMCDS, click on the box "T" on the left of the text line to open entire text box.

Rationale

Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted with coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Coding Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR or MCTR-approved abbreviations should be utilized (see website www.cancer.mt.gov for lists).
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including *Remarks Text*. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Suggestions for text:

- Date(s) of procedure(s), including clinical procedures, that provided information for assigning stage
- Organs involved by direct extension
- Size of tumor
- Status of margins
- Number and sites of positive lymph nodes
- Site(s) of distant metastasis
- Physician's specialty and comments

Data Item(s) to be verified/validated using the text entered in this field include the *Date of DX/Stage Procedure*, *Collaborative Stage variables*, *SEER Summary Stage 1977*, *SEER Summary Stage 2000*, *Tumor Size*, *Regional Nodes Positive*, *Regional Nodes Examined*, *Surgery of Primary Site, Scope of Regional Lymph Nodes, Surgery of Other Regional/Distant Sites, Laterality, Behavior Code*, and *Sites of Distant Metastasis* fields. After manual entry of the text field, ensure that the text entered on both agrees with the coded values and clearly justifies the selected codes.

Summary Stage 2018

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	764	1	New 01/18	Required

Description

This item stores the directly coded Summary Stage 2018. Effective for cases diagnosed 1/1/2018+. Code summary stage at the initial diagnosis or treatment of the reportable tumor. Summary stage should include all information available through completion of surgery(ies) in the first course of treatment or within 4 months of diagnosis in the absence of disease progression, whichever is longer.

Rationale

The SEER Program has collected staging information on cases since its inception in 1973. Summary Stage groups cases into broad categories of in situ, local, regional, and distant. Summary Stage can be used to evaluate disease spread at diagnosis, treatment patterns and outcomes over time.

Stage information is important when evaluating the effects of cancer control programs. It is crucial in understanding whether changes over time in incidence rates or outcomes are due to earlier detection of the cancers. In addition, cancer treatment cannot be studied without knowing the stage at diagnosis.

Coding Instructions

- Refer to the site and histology-specific definitions of categories and coding instructions in the *SEER Summary Staging Manual 2018.*
- Use code 8 for benign and borderline brain/CNS cases.
- Note: For Summary Stage 2018, code 5 for "Regional, NOS" can no longer be coded.

Code	Definition
0	In situ
1	Localized only
2	Regional by direct extension only
3	Regional lymph nodes only
4	Regional by BOTH direct extension and regional lymph node involvement
7	Distant site(s)/node(s) involved
8	Benign/borderline*
9	Unknown if extension or metastasis (unstaged, unknown, or unspecified)

*Applicable for the following SS2018 chapters: Brain, CNS Other, Intracranial Gland.

Tumor Size Summary

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	756	3	01/16	Required

Description

This data item records the most accurate measurement of a solid primary tumor, usually measured on the surgical resection specimen.

Rationale

Tumor size is one indication of the extent of disease. As such, it is used by both clinicians and researchers. Tumor size that is independent of stage is also useful for quality assurance efforts.

Coding Instructions

Note: All measurements should be in millimeters (mm).

Record size in specified order:

1. Size measured on the surgical resection specimen, when **surgery is administered as the first definitive treatment, i.e., no pre-surgical treatment administered**.

    a. If there is a discrepancy among tumor size measurements in the various sections of the pathology report, code the size from the synoptic report (also known as CAP protocol or pathology report checklist). If only a text report is available, use: final diagnosis, microscopic, or gross examination, in that order.

    Example: Chest x-ray shows 3.5 cm mass; the pathology report from the surgery states that the same mass is malignant and measures 2.8 cm. Record tumor size as 028 (28 mm).

    Example: Pathology report states lung carcinoma is 2.1 cm x 3.2 cm x 1.4 cm. Record tumor size as 032 (32 mm).

2. If neoadjuvant therapy followed by surgery, do not record the size of the pathologic specimen. Code the largest size of tumor prior to neoadjuvant treatment; if unknown code size as 999.

    Example: Patient has a 2.2 cm mass in the oropharynx; fine needle aspiration of mass confirms squamous cell carcinoma. Patient receives a course of neoadjuvant combination chemotherapy. Pathologic size after total resection is 2.8 cm. Record tumor size as 022 (22 mm).

3. If no surgical resection, then largest measurement of the tumor from physical exam, imaging, or other diagnostic procedures prior to any other form of treatment (See Coding Rules below).

4. If 1, 2, and 3 do not apply, the largest size from all information available within four months of the date of diagnosis, in the absence of disease progression.

Coding Rules:

1. Tumor size is the **diameter** of the tumor, **not the depth or thickness** of the tumor.

2. **Recording less than/greater than Tumor Size**:

    a. If tumor size is reported as less than x mm or less than x cm, the reported tumor size should be 1 mm less; for example: if size is <10 mm, code size as 009. Often these are given in cm such as <1 cm which is coded as 009, <2 cm is coded as 019, <3 cm is coded as 029, <4 cm is coded as 039, <5 cm is coded as 049. If stated as less than 1 mm, use code 001.

b. If tumor size is reported as more than x mm or more than x cm, code size as 1 mm more; for example, if size is >10 mm, size should be coded as 011. Often these are given in cm such as >1 cm, which is coded as 011, >2 cm is coded as 021, >3 cm is coded as 031, >4 cm is coded as 041, >5 cm is coded as 051. If described as anything greater than 989 mm (98.9 cm) code as 989.

c. If tumor size is reported to be between two sizes, record tumor size as the midpoint between the two: i.e., add the two sizes together and then divide by two ("between 2 and 3 cm" is coded as 025).

3. **Rounding**: Round the tumor size only if it is described in fractions of millimeters. If the largest dimension of a tumor is less than 1 millimeter (between 0.1 and 0.9 mm), record size as 001 (do not round down to 000). If tumor size is greater than 1 millimeter, round tenths of millimeters in the 1-4 range down to the nearest whole millimeter, and round tenths of millimeters in the 5-9 range up to the nearest whole millimeter. Do not round tumor size expressed in centimeters to the nearest whole centimeter (rather, move the decimal point to one space to the right, converting the measurement to millimeters).

   Example: Breast cancer described as 6.5 millimeters in size. Round up Tumor Size as 007.

   Example: Cancer in polyp described as 2.3 millimeters in size. Round down Tumor Size as 002.

   Example: Focus of cancer described as 1.4 mm in size. Round down as 001.

   Example: 5.2 mm breast cancer. Round down to 5 mm and code as 005.

4. **Priority of imaging/radiographic techniques**: Information on size from imaging/radiographic techniques can be used to code size when there is no more specific size information from a pathology or operative report, but it should be taken as low priority, over a physical exam.

5. **Tumor size discrepancies among imaging and radiographic reports**: If there is a difference in reported tumor size among imaging and radiographic techniques, unless the physician specifies which imaging is most accurate, record the largest size in the record, regardless of which imaging technique report it is.

6. **Always code the size of the primary tumor, not the size of the polyp, ulcer, cyst, or distant metastasis**. However, if the tumor is described as a "cystic mass", and only the size of the entire mass is given, code the size of the entire mass, since the cysts are part of the tumor itself.

7. **Record the size of the invasive component, if given**.

   a. If both an in situ and an invasive component are present and the invasive component is measured, record the size of the invasive component even if it is smaller.

   Example: Tumor is mixed in situ and invasive adenocarcinoma, total 3.7 cm in size, of which 1.4 cm is invasive. Record tumor size as 014 (14 mm).

   b. If the size of the invasive component is not given, record the size of the entire tumor from the surgical report, pathology report, radiology report or clinical examination.

   Example: A breast tumor with infiltrating duct carcinoma with extensive in situ component; total size 2.3 cm. Record tumor size as 023 (23 mm).

   Example: Duct carcinoma in situ measuring 1.9 cm with an area of invasive ductal carcinoma. Record tumor size as 019 (19 mm).

8. **Record the largest dimension or diameter of the tumor, whether it is from an excisional biopsy specimen or the complete resection of the primary tumor**.

   Example: Tumor is described as 2.4 x 5.1 x 1.8 cm in size. Record tumor size as 051 (51 mm).

9. **Record the size as stated for purely in situ lesions**.

10. **Disregard microscopic residual or positive surgical margins when coding tumor size**. Microscopic residual tumor does not affect overall tumor size. The status of primary tumor margins may be recorded in a separate data item.

11. **Do not add the size of pieces or chips together to create a whole**; they may not be from the same location, or they may represent only a very small portion of a large tumor. However, if the pathologist states an aggregate or composite size (determined by fitting the tumor pieces together and measuring the total size) record that size. If the only measurement describes pieces or chips, record tumor size as 999.

12. **Multifocal/multicentric tumors**: If the tumor is multi-focal or if multiple tumors are reported as a single primary, code the size of the largest invasive tumor or if all of the tumors are in situ, code the size of the largest in situ tumor.

13. **Tumor size code 999 is used when size is unknown or not applicable**. Sites/morphologies where tumor size is not applicable are listed here.

    Hematopoietic, Reticuloendothelial, and Myeloproliferative neoplasms: histology codes 9590-9992

    Kaposi Sarcoma

    Melanoma Choroid

    Melanoma Ciliary Body

    Melanoma Iris

14. **Document the information to support coded tumor size in the appropriate text data item of the abstract.**

Code	Description
000	No mass/tumor found
001	1 mm or described as less than 1 mm
002-988	Exact size in millimeters (2 mm to 988 mm)
989	989 millimeters or larger
990	Microscopic focus or foci only and no size of focus is given
998	SITE-SPECIFIC CODES Alternate descriptions of tumor size for specific sites: Familial/multiple polyposis: Rectosigmoid and rectum (C19.9, C20.9) Colon (C18.0, C182.-C18.9) **If no size is documented**: Circumferential: Esophagus (C15.0-C15.5, C15.8-C15.9) Diffuse; widespread: 3/4s or more; linitis plastica: Stomach and Esophagus GE Junction (C16.0-C16.6, C16.8-C16.9) Diffuse, entire lung or NOS: Lung and main stem bronchus (C34.0-C34.3, C34.8-C34.9) Diffuse: Breast (C50.0-C50.6, C50.8-C50.9)
999	Unknown; size not stated Not documented in patient record Size of tumor cannot be assessed Not applicable

Mets at Diagnosis - Bone

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1112	1	01/16	Required

Description

This data item identifies whether bone is an involved metastatic site. The six Mets at DX – Metastatic Sites data items provide information on specific metastatic sites for data analysis.

Rationale

Information on site of metastatic disease at diagnosis has prognostic implications to survival among patients with initial late stage disease. Capturing data on where the patient's metastatic lesions (including the number of locations) will be an important variable to include when looking at survival. Survival among metastatic patients is becoming increasingly important for cancer survivors. This data item is required to be collected beginning with cases diagnosed January 1, 2016.

Coding Instructions

1. **Code information about bone metastasis only** (discontinuous or distant metastases to bone) identified at the time of diagnosis. This data item should not be coded for bone marrow involvement.
    a. Bone involvement may be single or multiple
    b. Information about bone involvement may be clinical or pathologic
    c. Code this data item for bone metastases even if the patient had any preoperative systemic therapy
    d. This data item should be coded for all solid tumors, Kaposi sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary Sites
2. **Use of codes**. Assign the code that best describes whether the case has bone metastases at diagnosis.
    a. Use code 0 when the medical record
        i. indicates that there are no distant (discontinuous) metastases at all
        ii. includes a clinical or pathologic statement that there are no bone metastases
        iii. includes imaging reports that are negative for bone metastases
        iv. indicates that the patient has distant (discontinuous) metastases but bone is not mentioned as an involved site

            Example: use code 0 when the patient has lung and liver metastases but not bone.
    b. Use code 1 when the medical record
        i. indicates that the patient has distant (discontinuous) metastases and bone is mentioned as an involved site
        ii. indicates that bone is the primary site and there are metastases in a different bone or bones
            1. Do not assign code 1 for a bone primary with multifocal bone involvement of the same bone
        iii. indicates that the patient is diagnosed as an unknown primary (C80.9) and bone is mentioned as a distant metastatic site
    c. Use code 8 (Not applicable) for the following site/histology combinations for which a code for distant metastasis is not clinically relevant.

ICD-O-3	ICD-O-3 Histology	
C000-C809	9740-9809, 9840-9992	Mast cell, histiocytosis, immunoproliferative, leukemias coded to any site
C420, C421, C424	9811-9818, 9823, 9827, 9837	Specific leukemia/lymphoma histologies coded to blood, bone marrow, hematopoietic
C000-C440, C442-C689, C691-C694, C698-C809	9820, 9826, 9831-9834	Mostly lymphoid leukemias coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS
C000-C440, C442-C689, C691-C694, C698-C809	9731, 9732, 9734	Plasma cell tumors coded to any site except eyelid, conjunctive, lacrimal gland, orbit, and eye overlapping and NOS

d. Use code 9 when it cannot be determined from the medical record whether the patient specifically has bone metastases; for example, when there is documentation of carcinomatosis, but bone is not specifically mentioned as a metastatic site. In other words, use code 9 when there are known distant metastases, but it is not known whether the distant metastases include bone.

Code	Definition
0	None, no bone metastases
1	Yes; distant bone metastases
8	Not applicable
9	Unknown whether bone is an involved metastatic site Not documented in patient record

Mets at Diagnosis – Brain

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1113	1	01/16	Required

Description

This data item identifies whether brain is an involved metastatic site. The six Mets at DX – Metastatic Sites data items provide information on specific metastatic sites for data analysis.

Rationale

Information on site of metastatic disease at diagnosis has prognostic implications to survival among patients with initial late stage disease. Capturing data on where the patient's metastatic lesions (including the number of locations) will be an important variable to include when looking at survival. Survival among metastatic patients is becoming increasingly important for cancer survivors. This data item is required to be collected beginning with cases diagnosed January 1, 2016.

Coding Instructions

1. **Code information about brain metastasis only** (discontinuous or distant metastases to brain) identified at the time of diagnosis. This data item should not be coded for involvement of spinal cord or other parts of the central nervous system.
    a. Brain involvement may be single or multiple
    b. Information about brain involvement may be clinical or pathologic
    c. Code this data item whether or not the patient had any preoperative systemic therapy
    d. This data item should be coded for all solid tumors, Kaposi sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary Sites
2. **Use of codes**. Assign the code that best describes whether the case has brain metastases at diagnosis.
    a. Use code 0 when the medical record
        i. indicates that there are no distant (discontinuous) metastases at all
        ii. includes a clinical or pathologic statement that there are no brain metastases
        iii. includes imaging reports that are negative for brain metastases
        iv. indicates that the patient has distant (discontinuous) metastases but brain is not mentioned as an involved site

        Example: use code 0 when the patient has lung and liver metastases but not brain.
    b. Use code 1 when the medical record
        i. indicates that the patient has distant (discontinuous) metastases and brain is mentioned as an involved site
        ii. indicates that the patient is diagnosed as an unknown primary (C80.9) and brain is mentioned as a distant metastatic site
    c. Use code 8 (Not applicable) for the following site/histology combinations for which a code for distant metastasis is not clinically relevant.

ICD-O-3	ICD-O-3 Histology	
C000-C809	9740-9809, 9840-9992	Mast cell, histiocytosis, immunoproliferative, leukemias coded to any site
C420, C421, C424	9811-9818, 9823, 9827, 9837	Specific leukemia/lymphoma histologies coded to blood, bone marrow, hematopoietic
C000-C440, C442-C689, C691-C694, C698-C809	9820, 9826, 9831-9834	Mostly lymphoid leukemias coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS
C000-C440, C442-C689, C691-C694, C698-C809	9731, 9732, 9734	Plasma cell tumors coded to any site except eyelid, conjunctive, lacrimal gland, orbit, and eye overlapping and NOS

d. Use code 9 when it cannot be determined from the medical record whether the patient specifically has brain metastases; for example, when there is documentation of carcinomatosis, but brain is not specifically mentioned as a metastatic site. In other words, use code 9 when there are known distant metastases, but it is not known whether the distant metastases include brain.

Code	Definition
0	None, no brain metastases
1	Yes; distant brain metastases
8	Not applicable
9	Unknown whether brain is an involved metastatic site Not documented in patient record

Mets at Diagnosis – Distant Lymph Nodes

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1114	1	01/16	Required

Description

This data item identifies whether distant lymph node(s) are an involved metastatic site. The six Mets at DX – Metastatic Sites data items provide information on specific metastatic sites for data analysis.

Rationale

Information on site of metastatic disease at diagnosis has prognostic implications to survival among patients with initial late stage disease. Capturing data on where the patient's metastatic lesions (including the number of locations) will be an important variable to include when looking at survival. Survival among metastatic patients is becoming increasingly important for cancer survivors. This data item is required to be collected beginning with cases diagnosed January 1, 2016.

Coding Instructions

1. **Code information about distant lymph node(s) metastases only** (metastases to distant lymph nodes) identified at the time of diagnosis.
    a. Distant lymph node involvement may be single or multiple
    b. Information about distant lymph node involvement may be clinical or pathologic
    c. Code this data item whether or not the patient had any preoperative systemic therapy
    d. This data item should not be coded for regional lymph node involvement with the exception of lymph nodes for placenta which are M1
    e. This data item should be coded for all solid tumors, Kaposi sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary Sites
2. **Use of codes**. Assign the code that best describes whether the case has distant lymph node metastases at diagnosis.
    a. Use code 0 when the medical record
        i. indicates that there are no distant (discontinuous) metastases at all
        ii. includes a clinical or pathologic statement that there are no distant lymph node metastases
        iii. includes imaging reports that are negative for distant lymph node metastases
        iv. indicates that the patient has distant (discontinuous) metastases but distant lymph node(s) are not mentioned as an involved site

        Example: use code 0 when the patient has lung and liver metastases but not distant lymph node(s).
    b. Use code 1 when the medical record
        i. indicates that the patient has distant (discontinuous) metastases and distant lymph node(s) are mentioned as an involved site
        ii. indicates that the patient is diagnosed as an unknown primary (C80.9) and distant lymph node(s) are mentioned as a distant metastatic site
    c. Use code 8 (Not applicable) for the following site/histology combinations for which a code for distant metastasis is not clinically relevant.

ICD-O-3	ICD-O-3 Histology	
C000-C809	9740-9809, 9840-9992	Mast cell, histiocytosis, immunoproliferative, leukemias coded to any site
C420, C421, C424	9811-9818, 9823, 9827, 9837	Specific leukemia/lymphoma histologies coded to blood, bone marrow, hematopoietic
C000-C440, C442-C689, C691-C694, C698-C809	9820, 9826, 9831-9834	Mostly lymphoid leukemias coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS
C000-C440, C442-C689, C691-C694, C698-C809	9731, 9732, 9734	Plasma cell tumors coded to any site except eyelid, conjunctive, lacrimal gland, orbit, and eye overlapping and NOS

d. Use code 9 when it cannot be determined from the medical record whether the patient specifically has distant lymph node metastases; for example, when there is documentation of carcinomatosis but distant lymph node(s) are not specifically mentioned as a metastatic site. In other words, use code 9 when there are known distant metastases, but it is not known whether the distant metastases include distant lymph node(s).

Code	Definition
0	None, no distant lymph node metastases
1	Yes; distant lymph node metastases
8	Not applicable
9	Unknown whether distant lymph node(s) are an involved metastatic site Not documented in patient record

Mets at Diagnosis - Liver

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1115	1	01/16	Required

Description

This data item identifies whether liver is an involved metastatic site. The six Mets at DX – Metastatic Sites data items provide information on specific metastatic sites for data analysis.

Rationale

Information on site of metastatic disease at diagnosis has prognostic implications to survival among patients with initial late stage disease. Capturing data on where the patient's metastatic lesions (including the number of locations) will be an important variable to include when looking at survival. Survival among metastatic patients is becoming increasingly important for cancer survivors. This data item is required to be collected beginning with cases diagnosed January 1, 2016.

Coding Instructions

1. **Code information about liver metastasis only** (discontinuous or distant metastases to liver) identified at the time of diagnosis.
    a. Liver involvement may be single or multiple
    b. Information about Liver involvement may be clinical or pathologic
    c. Code this data item whether or not the patient had any preoperative systemic therapy
    d. This data item should be coded for all solid tumors, Kaposi sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary Sites
2. **Use of codes**. Assign the code that best describes whether the case has liver metastases at diagnosis.
    a. Use code 0 when the medical record
        i. indicates that there are no distant (discontinuous) metastases at all
        ii. includes a clinical or pathologic statement that there are no liver metastases
        iii. includes imaging reports that are negative for liver metastases
        iv. indicates that the patient has distant (discontinuous) metastases but liver is not mentioned as an involved site

        Example: use code 0 when the patient has lung and brain metastases but not liver.
    b. Use code 1 when the medical record
        i. indicates that the patient has distant (discontinuous) metastases and liver is mentioned as an involved site
        ii. indicates that the patient is diagnosed as an unknown primary (C80.9) and liver is mentioned as a distant metastatic site
    c. Use code 8 (Not applicable) for the following site/histology combinations for which a code for distant metastasis is not clinically relevant.

ICD-O-3	ICD-O-3 Histology	
C000-C809	9740-9809, 9840-9992	Mast cell, histiocytosis, immunoproliferative, leukemias coded to any site
C420, C421, C424	9811-9818, 9823, 9827, 9837	Specific leukemia/lymphoma histologies coded to blood, bone marrow, hematopoietic
C000-C440, C442-C689, C691-C694, C698-C809	9820, 9826, 9831-9834	Mostly lymphoid leukemias coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS
C000-C440, C442-C689, C691-C694, C698-C809	9731, 9732, 9734	Plasma cell tumors coded to any site except eyelid, conjunctive, lacrimal gland, orbit, and eye overlapping and NOS

d. Use code 9 when it cannot be determined from the medical record whether the patient specifically has liver metastases; for example, when there is documentation of carcinomatosis, but liver is not specifically mentioned as a metastatic site. In other words, use code 9 when there are known distant metastases, but it is not known whether the distant metastases include liver.

Code	Definition
0	None, no liver metastases
1	Yes; distant liver metastases
8	Not applicable
9	Unknown whether liver is an involved metastatic site Not documented in patient record

Mets at Diagnosis - Lung

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1116	1	01/16	Required

Description

This data item identifies whether lung is an involved metastatic site. The six Mets at DX – Metastatic Sites data items provide information on specific metastatic sites for data analysis.

Rationale

Information on site of metastatic disease at diagnosis has prognostic implications to survival among patients with initial late stage disease. Capturing data on where the patient's metastatic lesions (including the number of locations) will be an important variable to include when looking at survival. Survival among metastatic patients is becoming increasingly important for cancer survivors. This data item is required to be collected beginning with cases diagnosed January 1, 2016.

Coding Instructions

1. **Code information about lung metastasis only** (discontinuous or distant metastases to lung) identified at the time of diagnosis. This data item should not be coded for pleural or pleural fluid involvement.
    a. Lung involvement may be single or multiple
    b. Information about lung involvement may be clinical or pathologic
    c. Code this data item whether or not the patient had any preoperative systemic therapy
    d. This data item should be coded for all solid tumors, Kaposi sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary Sites
2. **Use of codes**. Assign the code that best describes whether the case has lung metastases at diagnosis.
    a. Use code 0 when the medical record
        i. indicates that there are no distant (discontinuous) metastases at all
        ii. includes a clinical or pathologic statement that there are no lung metastases
        iii. includes imaging reports that are negative for lung metastases
        iv. indicates that the patient has distant (discontinuous) metastases but lung is not mentioned as an involved site

            Example: use code 0 when the patient has liver and brain metastases but not lung.
    b. Use code 1 when the medical record
        i. indicates that the patient has distant (discontinuous) metastases and lung is mentioned as an involved site
        ii. indicates that lung is the primary site and there are metastases in the contralateral lung
            1. Do not assign code 1 for a lung primary with multifocal involvement of the same lung
        iii. indicates that the patient is diagnosed as an unknown primary (C80.9) and lung is mentioned as a distant metastatic site
    c. Use code 8 (Not applicable) for the following site/histology combinations for which a code for distant metastasis is not clinically relevant.

ICD-O-3	ICD-O-3 Histology	
C000-C809	9740-9809, 9840-9992	Mast cell, histiocytosis, immunoproliferative, leukemias coded to any site
C420, C421, C424	9811-9818, 9823, 9827, 9837	Specific leukemia/lymphoma histologies coded to blood, bone marrow, hematopoietic
C000-C440, C442-C689, C691-C694, C698-C809	9820, 9826, 9831-9834	Mostly lymphoid leukemias coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS
C000-C440, C442-C689, C691-C694, C698-C809	9731, 9732, 9734	Plasma cell tumors coded to any site except eyelid, conjunctive, lacrimal gland, orbit, and eye overlapping and NOS

d. Use code 9 when it cannot be determined from the medical record whether the patient specifically has lung metastases; for example, when there is documentation of carcinomatosis, but lung is not specifically mentioned as a metastatic site. In other words, use code 9 when there are known distant metastases, but it is not known whether the distant metastases include lung.

Code	Definition
0	None, no lung metastases
1	Yes; distant lung metastases
8	Not applicable
9	Unknown whether lung is an involved metastatic site Not documented in patient record

Mets at Diagnosis - Other

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1117	1	01/16, 01/18	Required

Description

The six Mets at Dx-Metastatic Sites fields provide information on metastases for data analysis. This data item identifies any type of distant involvement not captured in the **Mets at Diagnosis – Bone, Mets at Diagnosis – Brain, Mets at Diagnosis – Liver, Mets at Diagnosis – Lung, and Mets at Diagnosis – Distant Lymph Nodes** fields. It includes involvement of other specific sites and more generalized metastases such as carcinomatosis. Some examples include but are not limited to adrenal gland, bone marrow, pleura, malignant pleural effusion, peritoneum, and skin.

Rationale

Information on site of metastatic disease at diagnosis has prognostic implications to survival among patients with initial late stage disease. Capturing data on where the patient's metastatic lesions (including the number of locations) will be an important variable to include when looking at survival. Survival among metastatic patients is becoming increasingly important for cancer survivors.

Coding Instructions

1. **Code information about other metastases only** (discontinuous or distant metastases) identified at the time of diagnosis. This data item should not be coded for bone, brain, liver, lung or distant lymph node metastases.
    a. Other involvement may be single or multiple
    b. Information about other involvement may be clinical or pathologic
    c. Code this data item whether or not the patient had any preoperative (neoadjuvant) systemic therapy
    d. This data item should be coded for all solid tumors, Kaposi sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary Sites
2. **Use of codes**. Assign the code that best describes whether the case has other metastases at diagnosis.
    a. Use code 0 when the medical record
        i. indicates that there are no distant (discontinuous) metastases at all
        ii. includes a clinical or pathologic statement that there are no other metastases
        iii. includes imaging reports that are negative for other metastases
        iv. indicates that the patient has distant (discontinuous) metastases but other sites are not mentioned as an involved

        Example: use code 0 when the patient has lung and liver metastases only.
    b. Use code 1 when the medical record
        i. indicates that the patient has distant (discontinuous) metastases in any site(s) other than bone, brain, liver, lung or distant lymph node(s)
        ii. includes but not limited to the adrenal gland, bone marrow, pleura, malignant pleural effusion, peritoneum and skin
    c. Use code 8 (Not applicable) for the following site/histology combinations for which a code for distant metastasis is not clinically relevant.

ICD-O-3	ICD-O-3 Histology	
C000-C809	9740-9809, 9840-9992	Mast cell, histiocytosis, immunoproliferative, leukemias coded to any site
C420, C421, C424	9811-9818, 9823, 9827, 9837	Specific leukemia/lymphoma histologies coded to blood, bone marrow, hematopoietic
C000-C440, C442-C689, C691-C694, C698-C809	9820, 9826, 9831-9834	Mostly lymphoid leukemias coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS
C000-C440, C442-C689, C691-C694, C698-C809	9731, 9732, 9734	Plasma cell tumors coded to any site except eyelid, conjunctive, lacrimal gland, orbit, and eye overlapping and NOS

d. Use code 9 when it cannot be determined from the medical record whether the patient has metastases other than bone, brain, liver, lung and distant lymph node(s). In other words, use code 9 when there are known distant metastases, but it is not known specifically what they are.

Code	Definition
0	None, no other metastases
1	Yes; distant metastases in known site(s) other than bone, brain, liver, lung or distant lymph nodes
2	Generalized metastases such as carcinomatosis
8	Not applicable
9	Unknown whether any other metastatic site Not documented in patient record

AJCC TNM Staging

AJCC TNM Stage is based on the clinical, operative, and pathologic assessment of the anatomic extent of disease and is used to make appropriate treatment decisions, determine prognosis, and measure end results. Use the rules in the current *AJCC Cancer Staging Manual* to assign AJCC T, N, M and Stage Group values. Clinical and pathologic staging components and stage groups should be recorded to the extent they are available. The following general rules apply to AJCC staging of all sites.

- *Clinical staging* includes any information obtained about the extent of cancer before initiation of definitive treatment (surgery, systemic or radiation therapy, active surveillance, or palliative care) or within four months after the date of diagnosis, whichever is *shorter*, as long as the cancer has not clearly progressed during that time frame.
- *Pathologic staging* includes any information obtained about the extent of cancer through completion of definitive surgery as part of first course treatment or identified within 4 months after the date of diagnosis whichever is *longer*, as long as there is no systemic or radiation therapy initiated or the cancer has not clearly progressed during that time frame.
- If a patient has multiple primaries, stage each primary independently.
- If the stage group cannot be determined from the recorded components, then record it as unknown.
- When a patient with multiple primaries develops metastases, a biopsy may distinguish the source of distant disease. Stage both primaries as having metastatic disease if the physician is unable to conclude which primary has metastasized. If, at a later time, the physician identifies which primary has metastasized, update the stage(s) as appropriate.
- If pediatric staging is used and AJCC staging is not applied, code 88 for clinical and pathologic T, N, and M as well as stage group. If either clinical or pathologic staging was applied for a pediatric tumor, enter the appropriate codes for both and do not code 88.
- If a site/histology combination is not defined in the AJCC Manual code 88 for clinical and pathologic T, N, and M as well as stage group.
- For in situ tumors that are considered as “impossible diagnoses” in the AJCC manual code 88 for clinical and pathologic T, N, and M as well as stage group.
- Beginning in 2016, new T, N, and M categories were implemented that include “c” and “p” designations to enable registrars to comply with AJCC clinical and pathologic staging/classification timeframe rules.

Please note that not all possible categories were added in 2016, only those addressing prominent issues. Additional T, N, and M categories will be added and use of existing categories will be expanded with the implementation of the AJCC 8th Edition Manual. For example, the new category of cN0 for the TNM Path N data item is limited to in situ tumors only in 2016.

AJCC TNM Clin T

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1001	15	New 01/18	Required by CoC

Description

Evaluates the primary tumor (T) and reflects the tumor size and/or extension of the tumor known ***prior*** to the start of any therapy. Detailed site-specific values for the clinical T category as defined by the current AJCC edition.

Rationale

The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

With the implementation of the 8th Edition, storage codes are no longer utilized. Codes and labels for the different categories are exact matches to what is listed in the 8th Edition Manual (except for code 88). The new categories will be used for cases diagnosed in 2018 and later.

Coding Instructions

- The clinical T staging element must be assigned for *Class of Case* 10-22.
- It is strongly recommended that the clinical T staging element be recorded for *Class of Case* 00 cases if the patient's workup at the facility allows coding of clinical T.
- Code clinical T as documented by the first treating physician or the managing physician in the medical record.
- If the managing physician has not recorded clinical T, registrars *will* assign this item based on the best available information, without necessarily requiring additional contact with the physician.
- Code 88 for clinical and pathological or post therapy T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
- If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
- Refer to the current *AJCC Cancer Staging Manual, 8th edition* for detailed staging rules.

AJCC TNM Clin T Suffix

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1031	4	New 01/18	Required by CoC

Description

Identifies the AJCC TNM clinical T category suffix for the tumor ***prior*** to the start of any therapy. Stage suffices identify special cases that need separate analysis. Suffices are adjuncts to and do not change the stage group.

Rationale

The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

With the implementation of the 8th Edition, storage codes are no longer utilized. Codes and labels for the different categories are exact matches to what is listed in the 8th Edition Manual (except for code 88). The new categories will be used for cases diagnosed in 2018 and later.

Coding Instructions

- Record the clinical T category suffix as documented by the treating physician or the managing physician in the medical record.
- If the managing physician has not recorded the suffix when applicable, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
- If the tumor is not staged according to the AJCC manual, leave this data item blank
- Refer to the current *AJCC Cancer Staging Manual* for detailed staging rules.

Code	Label
(blank)	No information available; not recorded
(m)	Multiple synchronous tumors OR Multifocal tumor (differentiated and anaplastic thyroid only)
(s)	Solitary tumor (differentiated and anaplastic thyroid only)

AJCC TNM Clin N

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1002	15	New 01/18	Required by CoC

Description

Identifies the absence or presence of regional lymph node (N) metastasis and describes the extent of regional lymph node metastasis of the tumor known ***prior*** to the start of any therapy. Detailed site-specific values for the clinical N category as defined by the current AJCC edition.

Rationale

The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

With the implementation of the 8th Edition, storage codes are no longer utilized. Codes and labels for the different categories are exact matches to what is listed in the 8th Edition Manual (except for code 88). The new categories will be used for cases diagnosed in 2018 and later.

Coding Instructions

- The clinical N staging element must be assigned for *Class of Case* 10-22.
- It is strongly recommended that the clinical N staging element be recorded for *Class of Case* 00 cases if the patient's workup at the facility allows assignment of clinical N category.
- Record clinical N as documented by the first treating physician or the managing physician in the medical record.
- If the managing physician has not recorded clinical N, registrars *will* assign this item based on the best available information, without necessarily requiring additional contact with the physician.
- Code 88 for clinical and pathological or post therapy T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
- If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.

AJCC TNM Clin N Suffix

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1034	4	New 01/18	Required by CoC

Description

Identifies the AJCC TNM clinical N category suffix for the tumor ***prior*** to the start of any therapy. Stage suffices identify special cases that need separate analysis. Suffices are adjuncts to and do not change the stage group.

Rationale

The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

With the implementation of the 8th Edition, storage codes are no longer utilized. Codes and labels for the different categories are exact matches to what is listed in the 8th Edition Manual (except for code 88). The new categories will be used for cases diagnosed in 2018 and later.

Coding Instructions

- Record the clinical N category suffix as documented by the treating physician or the managing physician in the medical record.
- If the managing physician has not recorded the suffix when applicable, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
- If the tumor is not staged according to the AJCC manual, leave this data item blank
- Refer to the current *AJCC Cancer Staging Manual* for detailed staging rules.

Code	Label
(blank)	No information available; not recorded
(sn)	Sentinel node procedure with or without FNA or core needle biopsy
(f)	FNA or core needle biopsy only

AJCC TNM Clin M

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1003	15	New 01/18	Required by CoC

Description

Identifies the absence or presence of distant metastasis (M) of the tumor known ***prior*** to the start of any therapy. Detailed site-specific values for the clinical N category as defined by the current AJCC edition.

Rationale

The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

With the implementation of the 8th Edition, storage codes are no longer utilized. Codes and labels for the different categories are exact matches to what is listed in the 8th Edition Manual (except for code 88). The new categories will be used for cases diagnosed in 2018 and later.

Coding Instructions

- The clinical M staging element must be assigned for *Class of Case* 10-22.
- It is strongly recommended that the clinical M category staging data item be recorded for *Class of Case* 00 cases if the patient's workup at the facility allows assignment of clinical M.
- Record clinical M as documented by the first treating physician or the managing physician in the medical record.
- If the managing physician has not recorded clinical N, registrars *will* assign this item based on the best available information, without necessarily requiring additional contact with the physician.
- Code 88 for clinical and pathological or post therapy T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
- If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.

AJCC TNM Clin Stage Group

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1004	15	New 01/18	Required by CoC

Description

Identifies the anatomic extent of disease based on the T, N, and M elements known **prior** to the start of any therapy. Detailed site-specific values for the clinical stage group as defined by the current AJCC edition.

Rationale

The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

With the implementation of the 8th Edition, storage codes are no longer utilized. Codes and labels for the different categories are exact matches to what is listed in the 8th Edition Manual (except for code 88). The new categories will be used for cases diagnosed in 2018 and later.

Coding Instructions

- Record the clinical stage group as documented by the first treating physician or the managing physician in the medical record.
- If the managing physician has not recorded the clinical stage, registrars *will* assign this item based on the best available information, without necessarily requiring additional contact with the physician.
- Code 88 for clinical and pathological or post therapy T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
- If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
- Convert all Roman numerals to Arabic numerals and use upper-case (capital letters) only.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.

AJCC TNM Path T

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1011	15	New 01/18	Required by CoC

Description

Evaluates the primary tumor (T) and reflects the tumor size and/or extension of the tumor known ***following*** the completion of surgical therapy. Detailed site-specific values for the pathological tumor (T) as defined by the current AJCC edition.

Rationale

The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

With the implementation of the 8th Edition storage codes are no longer utilized. Values and Labels for the different categories are exact matches to what is listed in the 8th Edition Manual (except for code 88). The new categories will be used for cases diagnosed in 2018 and later.

Coding Instructions

- The pathological T category staging data item must be assigned for Class of Case 10-22.
- Assign pathological T as documented by the treating physician(s) or the managing physician in the medical record.
- If the managing physician has not recorded pathological T category, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
- Code 88 for clinical and pathological or post therapy T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
- For lung, occult carcinoma is assigned TX.
- If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.

AJCC TNM Path T Suffix

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1032	4	New 01/18	Required by CoC

Description

Identifies the AJCC TNM pathological T category suffix for the tumor ***following*** the completion of surgical therapy. Stage suffices identify special cases that need separate analysis. Suffices are adjuncts to and do not change the stage group.

Rationale

The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

- Record the pathological T category suffix as documented by the first treating physician or the managing physician in the medical record.
- If the managing physician has not recorded the suffix when applicable, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
- If the tumor is not staged according to the AJCC manual, leave this data item blank
- Refer to the current *AJCC Cancer Staging Manual* for detailed staging rules.

Code	Label
(blank)	No information available; not recorded
(m)	Multiple synchronous tumors OR Multifocal tumor (differentiated and anaplastic thyroid only)
(s)	Solitary tumor (differentiated and anaplastic thyroid only)

AJCC TNM Path N

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1012	15	New 01/18	Required by CoC

Description

Identifies the absence or presence of regional lymph node (N) metastasis and describes the extent of regional lymph node metastasis of the tumor known ***following*** the completion of surgical therapy.

Rationale

The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

With the implementation of the 8th Edition storage codes are no longer utilized. Values and Labels for the different categories are exact matches to what is listed in the 8th Edition Manual (except for code 88). The new categories will be used for cases diagnosed in 2018 and later.

Coding Instructions

- The pathological N category staging data item must be recorded for *Class of Case* 10-22.
- Assign pathological N category as documented by the treating physician(s) or managing physician in the medical record.
- If the managing physician has not recorded pathological N category, registrars *will* assign this item based on the best available information, without necessarily requiring additional contact with the physician.
- Code 88 for clinical and pathological or post therapy T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
- If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.

AJCC TNM Path N Suffix

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1035	4	New 01/18	Required by CoC

Description

Identifies the AJCC TNM pathological N suffix for the tumor ***following*** the completion of surgical therapy. Stage suffices identify special cases that need separate analysis. Suffices are adjuncts to and do not change the stage group.

Rationale

The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

- Record the pathological N category suffix as documented by the first treating physician or the managing physician in the medical record.
- If the managing physician has not recorded the suffix, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
- If the tumor is not staged according to the AJCC manual, leave this data item blank
- Refer to the current *AJCC Cancer Staging Manual* for detailed staging rules.

Code	Label
(blank)	No information available; not recorded
(sn)	Sentinel node procedure with or without FNA or core needle biopsy
(f)	FNA or core needle biopsy only

AJCC TNM Path M

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1013	15	New 01/18	Required by CoC

Description

Identifies the presence or absence of distant metastasis (M) of the tumor known ***following*** the completion of surgical therapy.

Rationale

The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

With the implementation of the 8th Edition storage codes are no longer utilized. Values and Labels for the different categories are exact matches to what is listed in the 8th Edition Manual (except for code 88). The new categories will be used for cases diagnosed in 2018 and later.

Coding Instructions

- The pathological M category staging data item must be assigned for *Class of Case* 10-22.
- Assign pathological M as documented by the treating physician(s) or the managing physician in the medical record.
- If the managing physician has not recorded pathological M category, registrars *will* code this item based on the best available information, without necessarily requiring additional contact with the treating physician.
- Code 88 for clinical and pathological or post therapy T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
- If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.

AJCC TNM Path Stage Group

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1014	15	New 01/18	Required by CoC

Description

Identifies the anatomic extent of disease based on the T, N, and M category data items known ***following*** the completion of surgical therapy.

Rationale

The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

- Record the pathological stage group as documented by the treating physician(s) or the managing physician in the medical record.
- If the managing physician has not recorded the pathological stage, registrars *will* assign this item based on the best available information, without necessarily requiring additional contact with the physician(s).
- Code 88 for clinical and pathological or post therapy T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
- If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
- Convert all Roman numerals to Arabic numerals and use upper-case (capital letters) only.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.

AJCC TNM Post Therapy T

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1021	15	New 01/18	Required by CoC

Description

Evaluates the primary tumor (T) and reflects the tumor size and/or extension of the tumor known ***following*** the completion of neoadjuvant therapy (satisfying the definition for that disease site) and planned post-neoadjuvant therapy surgical resection.

Rationale

The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

With the implementation of the 8th Edition storage codes are no longer utilized. Values and Labels for the different categories are exact matches to what is listed in the 8th Edition Manual (except for code 88). The new categories will be used for cases diagnosed in 2018 and later.

Coding Instructions

- The post therapy T category staging data item must be assigned for Class of Case 10-22.
- Assign post therapy T category as documented by the treating physician(s) or the managing physician in the medical record.
- If the managing physician has not recorded post therapy T category, registrars *will* assign this item based on the best available information, without necessarily requiring additional contact with the physician.
- Code 88 for clinical and pathological or post therapy T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
- For lung, occult carcinoma is assigned TX.
- If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.

AJCC TNM Post Therapy T Suffix

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1033	4	New 01/18	Required by CoC

Description

Identifies the AJCC TNM post therapy T category suffix for the known tumor ***following*** the completion of neoadjuvant therapy (satisfying the definition for that disease site) and planned post-neoadjuvant therapy surgical resection. Stage suffices identify special cases that need separate analysis. Suffices are adjuncts to and do not change the stage group.

Rationale

The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

- Record the post therapy T category suffix as documented by the first treating physician or the managing physician in the medical record.
- If the managing physician has not recorded the post therapy T category suffix, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
- If the tumor is not staged according to the AJCC manual, leave this data item blank
- Refer to the current *AJCC Cancer Staging Manual* for detailed staging rules.

Code	Label
(blank)	No information available; not recorded
(m)	Multiple synchronous tumors OR Multifocal tumor (differentiated and anaplastic thyroid only)
(s)	Solitary tumor (differentiated and anaplastic thyroid only)

AJCC TNM Post Therapy N

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1022	15	New 01/18	Required by CoC

Description

Identifies the absence or presence of regional lymph node (N) metastasis and describes the extent of regional lymph node metastasis of the tumor known ***following*** the completion of neoadjuvant therapy (satisfying the definition for that disease site) and planned post-neoadjuvant therapy surgical resection.

Rationale

The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

With the implementation of the 8th Edition storage codes are no longer utilized. Values and Labels for the different categories are exact matches to what is listed in the 8th Edition Manual (except for code 88). The new categories will be used for cases diagnosed in 2018 and later.

Coding Instructions

- The post therapy N category staging data item must be recorded for *Class of Case* 10-22.
- Assign post therapy N category as documented by the treating physician(s) or managing physician in the medical record.
- If the managing physician has not recorded post therapy N category, registrars *will* assign this item based on the best available information, without necessarily requiring additional contact with the physician.
- Code 88 for clinical and pathological or post therapy T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
- If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.

AJCC TNM Post Therapy N Suffix

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1036	4	New 01/18	Required by CoC

Description

Identifies the AJCC TNM post therapy N suffix for the known tumor ***following*** the completion of neoadjuvant therapy (satisfying the definition for that disease site) and planned post-neoadjuvant therapy surgical resection. Stage suffices identify special cases that need separate analysis. Suffices are adjuncts to and do not change the stage group.

Rationale

The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

- Record the post therapy N category suffix as documented by the first treating physician or the managing physician in the medical record.
- If the managing physician has not recorded the post therapy N category suffix, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
- If the tumor is not staged according to the AJCC manual, leave this data item blank
- Refer to the current *AJCC Cancer Staging Manual* for detailed staging rules.

Code	Label
(blank)	No information available; not recorded
(sn)	Sentinel node procedure with or without FNA or core needle biopsy
(f)	FNA or core needle biopsy only

AJCC TNM Post Therapy M

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1023	15	New 01/18	Required by CoC

Description

Identifies the presence or absence of distant metastasis (M) of the known tumor ***following*** the completion of neoadjuvant therapy (satisfying the definition for that disease site) and planned post-neoadjuvant therapy surgical resection.

Rationale

The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

With the implementation of the 8th Edition storage codes are no longer utilized. Values and Labels for the different categories are exact matches to what is listed in the 8th Edition Manual (except for code 88). The new categories will be used for cases diagnosed in 2018 and later.

Coding Instructions

- The post therapy M category staging data item must be assigned for *Class of Case* 10-22.
- Assign post therapy M category as documented by the treating physician(s) or the managing physician in the medical record.
- If the managing physician has not recorded post therapy M category, registrars *will* code this item based on the best available information, without necessarily requiring additional contact with the treating physician.
- Code 88 for clinical and pathological or post therapy T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
- If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.

AJCC TNM Post Therapy Stage Group

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1024	15	New 01/18	Required by CoC

Description

Identifies the anatomic extent of disease based on the T, N, and M category data items of the known tumor ***following*** the completion of neoadjuvant therapy (satisfying the definition for that disease site) and planned post-neoadjuvant therapy surgical resection.

Rationale

The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

- Record the post therapy stage group as documented by the treating physician(s) or the managing physician in the medical record.
- If the managing physician has not recorded the post therapy stage, registrars *will* assign this item based on the best available information, without necessarily requiring additional contact with the physician(s).
- Code 88 for clinical and pathological or post therapy T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
- If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
- Convert all Roman numerals to Arabic numerals and use upper-case (capital letters) only.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.

Lymph-Vascular Invasion

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1182	1	01/11, 01/15, 01/18	Required

Description

Indicates the presence or absence of tumor cells in the lymphatic channels (not lymph nodes) or blood vessels within the primary tumor as noted microscopically by the pathologist.

Rationale

Lymph-vascular invasion is an indicator of prognosis.

Coding Instructions

- This coding convention has been developed and implemented for use in the AJCC Cancer Staging Manual, 7th Edition, and updated with new codes in the AJCC 8th Edition staging manual for appropriate disease sites.
- Revised CAP Protocols and 8th Edition chapters will indicate which chapters will use the new codes (2, 3, and 4) and which will only use the existing codes (0, 1, 8, 9), as there are some disease sites where distinguishing between L and V is not medically appropriate.
- Code 8, Not Applicable for benign/borderline brain and CNS tumors.
- For cases diagnosed January 1, 2018 and later, new codes indicating lymphatic, small vessel, and/or large vessel invasion were added.

1. Code from pathology report(s). Code the absence or presence of lymphovascular invasion as described in the medical record.
    a. The primary sources of information about lymphovascular invasion are the pathology check lists (synoptic reports) developed by the College of American Pathologists. If the case does not have a checklist or synoptic report, code from the pathology report or a physician's statement, in that order.
    b. Do not code perineural invasion in this field.
    c. Information to code this field can be taken from any specimen from the primary tumor (biopsy or resection).
    d. If lymphovascular invasion is identified in any specimen, it should be coded as present/identified.
    e. For cases with benign or borderline behavior, code the lymphovascular invasion documented (negative or positive) and, if not documented, code unknown.
    f. For cases treated with neoadjuvant therapy, refer to table below in order to code this field. However, if documentation in the medical record indicates information that conflicts with this table, code lymphovascular invasion with the documentation in the medical record.

LVI on pathology report PRIOR to neoadjuvant therapy	**LVI on pathology report AFTER neoadjuvant therapy**	**Code LVI to:**
0 – Not present/Not identified	0 – Not present/Not identified	*0 – Not present/Not identified*
0 – Not present/Not identified	1 – Present/Identified	*1 – Present/Identified*
0 – Not present/Not identified	9 – Unknown/Indeterminate	*9 – Unknown/Indeterminate*
1 – Present/Identified	0 – Not present/Not identified	*1 – Present/Identified*
1 – Present/Identified	1 – Present/Identified	*1 – Present/Identified*
1 – Present/Identified	9 – Unknown/Indeterminate	*1 – Present/Identified*
9 – Unknown/Indeterminate	0 – Not Present/Not Identified	*9 – Unknown/Indeterminate*
9 – Unknown/Indeterminate	1 – Present/Identified	*1 – Present/Identified*
9 – Unknown/Indeterminate	9 – Unknown/Indeterminate	*9 – Unknown/Indeterminate*

2. Use of codes.
    a. Use code 0 when the pathology report indicates that there is no lymphovascular invasion. This includes cases of purely in situ carcinoma, which biologically have no access to lymphatic or vascular channels below the basement membrane.

b. Use code 1 when the pathology report of a physician's statement indicates that lymphovascular invasion (or one of its synonyms) is present in the specimen.

c. Lymphovascular invasion must be coded 0, 1, 2, 3, 4, or 9 for the Schema ID's in the following list:

ID	Site
00071	Lip
00072	Tongue Anterior
00073	Gum
00074	Floor of Mouth
00075	Palate Hard
00076	Buccal Mucosa
00077	Mouth Other
00080	Major Salivary Glands
00100	Oropharynx (p16+)
00111	Oropharynx (p16-)
00112	Hypopharynx
00121	Maxillary Sinus
00122	Nasal Cavity and Ethmoid Sinus
00130	Larynx Other
00131	Larynx Supraglottic
00132	Larynx Glottic
00133	Larynx Subglottic
00161	Esophagus (incl GE Junction) Squamous
00169	Esophagus (incl GE Junction) (excl Squamous)
00170	Stomach
00180	Small Intestine
00190	Appendix
00200	Colon and Rectum
00230	Bile Ducts Intrahepatic
00250	Bile Ducts Perihilar
00260	Bile Ducts Distal
00270	Ampulla Vater
00280	Pancreas
00290	NET Stomach
00301	NET Duodenum
00302	NET Ampulla of Vater
00320	NET Appendix
00330	NET Colon and Rectum
00340	NET Pancreas
00350	Thymus
00360	Lung
00460	Merkel Cell Skin
00470	Melanoma Skin
00500	Vulva
00510	Vagina
00520	Cervix
00530	Corpus Carcinoma
00541	Corpus Sarcoma
00542	Corpus Adenosarcoma
00560	Placenta
00570	Penis
00590	Testis
00620	Bladder
00730	Thyroid

ID	Site
00740	Thyroid Medullary

d. Lymphovascular invasion must be coded 0, 1, 2, 3, 4, 8, or 9 for the Schema ID's in the following list:

ID	Site
00210	Anus
00220	Liver
00241	Gallbladder
00242	Cystic Duct
00381	Bone Appendicular Skeleton
00382	Bone Spine
00383	Bone Pelvis
00400	Soft Tissue Head and Neck
00410	Soft Tissue Trunk and Extremities
00421	Soft Tissue Abdomen and Thorax
00422	Heart, Mediastinum, and Pleura
00440	Retroperitoneum
00450	Soft Tissue Other
00480	Breast (invasive)
00580	Prostate
00600	Kidney Parenchyma
00610	Kidney Renal Pelvis
00631	Urethra
00632	Urethra-Prostatic
00640	Skin Eyelid
00660	Melanoma Conjunctiva
00671	Melanoma Iris
00672	Melanoma Choroid and Ciliary Body
00700	Orbital Sarcoma
00750	Parathyroid

e. Lymphovascular invasion must be coded 8 (not applicable) for all other Schema ID's:

ID	Site
00060	Cervical Lymph Nodes, Occult Head and Neck
00118	Pharynx Other
00119	Middle Ear
00128	Sinus Other
00140	Melanoma Head and Neck
00150	Cutaneous Carcinoma Head and Neck
00278	Biliary Other
00288	Digestive Other
00358	Trachea
00370	Pleural Mesothelioma
00378	Respiratory Other
00458	Kaposi Sarcoma
00478	Skin Other
00551	Ovary
00552	Primary Peritoneal Carcinoma
00553	Fallopian Tube
00558	Adnexa Uterine Other
00559	Genital Female Other
00598	Genital Male Other
00638	Urinary Other
00650	Conjunctiva

ID	Site
00680	Retinoblastoma
00690	Lacrimal Gland
00698	Lacrimal Sac
00710	Lymphoma Ocular Adnexa
00718	Eye Other
00721	Brain
00722	CNS Other
00723	Intracranial Gland
00770	NET Adrenal Gland
00778	Endocrine Other
00790	Lymphoma
00795	Lymphoma (CLL/SLL)
00811	Mycosis Fungoides
00812	Primary Cutaneous Lymphoma non-MF
00821	Plasma Cell Myeloma
00822	Plasma Cell Disorders
00830	Heme/Retic
99999	Ill-Defined Other

f. Use code 9 when:

i. there is no microscopic examination of a primary tissue specimen

ii. the primary site specimen is cytology only or a fine needle aspiration

iii. the biopsy is only a very small tissue sample

iv. it is not possible to determine whether lymphovascular invasion is present

v. the pathologist indicates the specimen is insufficient to determine lymphovascular invasion

vi. lymphovascular invasion is not mentioned in the pathology report

vii. primary site is unknown

g. Clarification between codes 8 and 9:

i. Code 8 should only be used in the following situations: 1. Standard-setter does not require this item and you are not collecting it. 2. Those schemas noted above described in code 8 for which LVI is always not applicable.

ii. For those cases where there is no information/documentation from the pathology report or other sources, use code 9.

Code	Label
0	Lymphovascular Invasion stated as Not Present
1	Lymphovascular Invasion Present/Identified
2	Lymphatic and small vessel invasion only (L)
3	Venous (large vessel) invasion only (V)
4	BOTH lymphatic and small vessel AND venous (large vessel) invasion
8	Not Applicable
9	Unknown/Indeterminate/not mentioned in path report

Date of Sentinel Lymph Node Biopsy

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	832	8	New 01/18	Required by CoC

Description

Records the date of the sentinel lymph node(s) biopsy procedure. **This data item is used for breast and cutaneous melanoma cases only**.

Rationale

It is a known fact that sentinel lymph node biopsies have been under-reported. Additionally, the timing and results of sentinel lymph node biopsy procedures are used in quality of care measures. This data item can be used to more accurately assess the date of the sentinel lymph node biopsy procedure separate from the date of a subsequent regional node dissection procedure, if performed.

Coding Instructions

- Record the date of the sentinel lymph node biopsy procedure documented in the *Sentinel Lymph Node Examined*.
- This data item documents the date of sentinel node biopsy; do not record the date of lymph node aspiration, fine needle aspiration, fine needle aspiration biopsy, core needle biopsy, or core biopsy.
- Sentinel node procedures are common for other sites, but data is only collected in these fields for breast and cutaneous melanoma. Use the AJCC N suffix to designate sentinel node procedures for ALL sites.
- If the sentinel lymph node biopsy is the first or only surgical procedure performed, record the date documented in this data item in the *Date First Surgical Procedure*.
- If separate sentinel node biopsy procedure and subsequent regional node dissection procedure are performed, 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 Regional Lymph Node Dissection*.
- If a sentinel lymph node biopsy is performed in the same procedure as the regional node dissection, record the date of the procedure in both this data item and in the *Date of Regional Lymph Node Dissection* (i.e., the dates should be equal).
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this modification does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date of Sentinel Lymph Node Biopsy* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of Sentinel Lymph Node Biopsy* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *Date of Sentinel Lymph Node Biopsy Flag* is used to explain why *Date of Sentinel Lymph Node Biopsy* is not a known date. See *Date of Sentinel Lymph Node Biopsy Flag* for an illustration of the relationships among these items.

Date of Sentinel Lymph Node Biopsy Flag

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	833	2	New 01/18	Required by CoC

Description

This flag explains why there is no appropriate value in the corresponding *Date of Sentinel Lymph Node Biopsy*. **This data item is used for breast and cutaneous melanoma cases only**.

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

- Leave this item blank if *Date of Sentinel Lymph Node Biopsy* has a full or partial date recorded.
- Code 10 if it is unknown whether sentinel lymph nodes were biopsied.
- Code 11 if no sentinel lymph node biopsy was performed.
- Code 12 if *the Date of Sentinel Lymph Node Biopsy* cannot be determined, but a sentinel lymph node biopsy was performed.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of data entry is used in the software.

Code	Label
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any sentinel lymph node biopsy was performed)
11	No proper value is applicable in this context (for example, no sentinel lymph node biopsy performed; autopsy only cases)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (for example, sentinel lymph node biopsy performed but date is unknown)
(blank)	A valid date value is provided in item *Date of Sentinel Lymph Node Biopsy*. Case was diagnosed prior to January 1, 2018

Sentinel Lymph Nodes Examined

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	834	2	New 01/18	Required by CoC

Description

Records the total number of lymph nodes sampled during the sentinel node biopsy and examined by the pathologist. **This data item is used for breast and cutaneous melanoma cases only**.

Rationale

It is a known fact that sentinel lymph node biopsies have been under-reported. Additionally, the timing and results of sentinel lymph node biopsy procedures are used in quality of care measures. This data item can be used to more accurately assess the number of lymph nodes biopsied during the sentinel node biopsy procedure separate from the number of lymph nodes dissected during additional subsequent regional node procedures.

Coding Instructions

- If, during a sentinel node biopsy procedure, a few non-sentinel nodes happen to be sampled, document the **total number of nodes sampled during the sentinel node procedure** in this data item. Record the total number of nodes from the sentinel node biopsy procedure regardless of sentinel node status.
- If a sentinel node biopsy procedure and then a subsequent, separate regional node dissection procedure are performed, record the total number of nodes biopsied during the sentinel node 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*.
- If a sentinel lymph node biopsy is performed during the same procedure as the regional node dissection, record the total number of nodes biopsied during the sentinel node procedure in this data item, and record the total number of regional lymph nodes biopsied/dissection (**which includes the number of nodes documented in this data item**) in *Regional Lymph Nodes Examined*.
- If aspiration of sentinel lymph node(s) AND a sentinel node biopsy procedure were performed for the same patient, record the results for the sentinel node biopsy.
- The number of sentinel lymph nodes examined 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.
- Sentinel node procedures are common for other sites, but data is only collected in these fields for breast and cutaneous melanoma. Use the AJCC N suffix to designate sentinel node procedures for ALL sites.
- The number of sentinel nodes should be equal to or less than the number of regional nodes examined recorded in the *Regional Lymph Nodes Examined* data item.

Code	Label
00	No sentinel nodes were examined
01-90	Sentinel nodes were examined (code the exact number of sentinel lymph nodes examined)
95	No sentinel nodes were removed, but aspiration of sentinel node(s) was performed
98	Sentinel lymph nodes were biopsied, but the number is unknown
99	It is unknown whether sentinel nodes were examined; not applicable or negative; not stated in patient record

Sentinel Lymph Nodes Positive

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	835	2	New 01/18	Required by CoC

Description

Records the exact number of sentinel lymph nodes biopsied and found to contain metastases by the pathologist. **This data item is used for breast and cutaneous melanoma cases only**.

Rationale

It is a known fact that sentinel lymph node biopsies have been under-reported. Additionally, the timing and results of sentinel lymph node biopsy procedures are used in quality of care measures. This data item can be used to more accurately assess the number of positive sentinel lymph nodes biopsied separate from the number of positive lymph nodes identified during additional subsequent regional node dissection procedures, if performed.

Coding Instructions

- If, during a sentinel node biopsy procedure, a few non-sentinel nodes happen to be sampled and are positive, document the **total number of positive nodes sampled during the sentinel node procedure** in this data item. Record the total number of positive nodes from the sentinel node biopsy procedure regardless of whether the nodes contain dye or colloidal material (tracer or radiotracer).
- If both a sentinel node biopsy procedure and then a subsequent, separate regional node dissection procedure are performed, record the total number of positive sentinel nodes identified during the sentinel node procedure in this data item, and record the total number of positive regional lymph nodes biopsied/dissected (**which includes the number of sentinel nodes documented in this data item**) in *Regional Lymph Nodes Positive*.
- If a positive aspiration of sentinel lymph node(s) AND a positive sentinel node biopsy procedure were performed for the same patient, record the results for the positive sentinel node biopsy procedure.
- Sentinel node procedures are common for other sites, but data is only collected in these fields for breast and cutaneous melanoma. Use the AJCC N suffix to designate sentinel node procedures for ALL sites.
- **For BREAST only**: If a sentinel lymph node biopsy is performed **during the same procedure as the regional node dissection**, use code 97 in this data item, and record the total number of positive regional lymph nodes biopsied/dissected (both sentinel and regional) in *Regional Lymph Nodes Positive*.
- The CAP protocol for Breast is designed to capture information from the resection (there is no diagnostic protocol for breast). As a result, when the sentinel lymph node biopsy is performed during the same procedure as the regional node dissection, only the overall total number of positive regional nodes (both sentinel and regional) is recorded; the number of positive sentinel nodes is not captured.
- **For MELANOMA only**: If a sentinel lymph node biopsy is performed **during the same procedure as the regional node dissection**, record the total number of positive sentinel nodes identified in this data item, and record the total number of positive regional lymph nodes identified (**which includes the number of positive sentinel nodes documented in this data item**) in *Regional Lymph Nodes Positive*.
- When the sentinel lymph node biopsy is performed during the same procedure as the regional node dissection, the CAP Protocol for Melanoma captures both the number of positive sentinel nodes as well as the number of positive regional nodes **(i**.e., the number of positive sentinel nodes is captured).
- The number of sentinel lymph nodes biopsied and found positive will typically be found in the pathology report, radiology reports, or documented by the physician. Determination of the exact number of sentinel lymph nodes positive may require assistance from the managing physician for consistent coding.
- The number of sentinel nodes positive should be less than or equal to the total number of *Regional Nodes Positive*.
- For carcinoma of the **breast**, if only positive Isolated Tumor Cells (ITC) are identified, the sentinel lymph nodes are considered **negative**.
- For **melanoma**, if only positive Isolated Tumor Cells (ITC) are identified, the sentinel lymph nodes are considered **positive**.

- mi (microscopic or micro mets) sentinel lymph nodes are considered positive.

Code	Label
00	All sentinel nodes examined are negative
01-90	Sentinel nodes are positive (code exact number of nodes positive)
95	Positive aspiration of sentinel lymph node(s) was performed
97	Positive sentinel nodes are documented, but the number is unspecified; **for breast ONLY**: SLN and RLND occurred during the same procedure
98	No sentinel nodes were biopsied
99	It is unknown whether sentinel nodes are positive; not applicable; not stated in patient record

Date Regional Lymph Node Dissection

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	682	8	New 01/18	Required by CoC

Description

Records the date non-sentinel regional node dissection was performed.

Rationale

It is a known fact that sentinel lymph node biopsies have been under-reported. Additionally, the timing and results of sentinel lymph node biopsy procedures are used in quality of care measures. This data item can be used to more accurately assess the date of regional node dissection separate from the date of sentinel lymph node biopsy, if performed.

Coding Instructions

- Record the date of regional lymph node dissection documented in the *Regional Lymph Nodes Examined*.
- Sentinel node procedures are common for other sites, but data is only collected in these fields for breast and cutaneous melanoma. Use the AJCC N suffix to designate sentinel node procedures for ALL sites.
- **For Breast and Melanoma cases**, if both a sentinel node biopsy procedure and then a subsequent, separate regional node dissection procedure are performed, 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*.
    - If a sentinel lymph node biopsy is **performed in the same procedure** as the regional node dissection, record the date of the procedure in both this data item and in the Date of Sentinel Lymph Node Biopsy data item (i.e., the dates should be equal).
- **For all other cases**, record the date of the regional lymph node dissection in this data item.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this modification does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date Regional Lymph Node Dissection* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date Regional Lymph Node Dissection* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *Date Regional Lymph Node Dissection Flag* is used to explain why *Date Regional Lymph Node Dissection* is not a known date. See *Date Regional Lymph Node Dissection Flag* for an illustration of the relationships among these items.

Date Regional Lymph Node Dissection Flag

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	683	2	New 01/18	Required by CoC

Description

This flag explains why there is no appropriate value in the corresponding data item, *Date Regional Lymph Node Dissection*.

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

- Leave this item blank if *Date Regional Lymph Node Dissection* has a full or partial date recorded.
- Code 10 if it is unknown whether regional lymph nodes were dissected.
- Code 11 if no regional lymph nodes were dissected.
- Code 12 if the *Date of Regional Lymph Node Dissection* cannot be determined, but regional lymph nodes were dissected.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of data entry is used in the software.

Code	Label
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any regional lymph node dissection was performed)
11	No proper value is applicable in this context (for example, no regional lymph node dissection was performed; autopsy only cases)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (for example, regional lymph node dissection was performed but date is unknown)
(blank)	A valid date value is provided in item *Date of Regional Lymph Node Dissection*. Case was diagnosed prior to January 1, 2018

Regional Lymph Nodes Positive

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	820	2	01/04, 09/06, 01/10, 01/18	Required

Description

Records the exact number of regional lymph nodes examined by the pathologist and found to contain metastases.

Rationale

This data item is necessary for pathologic staging, and it serves as a quality measure for pathology reports and the extent of the surgical evaluation and treatment of the patient.

Coding Instructions

- **Regional lymph nodes only**. Record information about only regional lymph nodes in this field. Involved distant lymph nodes should not be coded in this field.
- This field is **based on pathologic information only**. This field is to be recorded regardless of whether the patient received preoperative treatment.
- **Cumulative nodes positive**. Record the total number of regional lymph nodes removed and found to be positive by pathologic examination.
    - The number of regional lymph nodes positive is cumulative from all procedures that remove lymph nodes through the completion of surgeries in the first course of treatment
    - Do not count a positive aspiration or core biopsy of a lymph node in the same lymph node chain removed at surgery as an additional node in *Regional Nodes Positive* when there are positive nodes in the resection. In other words, if there are positive regional lymph nodes in a lymph node dissection, do not count the core needle biopsy or the fine needle aspiration if it is in the same chain. See also Use of Code 95 below.
    - If the positive aspiration or core biopsy is from a node in a different node region, include the node in the count of *Regional Nodes Positive*.
    - If the location of the lymph node that is core-biopsied or aspirated is not known, assume it is part of the lymph node chain surgically removed, and do not include it in the count of *Regional Nodes Positive*.
- **Priority of lymph node counts**. If there is a discrepancy regarding the number of positive lymph nodes, use information in the following priority: final diagnosis, synoptic report (also known as CAP) protocol or pathology report checklist), microscopic, gross.
- **Positive Nodes in Multiple Primaries in Same Organ**. If there are multiple primary cancers with different histologic types in the same organ and the pathology report just states the number of nodes positive, the registrar should first try to determine the histology of the metastases in the nodes and code the nodes as positive for the primary with that histology. If no further information is available, code the nodes as positive for all primaries.
- **Isolated tumor cells (ITCs) in lymph nodes**. For all primary sites except cutaneous melanoma and Merkel cell carcinoma of skin, count only lymph nodes that contain micrometastases or larger (metastases greater than 0.2 millimeters in size). Do not include in the count of lymph nodes positive any nodes that are identified as containing isolated tumor cells (ITCs). If the path report indicates that nodes are positive but the size of metastasis is not stated, assume the metastases are larger than 0.2 mm and count the lymph node(s) as positive.
    - **For cutaneous melanoma and Merkel cell carcinoma**, count nodes with ITCs as positive lymph nodes.
- **Use of code 95**. Use code 95 when the only procedure for regional lymph nodes is a needle aspiration (cytology) or core biopsy (tissue).
    - Use code 95 when a positive lymph node is aspirated and there are no surgically resected lymph nodes.
    - Use code 95 when a positive lymph node is aspirated and surgically resected lymph nodes are negative.

- **Definition of Code 97**. Use code 97 for any combination of positive aspirated, biopsied, sampled or dissected lymph nodes if the number of involved nodes cannot be determined on the basis of cytology or histology. Code 97 includes positive lymph nodes diagnosed by either cytology or histology.
    - Note: if the aspirated node is the only one that is microscopically positive, use code 95.
- **Use of Code 98**. Code 98 may be used in several situations.
    - When the assessment of lymph nodes is clinical only.
    - When no lymph nodes are removed and examined
    - When a "dissection" of a lymph node drainage area is found to contain no lymph nodes at the time of pathologic examination.
    - If *Regional Nodes Positive* is coded as 98, *Regional Nodes Examined* is usually coded 00.
- **Use of code 99**. Use code 99 if it is unknown whether regional lymph nodes are positive.
- **Primary Sites always coded to 99**. For the following primary sites and histologies, the *Regional Nodes Positive* field is always coded as 99.
    - Placenta
    - Brain and Cerebral Meninges
    - Other Parts of Central Nervous System
    - Intracranial Gland
    - Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms
    - Hodgkin and non-Hodgkin Lymphoma
    - Myeloma and Plasma Cell Disorders
    - Other and Ill-Defined Primary Sites
    - Unknown Primary Site
- When definition of regional nodes differs between the AJCC Cancer Staging Manual and the SEER Program Coding and Staging Manual, use the AJCC definition.

Code	Label
00	All nodes examined are negative
01-89	1-89 nodes are positive (code exact number of nodes positive)
90	90 or more nodes are positive
95	Positive aspiration of lymph node(s) was performed
97	Positive nodes are documented, but the number is unspecified
98	No nodes were examined
99	It is unknown whether nodes are positive; not applicable; not stated in patient record.

Regional Lymph Nodes Examined

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	830	2	01/04, 09/06, 01/10, 01/18	Required

Description

Records the total number of regional lymph nodes that were removed and examined by the pathologist.

Rationale

This data item is a quality measure of the pathologic and surgical evaluation and treatment of the patient.

Coding Instructions

- **Regional lymph nodes only**. Record information about only regional lymph nodes in this field. Distant lymph node information should not be coded in this field.
- This field is **based on pathologic information only**. This field is to be recorded regardless of whether the patient received preoperative treatment.
- **Use of Code 00**. Code 00 may be used in several situations.
    - When the assessment of lymph nodes is clinical.
    - When no lymph nodes are removed and examined.
    - When a "dissection" of a lymph node drainage area is found to contain no lymph nodes at the time of pathologic examination.
    - If *Regional Nodes Examined* is coded 00, *Regional Nodes Positive* is coded as 98.
- **Cumulative nodes removed and examined**. Record the total number of regional lymph nodes removed and examined by the pathologist.
    - The number of regional lymph nodes examined is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment with the exception of aspiration or core biopsies coded to 95.
    - Do not count a positive aspiration or core biopsy of a lymph node in the same lymph node chain removed at surgery as an additional node in *Regional Nodes Examined*.
    - If the positive aspiration or core biopsy is from a node in a different node region, include the node in the count of *Regional Nodes Examined*.
    - If the location of the lymph node that is aspirated ore core-biopsied is not known, assume it is part of the lymph node chain surgically removed, and do not include it in the count of *Regional Nodes Examined*.
    - When neither the type of lymph node removal procedure nor the number of lymph nodes examined is known, use code 98.
- **Priority of lymph node counts**. If there is a discrepancy regarding the number of lymph nodes examined, use information in the following priority: final diagnosis, synoptic report (also known as CAP protocol or pathology report checklist), microscopic, gross.
- **Use of code 95**. Use code 95 when the only procedure for regional lymph nodes is a needle aspiration (cytology) or core biopsy (tissue).
- **Lymph node biopsy**. If a lymph node biopsy was performed, code the number of nodes removed, if known. If the number of nodes removed by biopsy is not known, use code 96.
- **Definition of "sampling" (code 96)**. A lymph node "sampling" is removal of a limited number of lymph nodes. Other terms for removal of a limited number of nodes include lymph node biopsy, berry picking, sentinel lymph node procedure, sentinel node biopsy, selective dissection. Use code 96 when a limited number of nodes are removed but the number is unknown.

- **Definition of "dissection" (code 97)**. A lymph node "dissection" is removal of most or all of the nodes in the lymph node chain(s) that drain the area around the primary tumor. Other terms include lymphadenectomy, radical node dissection, lymph node stripping. Use code 97 when more than a limited number of lymph nodes are removed and the number is unknown.
- **Multiple lymph node procedures**. If both a lymph node sampling and a lymph node dissection are performed and the total number of lymph nodes examined is unknown, use code 97.
- **Use of Code 99**. If it is unknown whether nodes were removed or examined, code as 99.
- **Primary sites always coded 99**. For the following schemas, the *Regional Nodes Examined* field is always coded as 99.
    - Placenta
    - Brain and Cerebral Meninges
    - Other Parts of Central Nervous System
    - Intracranial Gland
    - Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms
    - Hodgkin and non-Hodgkin Lymphoma
    - Myeloma and Plasma Cell Disorders
    - Other and Ill-Defined Primary Sites
    - Unknown Primary Site
- When definition of regional nodes differs between the AJCC Cancer Staging Manual and the SEER Program Coding and Staging Manual, use the AJCC definition.

Code	Label
00	No nodes were examined
01-89	1-89 nodes were examined (code the exact number of regional lymph nodes examined)
90	90 or more nodes were examined
95	No regional nodes were removed, but aspiration of regional nodes was performed
96	Regional lymph node removal was documented as a sampling, and the number of nodes is unknown/not stated
97	Regional lymph node removal was documented as a dissection, and the number of nodes is unknown/not stated
98	Regional lymph nodes were surgically removed, but the number of lymph nodes is unknown/not stated and not documented as a sampling or dissection; nodes were examined, but the number is unknown
99	It is unknown whether nodes were examined; not applicable or negative; not stated in patient record.

Site-Specific Data Items (SSDI)

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	3803-3937		New 01/18	See below

Description

Site-Specific Data Items (SSDIs) are assigned based on a Schema ID. The Schema ID is derived based on site/histology, schema discriminators, and AJCC TNM staging chapter and staging algorithm. The Schema ID and AJCC ID will be derived by registry software based on site and histology codes entered by the registrar.

In RMCDS, Click on the SSDI button at the bottom of the abstract to code items.

Rationale

Site-Specific Data Items (SSDIs) are used for the collection of site-specific information for cases diagnosed on or after January 1, 2018. Collaborative Stage (CS) Site-Specific Factors is discontinued and Site-Specific Data Items (SSDIs) are used for the collection of information. SSDI's allow for more flexibility, can have varied lengths, registrars can code decimal points, the field names are more meaningful, retrieving data is easier, and there is less duplication. Each SSDI applies only to selected schemas. SSDI fields should be blank for schemas where they do not apply.

Coding Instructions

- Please see the SSDI Manual at the following URL for detailed descriptions, rationales, coding instructions and site-specific coding rules: https://www.naaccr.org/SSDI/SSDI-Manual.pdf .

Item#	Site-Specific Data Item	Length	*Required
3801	Chromosome 1p: Loss of Heterozygosity (LOH)	1	CoC
3802	Chromosome 19q: Loss of Heterozygosity (LOH)	1	CoC
3803	Adenoid Cystic Basaloid Pattern	5	CoC
3804	Adenopathy	1	CoC
3805	AFP Post-Orchiectomy Lab Value	7	CoC
3806	AFP Post-Orchiectomy Range	1	CoC
3807	AFP Pre-Orchiectomy Lab Value	7	CoC
3808	AFP Pre-Orchiectomy Range	1	CoC
3809	AFP Pretreatment Interpretation	1	CoC
3810	AFP Pretreatment Lab Value	6	CoC
3811	Anemia	1	CoC
3812	B symptoms	1	CoC
3813	Bilirubin Pretreatment Total Lab Value	5	CoC
3814	Bilirubin Pretreatment Unit of Measure	1	CoC
3815	Bone Invasion	1	CoC
3816	Brain Molecular Markers	2	**MCTR**
3817	Breslow Tumor Thickness	4	**MCTR**
3818	CA-125 Pretreatment Interpretation	1	CoC
3819	CEA Pretreatment Interpretation	1	CoC
3820	CEA Pretreatment Lab Value	6	CoC
3821	Chromosome 3 Status	5	CoC
3822	Chromosome 8q Status	5	CoC
3823	Circumferential Resection Margin (CRM)	4	CoC
3824	Creatinine Pretreatment Lab Value	4	CoC
3825	Creatinine Pretreatment Unit of Measure	1	CoC
3826	Estrogen Receptor Percent Positive or Range	3	CoC
3827	Estrogen Receptor Summary	1	**MCTR**
3828	Estrogen Receptor Total Allred Score	3	**MCTR**
3829	Esophagus and EGJ Tumor Epicenter	1	CoC
3830	Extranodal Extension Clin (non-Head and Neck)	1	CoC
3831	Extranodal Extension Head and Neck Clinical	1	CoC
3832	Extranodal Extension Head and Neck Pathological	1	CoC

Item#	Site-Specific Data Item	Length	*Required
3833	Extranodal Extension Path (non-Head and Neck)	1	CoC
3834	Extravascular Matrix Patterns	1	CoC
3835	Fibrosis Score	1	**MCTR**
3836	FIGO Stage	2	CoC
3837	Gestational Trophoblastic Prognostic Scoring Index	2	CoC
3838	Gleason Patterns Clinical	2	CoC
3839	Gleason Patterns Pathological	2	CoC
3840	Gleason Score Clinical	2	CoC
3841	Gleason Score Pathological	2	CoC
3842	Gleason Tertiary Pattern	2	CoC
3843	Grade Clinical	1	**MCTR**
3844	Grade Pathological	1	**MCTR**
3845	Grade Post Therapy	1	**MCTR**
3846	hCG Post-Orchiectomy Lab Value	7	CoC
3847	hCG Post-Orchiectomy Range	1	CoC
3848	hCG Pre-Orchiectomy Lab Value	7	CoC
3849	hCG Pre-Orchiectomy Range	1	CoC
3850	HER2 IHC Summary	1	CoC
3851	HER2 ISH Dual Probe Copy Number	4	CoC
3852	HER2 ISH Dual Probe Ratio	4	CoC
3853	HER2 ISH Single Probe Copy Number	4	CoC
3854	HER2 ISH Summary	1	CoC
3855	HER2 Overall Summary	1	**MCTR**
3856	Heritable Trait	1	CoC
3857	High Risk Cytogenetics	1	CoC
3858	High Risk Histologic Features	1	CoC
3859	HIV Status	1	CoC
3860	International Normalized Ratio Prothrombin Time	1	CoC
3861	Ipsilateral Adrenal Gland Involvement	1	CoC
3862	JAK2	1	CoC
3863	Ki-67	5	CoC
3864	Invasion Beyond Capsule	1	CoC
3865	KIT Gene Immunohistochemistry	1	CoC
3866	KRAS	1	CoC
3867	LDH Post-Orchiectomy Range	1	CoC
3868	LDH Pre-Orchiectomy Range	1	CoC
3869	LDH Pretreatment Level	1	CoC
3870	LDH Upper Limits of Normal	3	CoC
3871	LN Assessment Method Femoral-Inguinal	1	CoC
3872	LN Assessment Method Para-Aortic	1	CoC
3873	LN Assessment Method Pelvic	1	CoC
3874	LN Distant Assessment Method	1	CoC
3875	LN Distant: Mediastinal, Scalene	1	CoC
3876	LN Head and Neck Levels I-III	1	CoC
3877	LN Head and Neck Levels IV-V	1	CoC
3878	LN Head and Neck Levels VI-VII	1	CoC
3879	LN Head and Neck Other	1	CoC
3880	LN Isolated Tumor Cells (ITC)	1	CoC
3881	LN Laterality	1	CoC
3882	LN Positive Axillary Level I-II	2	CoC
3883	LN Size	4	CoC
3884	LN Status Femoral-Inguinal, Para-Aortic, Pelvic	1	CoC
3885	Lymphocytosis	1	CoC

Item#	Site-Specific Data Item	Length	*Required
3886	Major Vein Involvement	1	CoC
3887	Measured Basal Diameter	4	CoC
3888	Measured Thickness	4	CoC
3889	Methylation of O6-Methylguanine-Methyltransferase	1	CoC
3890	Microsatellite Instability (MSI)	1	**MCTR**
3891	Microvascular Density	2	CoC
3892	Mitotic County Uveal Melanoma	4	CoC
3893	Mitotic Rate Melanoma	2	CoC
3894	Multigene Signature Method	1	CoC
3895	Multigene Signature Results	1	CoC
3896	NCCN International Prognostic Index (IPI)	2	CoC
3897	Number of Cores Examined	2	CoC
3898	Number of Cores Positive	2	CoC
3899	Number of Examined Para-Aortic Nodes	2	CoC
3900	Number of Examined Pelvic Nodes	2	CoC
3901	Number of Positive Para-aortic Nodes	2	CoC
3902	Number of Positive Pelvic Nodes	2	CoC
3903	Oncotype Dx Recurrence Score-DCIS	3	CoC
3904	Oncotype Dx Recurrence Score-Invasive	3	CoC
3905	Oncotype Dx Risk Level-DCIS	1	CoC
3906	Oncotype Dx Risk Level-Invasive	1	CoC
3907	Organomegaly	1	CoC
3908	Percent Necrosis Post Neoadjuvant	5	CoC
3909	Perineural Invasion	1	CoC
3910	Peripheral Blood Involvement	1	CoC
3911	Peritoneal Cytology	1	CoC
3913	Pleural Effusion	1	CoC
3914	Progesterone Receptor Percent Positive or Range	3	CoC
3915	Progesterone Receptor Summary	1	**MCTR**
3916	Progesterone Receptor Total Allred Score	2	**MCTR**
3917	Primary Sclerosing Cholangitis	1	CoC
3918	Profound Immune Suppression	1	CoC
3919	Prostate Pathological Extension	3	CoC
3920	PSA (Prostatic Specific Antigen) Lab Value	5	**MCTR**
3921	Residual Tumor Volume Post Cytoreduction	2	CoC
3922	Response to Neoadjuvant Therapy	1	CoC
3923	S Category Clinical	1	CoC
3924	S Category Pathological	1	CoC
3925	Sarcomatoid Features	3	CoC
3926	Schema Discriminator 1	1	**MCTR**
3927	Schema Discriminator 2	1	**MCTR**
3928	Schema Discriminator 3	1	CoC
3929	Separate Tumor Nodules	1	CoC
3930	Serum Albumin Pretreatment Level	1	CoC
3931	Serum Beta-2 Microglobulin Pretreatment Level	1	CoC
3932	LDH Pretreatment Lab Value	7	**MCTR**
3933	Thrombocytopenia	1	CoC
3934	Tumor Deposits	2	CoC
3935	Tumor Growth Pattern	1	CoC
3936	Ulceration	1	CoC
3937	Visceral and Parietal Pleural Invasion	1	CoC

*MCTR: Required from all facilities, when available.
CoC: Required from ACoS-CoC approved facilities only; recommended as available from all other facilities.

Physical Exam Text

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Text – DX Proc – PE	2520	1,000	01/10, 01/12	Required

Description

Text area for manual documentation from the history and physical examination about the history of the current tumor and the clinical description of this tumor.

In RMCDS, click on the box "T" on the left of the text line to open entire text box.

Rationale

Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted with coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values.

Coding Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR or MCTR-approved abbreviations should be utilized.
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including *Remarks Text*. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Suggestions for text:

- Date of physical exam
- Age, sex, race/ethnicity
- History that relates to cancer diagnosis
- Primary Site
- Histology (if diagnosis prior to this admission)
- Tumor location
- Tumor size
- Palpable lymph nodes
- Record positive and negative clinical findings; record positive results first
- Impression (when stated and pertains to cancer diagnosis)
- Treatment plan

Data Item(s) to be verified/validated using the text entered in this field include the *Date of First Contact*, *Date of Diagnosis*, *Age at Diagnosis*, *Race 1-5*, *Spanish Hispanic Origin*, *Sex*, *Primary Site*, *Laterality*, *Histology*, *Sequence Number*, *Collaborative*

Stage variables, *SEER Summary Stage 1977*, and *SEER Summary Stage 2000* fields. After manual entry of the text field, ensure that the text entered on both agrees with the coded values and clearly justifies the selected codes.

Scopes Text

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Text – DX Proc – Scopes	2540	1,000	01/10, 01/12	Required

Description

Text area for manual documentation from endoscopic examinations that provide information for staging and treatment.

In RMCDS, click on the box "T" on the left of the text line to open entire text box.

Rationale

Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted with coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values.**

Coding Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR or MCTR-approved abbreviations should be utilized.
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including *Remarks Text*. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Suggestions for text:

- Date(s) of endoscopic exam(s)
- Primary site
- Histology (if given)
- Tumor location
- Tumor size
- Record site and type of endoscopic biopsy
- Lymph nodes
- Record positive and negative clinical findings; record positive results first

Data Item(s) to be verified/validated using the text entered in this field include the *Date of Diagnosis*, *Dx/Stage Procedure*, *Diagnostic Confirmation*, *Primary Site*, *Laterality*, *Histology*, *Collaborative Stage variables*, *Date of Surgery, Surgery of Primary Site, SEER Summary Stage 1977*, and *SEER Summary Stage 2000* fields. After manual entry of the text field, ensure that the text entered on both agrees with the coded values and clearly justifies the selected codes.

X-Ray/Scan Text

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Text – DX Proc – X-ray/Scan	2530	1,000	01/10, 01/12	Required

Description

Text area for manual documentation from all X-rays, scans, and/or other imaging examinations that provide information about staging.

In RMCDS, click on the box "T" on the left of the text line to open entire text box.

Rationale

Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted with coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Coding Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR or MCTR-approved abbreviations should be utilized.
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including *Remarks Text*. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Suggestions for text:

- Date(s) and type(s) of X-ray/Scan(s)
- Primary Site
- Histology (if given)
- Tumor location
- Tumor size
- Lymph nodes
- Record positive and negative clinical findings; record positive results first
- Distant disease or metastasis

Data Item(s) to be verified/validated using the text entered in this field include the *Date of Diagnosis*, *Dx/Stage Procedure*, *Primary Site*, *Laterality*, *Histology*, *Collaborative Stage variables*, *SEER Summary Stage 1977*, and *SEER Summary Stage 2000* fields. After manual entry of the text field, ensure that the text entered on both agrees with the coded values and clearly justifies the selected codes.

Lab Tests Text

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Text – DX Proc – Lab Tests	2550	1,000	01/10, 01/12	Required

Description

Text area for manual documentation of information from laboratory examinations other than cytology or histopathology.

In RMCDS, click on the box "T" on the left of the text line to open entire text box.

Rationale

Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted with coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Coding Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR or MCTR-approved abbreviations should be utilized.
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including *Remarks Text*. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Suggestions for text:

- Type of laboratory test/tissue specimen(s)
- Record positive and negative clinical findings; record positive results first
- Information can include tumor markers, serum and urine electrophoresis, special studies, etc
- Date(s) of laboratory test(s)
- Tumor markers included, but are 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)

Data Item(s) to be verified/validated using the text entered in this field include the *Primary Site*, *Grade*, *Diagnostic Confirmation*, *Collaborative Stage variables*, and *Date of Diagnosis* fields. After manual entry of the text field, ensure that the text entered on both agrees with the coded values and clearly justifies the selected codes.

Remarks Text

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Text – Remarks	2680	1,000	01/10, 01/12	Required

Description

Text area for information that is given only in coded form elsewhere or for which the abstract provides no other place. Overflow data can also be placed here. Problematic coding issues can also be discussed in this section.

In RMCDS, click on the box "T" on the left of the text line to open entire text box.

Rationale

Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted with coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

Coding Instructions

- NAACCR or MCTR-approved abbreviations should be utilized.
- Do not repeat information from other text fields.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Suggestions for text:

- Smoking and alcohol history
- Family and personal history of cancer (other primary tumors of patient to justify sequence)
- Comorbidities
- Information on sequence numbers if a person was diagnosed with another cancer out-of-state or before the registry's reference date
- Place of birth
- Justification of over-ride flags
- Information clarifying anything unusual such as reason for reporting a case seemingly not reportable for that facility or reason for coding numerous fields as "unknown"

Treatment Information

First Course Treatment

In RMCDS, click on the box "First Course Treatment" to enter the screen for recording first course treatment.

The first course of treatment includes all methods of treatment recorded in the treatment plan and administered to the patient before disease progression or recurrence. "Active Surveillance" is a form of planned treatment for some patients; its use is coded in the new *Treatment Status* item. "No therapy" is a treatment option that occurs if the patient refuses treatment, the family or guardian refuses treatment, the patient dies before treatment starts, or the physician recommends no treatment be given. If the patient refuses all treatment, code "patient refused" (code 7 or 87) for all treatment modalities. Maintenance treatment given as part of the first course of planned care (for example, for leukemia) is first course treatment, and cases receiving that treatment are analytic.

Treatment Plan

A treatment plan describes the type(s) of therapies intended to modify, control, remove, or destroy proliferating cancer cells. The documentation confirming a treatment plan may be found in several different sources; for example, medical or clinical records, consultation reports, and outpatient records.

- All therapies specified in the physician(s) treatment plan are a part of the first course of treatment if they are actually administered to the patient.
- A discharge plan must be part of the patient's record in a JCAHO-approved program and may contain part or all of the treatment plan.
- An established protocol or accepted management guidelines for the disease can be considered a treatment plan in the absence of other written documentation.
- If there is no treatment plan, established protocol, or management guidelines, and consultation with a physician advisor is not possible, use the principle: "initial treatment must begin within four months of the date of initial diagnosis".

Time Periods for First Course of Treatment

If first course treatment was provided, the *Date of First Course of Treatment* is the earliest of *Date of First Surgical Procedure*, *Date Radiation Started*, *Date Systemic Therapy Started*, or *Date Other Treatment Started*.

- If no treatment is given, record the date of the decision not to treat, the date of patient refusal, or the date the patient expired.
- If active surveillance ("watchful waiting") was selected, record the date of that decision.
- Additional data items further define the parameters for specific treatments and treatment modalities, as described in the following sections.

A new item, *Treatment Status*, implemented in 2010, summarizes whether the patient received any first course treatment, no treatment, or is being managed by active surveillance.

All Malignancies except Leukemias

The first course of treatment includes all therapy planned and administered by the physician(s) during the first diagnosis of cancer. Planned treatment may include multiple modes of therapy and may encompass intervals of a year or more. Any therapy administered after the discontinuation of first course treatment is subsequent treatment.

Leukemias

The first course of treatment includes all therapies planned and administered by the physician(s) during the first diagnosis of leukemia. Record all remission-inducing or remission-maintaining therapy as the first course of treatment. Treatment regimens may include multiple modes of therapy. The administration of these therapies can span a year or more. A patient may relapse after achieving a first remission. All therapy administered after the relapse is secondary or subsequent treatment.

IN UTERO DIAGNOSIS AND TREATMENT

Beginning in 2009, diagnosis and treatment dates for a fetus prior to birth are to be assigned the actual date of the event. In the past, those dates were set by the rule to the date the baby was born. The exact date may be used for cases diagnosed prior to 2009.

TREATMENT, PALLIATIVE, AND PROPHYLACTIC CARE

Any first course radiation or systemic treatment that acts to kill cancer cells is to be reported as treatment. For example, when total body irradiation (TBI) is given to prepare the patient for a bone marrow transplant (BMT), the TBI acts in two ways. First, it suppresses the immune system to reduce the body's ability to reject the BMT. Second, it contributes to the patient's treatment by destroying cancer cells in the bone marrow, though its use alone would generally not be sufficient to produce a cure. Both the TBI and the BMT should be coded as treatment. The situation is analogous to the use of breast-conserving surgery and adjuvant radiation when the surgery or radiation alone may not be sufficient to produce a cure, though together they are more effective.

When first course surgery, systemic treatment, or radiation is undertaken to reduce the patient's symptoms, that treatment should be coded as palliative care. An example is radiation to bone metastases for prostate cancer to reduce bone pain, which is palliative when there is no expectation that the radiation will effectively reduce the cancer burden. Palliative care involving surgery, systemic treatment, or radiation is also coded as treatment. This treatment qualifies the patient as analytic if it is given as part of planned first course treatment.

The term "prophylactic" is used in medical practice in a variety of ways. An action taken to prevent cancer from developing (such as a double mastectomy for a healthy woman who has several relatives diagnosed with breast cancer when they were young) is not reportable; there is no cancer to report. Actions taken as part of planned first course treatment to prevent spread or recurrence of the cancer are sometimes characterized as "prophylactic" (for example, performing an oophorectomy or providing Tamoxifen to a breast cancer mastectomy patient). These treatments are to be coded as treatment.

EMBOLIZATION

The term embolization refers to the intentional blocking of an artery or vein. The mechanism and the reason for embolization determine how and whether it is to be recorded.

Chemoembolization is a procedure in which the blood supply to the tumor is blocked surgically or mechanically and anticancer drugs are administered directly into the tumor. This permits a higher concentration of drug to be in contact with the tumor for a longer period of time. Code chemoembolization as *Chemotherapy* when embolizing agent(s) is a chemotherapeutic drug(s) or when the term *chemoembolization* is used with no reference to the agent. Use *SEER*Rx Interactive Drug Database* (http://seer.cancer.gov/) to determine whether the drugs used are classified as chemotherapeutic agents. Also, code as *Chemotherapy* when the patient has primary or metastatic cancer in the liver and the only information about embolization is a statement that the patient had chemoembolization, tumor embolization, or embolization of the tumor in the liver. However, if alcohol is specified as the embolizing agent, even in the liver, code the treatment as *Other Treatment*.

Radioembolization is embolization combined with injection of small radioactive beads or coils into an organ or tumor. Code *Radiation Modality* as brachytherapy when tumor embolization is performed using a radioactive agent or radioactive seeds.

Embolization is coded as *Other Treatment* (code 1) if the embolizing agent is alcohol, or if the embolized site is other than the liver and the only information in the record is that the patient was given "embolization" with no reference to the agent.

Do not code pre-surgical embolization of hypervascular tumors with particles, coils, or alcohol. These pre-surgical embolizations are typically performed to make the resection of the primary tumor easier. Examples where pre-surgical embolization is used include meningiomas, hemangioblastomas, paragangliomas, and renal cell metastases in the brain.

Surgery

First course surgery items describe the most definitive type of surgical treatment the patient received from any facility, when it was performed, and its efficacy. When no surgical treatment is given, the reason is recorded. Major aspects of surgical care provided by the individual facility are also recorded so that hospital cancer programs can evaluate local patient care.

Relationships among Surgical Items

Date of Surgery is the date that the first *Surgery of Primary Site*, *Scope of Regional Lymph Node Surgery*, or *Surgical Procedure/Other Site* was performed as part of first course treatment.

- If surgery was the only type of first course treatment performed or was the first of multiple treatment modalities, *Date of Surgery* is the same as *Date of First Course of Treatment*. Both dates can be used to describe lag time between diagnosis and initialization of specific aspects of treatment.

Surgery of Primary Site, *Scope of Regional Lymph Node Surgery*, and *Surgical Procedure/Other Site* record three distinct aspects of first course therapeutic surgical procedures that may be performed during one or multiple surgical events. If multiple primaries are treated by a single surgical event, code the appropriate surgical items separately for each primary.

When multiple first course procedures coded under the same item are performed for a primary, the most extensive or definitive is the last performed, and the code represents the cumulative effect of the separate procedures. Do not rely on your registry software to accumulate separate surgeries into the correct code.

- *Surgery of Primary Site* is a site-specific item that describes the most invasive extent of local tumor destruction or surgical resection of the primary site and of surrounding tissues or organs that are removed in continuity with the primary site.
- *Scope of Regional Lymph Node Surgery* describes the removal, biopsy, or aspiration of sentinel nodes and other regional lymph nodes that drain the primary site and may include surgical procedures that aspirate, biopsy, or remove regional lymph nodes in an effort to diagnose and/or stage disease.
- *Surgical Procedure/Other Site* describes first course resection of distant lymph node(s) and/or regional or distant tissue or organs beyond the *Surgery of Primary Site* range.

If surgery of the respective type was performed, the code that best describes the surgical procedure is recorded whether or not any cancer was found in the resected portion. Incidental removal of tissue or organs, when it is not performed as part of cancer treatment (for example, incidental removal of an appendix), does not alter code assignment.

The code ranges and corresponding descriptions for most site-specific *Surgery of Primary Site* code are grouped according to the general nature of the procedure:

- Codes 10 through 19 are site-specific descriptions of tumor-destruction procedures that do not produce a pathologic specimen.
- Codes 20 through 80 are site-specific descriptions of resection procedures.
- The special code 98 applies to specific tumors that cannot be clearly defined in terms of primary or non-primary site. *Surgery* should be coded 98 for any tumor characterized by the specific sites and/or morphologies identified in the site-specific code instructions for *Unknown and Ill-Defined Primary Sites* and *Hematopoietic/Reticuloendothelial/Immunoproliferating/Myeloproliferative Disease*. The item *Surgical Procedure/Other Site* is used to indicate whether surgery was performed for these tumors.

When multiple first course primary site surgical procedures are performed for a single tumor, the most extensive or definitive is the last performed, and the code represents the cumulative effect of the separate procedures.

Response categories are defined in logical sequence. Within groups of codes, procedures are defined with increasing degrees of descriptive precision. Succeeding groups of codes define progressively more extensive forms of resection.

For codes 00 through 79, the descriptions of the surgical procedures are hierarchical. Last-listed responses take precedence over earlier-listed responses (regardless of the code or numeric value).

To the extent possible, codes and their definitions are the same as those previously assigned in *ROADS* to accommodate analysis in registries that maintain unconverted data. As a result of added and modified codes, however, the numeric code sequence may deviate from the order in which the descriptions of the surgical procedures are listed.

Example: A rectosigmoid primary surgically treated by polypectomy with electrocautery, which is listed *after* polypectomy alone, is coded 22.

20 Local tumor excision, NOS
26 Polypectomy
27 Excisional biopsy
Combination of 20 or 26-27 WITH
21 Photodynamic therapy (PDT)

22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision

Scope of Regional Lymph Node Surgery distinguishes between sentinel lymph node biopsy and removal of other regional lymph nodes and distinguishes removal of regional lymph nodes during the same surgical procedure as a sentinel node biopsy from subsequent removal.

- One important use of registry data is the tracking of treatment patterns over time. In order to compare contemporary treatment to previously published treatment based on the former codes, or to data still unmodified from pre-1998 definitions, the ability to differentiate surgeries in which four or more regional lymph nodes are removed is desirable. The compromise incorporated in the *Scope of Regional Lymph Node Surgery* codes separates removal of one to three nodes (code 4) from removal of four or more nodes in the response categories (code 5). It is **very important** to note that this distinction is made to permit comparison of current surgical procedures with procedures coded in the past when the removal of fewer than four nodes was not reflected in surgery codes. The distinction between fewer than four nodes and four or more nodes removed is not intended to reflect clinical significance when applied to a particular procedure.

Surgical Procedure/Other Site describes surgery performed on tissue or organs other than the primary site or regional lymph nodes. It is also used to describe whether surgery was performed for tumors having unknown or ill-defined primary sites or hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease morphologies. If any surgical treatment was performed on these cancers, *Surgical Procedure/Other Site* is coded 1.

Six surgery items augment the information recorded in *Surgery of Primary Site*. These items apply to the most definitive (most invasive) first course primary site surgery performed, that is, to the event recorded under *Surgery of Primary Site*. When no surgical procedure of the primary site is performed, the reason is recorded in the item *Reason for No Surgery*.

- *Date of Most Definitive Surgical Resection* is the date on which the specific procedure recorded in *Surgery of Primary Site* was performed. If only one first course surgical procedure was performed, then the date will be the same as that for *Date of first Surgical Procedure*.
- *Date of Surgical Discharge* is the date the patient was discharged following the procedure recorded in *Surgical Procedure of Primary Site*. It is on or after the *Date of Most Definitive Surgical Resection*.
- *Surgical Approach 2010* distinguishes among open surgery, laparoscopic surgery, and robotic assisted surgery when it is performed by the reporting facility. If more than one surgical procedure is performed by the facility, this item refers to the most definitive (most invasive) first course primary site surgery performed.

- *Surgical Margins* records the pathologist's determination of the presence of microscopic or macroscopic involvement of cancer at the margins of resection following the surgical resection described by *Surgery of Primary Site*.
- *Readmission to the Same Hospital Within 30 Days of Surgical Discharge* distinguishes planned from an unplanned hospital admission and is used as a quality of care indicator.
- *Reason for No Surgery* identifies why surgical therapy was not provided to the patient and distinguishes a physician's not recommending surgical therapy due to contraindicating conditions from a patient's refusal of a recommended treatment plan.

Radiation

The radiation items in *FORDS* are clinically relevant and reflect contemporary practice. These items record regional and boost treatment information.

Relationships among Radiation Items

Date of Radiation is the date that the first radiation therapy was delivered to the patient as part of all the first course of therapy. This item in combination with *Date Radiation Ended* allows the duration of treatment to be calculated.

- If radiation was the only type of first course treatment performed or was the first of multiple treatment modalities, *Date of Radiation* is the same as *Date of First Course of Treatment*. Both dates can be used to describe lag time between diagnosis and initialization of specific aspects of treatment.

Location of Radiation Treatment can be used to assess where therapy was provided. This item allows for the distinction between summary treatment and treatment given at the accessioning facility. Codes are provided that allow the description of where regional and boost dose therapy were provided, whether all the therapy was provided at the accessioning facility or if all or some of the radiation therapy was referred out to another treatment location.

The targeted anatomic region is described by *Radiation Treatment Volume*. The treatment volume may be the same as the primary site of disease; however, the available code values provide descriptions of anatomic regions that may extend beyond the primary site of disease and may be used to describe the treatment of metastatic disease. If two distinct volumes are radiated, and one of those includes the primary site, record the radiation involving the primary site in all radiation fields.

The type of regional dose therapy and its concomitant dose are captured by the items *Regional Treatment Modality* and *Regional Dose (cGy)*. These two items describe the type of radiation delivered to the patient and the most significant therapeutic dose delivered.

A boost treatment is provided to a smaller field within the same volume as regional radiation in order to enhance the effect of the regional treatment.

- The boost dose may or may not employ the same treatment modality. For example, external beam radiation may be used for regional treatment and is followed by brachytherapy for the boost dose.
- Not all patients who receive radiation therapy receive a boost dose radiation. In these cases, the modality and dose should be coded as 00 and 00000, respectively.

In addition to knowing the duration of treatment and the modalities and doses involved, it is critical to know the number of treatments to be able to gauge the intensity of the dose delivered to the patient. The data item *Number of Treatments to This Volume* describes the total number of therapeutic treatments (regional and boost combined) delivered to the anatomic volume coded in *Radiation Treatment Volume*.

Two items augment the information recorded in the radiation modality, dose, volume, and number of treatment items.

- *Radiation/Surgery Sequence* identifies those instances where radiation therapy and the surgical management of the patient are not discrete and overlap with respect to time. Radiation therapy can precede the surgical resection of a tumor and then be continued after the patient's surgery, or radiation can be administered intraoperatively.

- *Reason for No Radiation* identifies why radiation therapy was not provided to the patient and distinguishes a physician's not recommending this therapy due to contraindicating conditions from a patient's refusal of a recommended treatment plan.

Systemic Therapy

Systemic therapy encompasses the treatment modalities captured by the items chemotherapy, hormone therapy, and immunotherapy. The systemic therapy items separate the administration of system agents or drugs from medical procedures which affect the hormonal or immunologic balance of the patient.

Clarification of Systemic Therapy Terms

Term	Definition
Chemotherapy	Cancer therapy that achieves its anti-tumor effect through the use of antineoplastic drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis.
Hormone Therapy	Cancer therapy that achieves its anti-tumor effect through changes in hormonal balance. This includes the administration of hormones, agents acting via hormonal mechanisms, antihormones, and steroids.
Immunotherapy	Cancer therapy that achieves its anti-tumor effect by altering the immune system or changing the host's response to the tumor cells.
Endocrine Therapy	Cancer therapy that achieves its anti-tumor effect through the use of radiation or surgical procedures that suppress the naturally occurring hormonal activity of the patient and, therefore, alter or affect the long-term control of the cancer's growth.
Hematologic Transplants	Bone marrow or stem cell transplants performed to protect patients from myelosuppression or bone marrow ablation associated with the administration of high-dose chemotherapy or radiation therapy.

Important information affecting classification of some systemic therapies. The six drugs listed in the table below were previously classified as Chemotherapy and are now classified as BRM/Immunotherapy. This change is effective for cases diagnosed January 1, 2013 and forward. For cases diagnosed prior to January 1, 2013, registrars have been instructed to continue coding these drugs as Chemotherapy. Coding instructions related to this change have been added to the remarks field for the applicable drugs in *SEER*Rx Interactive Drug Database*.

Drug Name(s)	Category Prior to 2013	Category 2013+
Alemtuzumab/Campath	Chemotherapy	BRM/Immunotherapy
Bevacizumab/Avastin	Chemotherapy	BRM/Immunotherapy
Rituximab	Chemotherapy	BRM/Immunotherapy
Trastuzumab/Herceptin	Chemotherapy	BRM/Immunotherapy
Pertuzumab/Perjeta	Chemotherapy	BRM/Immunotherapy
Cetuxumab/Erbitux	Chemotherapy	BRM/Immunotherapy

Chemotherapy agents are administered in treatment cycles, either singly or in a combination regimen of two or more drugs. If a patient has an adverse reaction, the managing physician may change one of the agents in a combination regimen. If the replacement agent belongs to the same group as the original agent, there is no change in the regimen. However, if the replacement agent is of a different group than the original agent, the new regimen represents the start of subsequent therapy, *only the original agent or regimen is recorded as first course therapy*. Refer to the *SEER*Rx Interactive Drug Database* (http://seer.cancer.gov/) for a list of systemic therapy agents.

Systemic agents may be administered by intravenous infusion or given orally. Other methods of administration include the following:

Method	Administration
Intrathecal	Administered directly into the cerebrospinal fluid through a lumbar puncture needle into an implanted access device (Ommaya reservoir).
Pleural/pericardial	Injected directly into pleural or pericardial space to control malignant effusions.
Intraperitoneal	Injected into the peritoneal cavity.
Hepatic artery	Injected into a catheter inserted into the artery that supplies blood to the liver.

Relationships among Systemic Therapy Items

The data item *Date Systemic Therapy* describes the first date on which any first course systemic treatment was administered to the patient. Nine out of 10 patients treated with systemic therapy receive only a single class of drugs (chemotherapy, hormone therapy, or immunotherapy). Of the remaining patients who receive a combined regimen of systemic therapies, two-thirds begin these combined regimens simultaneously. For the purposes of clinical surveillance, the collection of multiple dates to describe the sequence of systemic therapy administration is not necessary.

The data items *Chemotherapy*, *Hormone Therapy*, and *BRM/Immunotherapy* describe whether or not each respective class of agent(s) or drug(s) were administered to the patient as part of first course therapy based on *SEER*Rx*. In the case of chemotherapy, additional distinction is allowed for instances where single or multiagent regimens were administered. Each of these three items includes code values that describe the reason a particular class of drugs is not administered to the patient and distinguishes a physician's not recommending systemic therapy due to contraindicating conditions from a patient's refusal of a recommended treatment plan. The associated date items were previously defined by CoC, though discontinued in *FORDS* from 2003 through 2009 and the same fields may be used to collect them now, if allowed by the registry software.

Transplant and Endocrine captures those infrequent instances in which a medical, surgical, or radiation procedure is performed on a patient that has an effect on the hormonal or immunologic balance of the patient. Hematologic procedures, such as bone marrow transplants or stem cell harvests, are typically employed in conjunction with administration of systemic agent(s), usually chemotherapy.

- Endocrine procedures, either radiologic or surgical, may be administered in combination with systemic agent(s), typically hormonal therapeutic agents.
- As first course of therapy, hematologic procedures will rarely be administered in conjunction with endocrine radiation or surgery. The use of code 40 in response to this data item should be reviewed and confirmed with the managing physician(s).

Other Treatment

Other treatment encompasses first course treatment that cannot be described as surgery, radiation, or systemic therapy according to the defined data items found in this manual.

This item is also used for supportive care treatment for reportable hematopoietic diseases that do not meet the usual definition in which treatment "modifies, controls, removes, or destroys proliferating cancer tissue." Treatments such as phlebotomy, transfusions, and aspirin are recorded in *Other Treatment* data item for certain hematopoietic diseases and should be coded 1. Consult the most recent version of the **Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual** for Coding Instructions care of specific hematopoietic neoplasms in this item.

- Phlebotomy may be called blood removal, blood letting, or venisection.
- Transfusions may include whole blood, RBCs, platelets, plateletpheresis, fresh frozen plasma (FFP), plasmapheresis, and cryoprecipitate.
- Aspirin (also known as ASA, acetylsalicylic acid, or by a brand name) is used as a treatment for essential thrombocythemia. Record ONLY aspirin therapy to thin the blood for symptomatic control of thrombocythemia. To determine whether aspirin is administered for pain, cardiovascular protection, or thinning of platelets in the blood, use the following general guideline:
  - Pain control is approximately 325–1000 mg every 3–4 hours.
  - Cardiovascular protection starts at about 160 mg/day.
  - Aspirin treatment for essential thrombocythemia is low dose, approximately 70–100 mg/day.

Palliative Care

Palliative care is provided to prolong the patient's life by controlling symptoms, to alleviate persistent pain, or to make the patient more comfortable. Palliative care provided to relieve symptoms may include surgery, radiation therapy, systemic therapy (chemotherapy, hormone therapy, or other systemic drugs), and/or other pain management therapy. Palliative care is not used to diagnose or stage the primary tumor.

Any surgical procedure, radiation therapy, and/or systemic therapy that is provided to modify, control, remove, or destroy primary or metastatic cancer tissue, is coded in the respective first course treatment fields and also identified in the *Palliative Care* items. Refer to the preceding discussion of the surgery, radiation, and systemic therapy data items for specific coding guidelines. Because these treatments are less aggressive when given for palliation than for treatment, the treatment plan or treatment notes will indicate when they are performed for palliative purposes.

- Record as palliative care any of the treatment recorded in the first course therapy items that was provided to prolong the patient's life by managing the patient's symptoms, alleviating pain, or making the patient more comfortable.
- Palliative care can involve pain management that may not include surgery, radiation, or systemic treatment.
- It is possible for a patient to receive one or a combination of treatment modalities in conjunction with palliative care intended to reduce the burden of pain. For example, a patient with metastatic prostate cancer may receive an orchiectomy and systemic hormone therapy in combination with palliative radiation for bone metastasis.

Operative Text

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Text – DX Proc – OP	2570	1,000	01/10, 01/12	Required

Description

Text area for manual documentation of all surgical procedures that provide information for staging.

In RMCDS, click on the box "T" on the left of the text line to open entire text box.

Rationale

Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted with coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Coding Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR or MCTR-approved abbreviations should be utilized.
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including *Remarks Text*. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Suggestions for text:

- Dates and descriptions of biopsies and all other surgical procedures from which staging information was derived
- Number and description 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

Data Item(s) to be verified/validated using the text entered in this field include the *Date of Diagnosis, Dx/Stage Procedure*, *Diagnostic Confirmation*, *Primary Site*, *Surgery of Primary Site*, *Reason for No Surgery, Collaborative Stage variables*, *SEER Summary Stage 1977*, and *SEER Summary Stage 2000* fields. After manual entry of the text field, ensure that the text entered on both agrees with the coded values and clearly justifies the selected codes.

Surgery Text

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Text – Surgery	2610	1,000	01/10, 01/12	Required

Description

Text area for information describing all surgical procedures performed as part of treatment.

In RMCDS, click on the box "T" on the left of the text line to open entire text box.

Rationale

Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted with coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Coding Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR or MCTR-approved abbreviations should be utilized.
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including *Remarks Text*. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Suggestions for text:

- Date of each 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)

Data Item(s) to be verified/validated using the text entered in this field include the *Date of Surgery*, *Surgery of Primary Site*, *Scope Regional LN Surgery*, *Surgery Other Reg/Dis*, *Date of First Course of Treatment*, *Reason for No Surgery*, *Surgical Margins*, *Palliative Care*, and *Place of Diagnosis* fields. After manual entry of the text field, ensure that the text entered on both agrees with the coded values and clearly justifies the selected codes.

Radiation (Beam) Text

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Text – Radiation (Beam)	2620	1,000	01/10, 01/12	Required

Description

Text area for manual documentation of information regarding treatment of the tumor being reported with beam radiation.

In RMCDS, click on the box "T" on the left of the text line to open entire text box.

Rationale

Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted with coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Coding Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR or MCTR-approved abbreviations should be utilized.
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including *Remarks Text*. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Suggestions for text:

- Date when radiation treatment began and ended
- Where treatment was given (e.g., at this facility, at another facility)
- Type(s) of beam radiation (e.g., Orthovoltage, Cobalt 60, MV X-rays, Electrons, Mixed modalities)
    - Modality (regional and boost)
    - cGy (regional and boost)
    - Number of Treatment Volumes
    - Treatment Volume
- Other treatment information (e.g., patient discontinued after five treatments; unknown if radiation was given)

Data Item(s) to be verified/validated using the text entered in this field include the *Date of First Course of Treatment*, *Radiation*, *Surgery/Radiation Sequence*, *Reason for No Radiation*, *Date Radiation Started*, *Regional Radiation Modality*, *Date Radiation Ended*, *No of Treatment Volume*, *Regional Dose cGy*, *Treatment Volume*, *Location of Radiation*, *Boost Radiation Modality*, and *Boost Dose cGy* fields. After manual entry of the text field, ensure that the text entered on both agrees with the coded values and clearly justifies the selected codes.

Radiation (Other) Text

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Text – Radiation Other	2630	1,000	01/10, 01/12	Required

Description

Text area for manual documentation of information regarding treatment of the tumor being reported with radiation other than beam radiation. This includes brachytherapy and systemic radiation therapy.

In RMCDS, click on the box "T" on the left of the text line to open entire text box.

Rationale

Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted with coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Coding Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR or MCTR-approved abbreviations should be utilized.
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including *Remarks Text*. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Suggestions for text:

- Date treatment was started and ended
- 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))
    - Modality (regional and boost)
    - cGy (regional and boost)
    - Number of Treatment Volumes
    - Treatment Volume
- Other treatment information (e.g., unknown if radiation was given)

Data Item(s) to be verified/validated using the text entered in this field include the *Date of First Course of Treatment*, *Radiation*, *Surgery/Radiation Sequence*, *Reason for No Radiation*, *Date Radiation Started*, *Regional RX Modality*, *Date Radiation Ended*, *No of Treatment Volume*, *Regional Dose cGy*, *Treatment Volume*, *Location of Radiation*, *Boost RX Modality*, and *Boost Dose cGy* fields. After manual entry of the text field, ensure that the text entered on both agrees with the coded values and clearly justifies the selected codes.

Chemotherapy Text

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Text – Chemotherapy	2640	1,000	01/10, 01/12	Required

Description

Text area for manual documentation of information regarding chemotherapy treatment of the reported tumor.

In RMCDS, click on the box "T" on the left of the text line to open entire text box.

Rationale

Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted with coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Coding Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR or MCTR-approved abbreviations should be utilized.
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including *Remarks Text*. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Suggestions for text:

- Date chemotherapy began
- Where treatment was given (e.g., at this facility, at another facility)
- Type(s) of chemotherapy (e.g., name of agent(s) or protocol)
- Other treatment information (e.g., treatment cycle incomplete, unknown if chemotherapy was given)

Data Item(s) to be verified/validated using the text entered in this field include the *Date of First Course of Treatment*, *Chemotherapy*, *Date of Systemic Therapy, Systemic/Surgery Sequence*, and *Date of Chemotherapy* fields. After manual entry of the text field, ensure that the text entered on both agrees with the coded values and clearly justifies the selected codes.

Hormone Therapy Text

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Text – Hormone	2650	1,000	01/10, 01/12	Required

Description

Text area for information about hormonal cancer-directed treatment.

In RMCDS, click on the box "T" on the left of the text line to open entire text box.

Rationale

Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted with coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Coding Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR or MCTR-approved abbreviations should be utilized.
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including *Remarks Text*. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Suggestions for text:

- Date treatment was started
- Where treatment was given (e.g., at this facility, at another facility)
- Type of hormone or anti-hormone (e.g., Tamoxifen)
- Type of endocrine surgery or radiation (e.g., orchiectomy)
- Other treatment information (e.g., treatment cycle incomplete, unknown if hormones were given)

Data Item(s) to be verified/validated using the text entered in this field include the *Date of First Course of Treatment*, *Hormone*, *Date of Systemic Therapy, Systemic/Surgery Sequence*, and *Date of Hormone* fields. After manual entry of the text field, ensure that the text entered on both agrees with the coded values and clearly justifies the selected codes.

BRM/Immunotherapy Text

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Text – BRM	2660	1,000	01/10, 01/12	Required

Description

Text area for manual documentation of information regarding the treatment of the tumor being reported with biological response modifiers or immunotherapy.

In RMCDS, click on the box "T" on the left of the text line to open entire text box.

Rationale

Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted with coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values.

Coding Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR or MCTR-approved abbreviations should be utilized.
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including *Remarks Text*. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Suggestions for text:

- Date treatment was started
- Where treatment was given (e.g., at this facility, at another facility)
- Type of BRM agent (e.g., Interferon, BCG)
- BRM procedures (e.g., bone marrow transplant, stem cell transplant)
- Other treatment information (e.g., treatment cycle incomplete, unknown if BRM was given)

Data Item(s) to be verified/validated using the text entered in this field include the *Date of First Course of Treatment*, *Transplant/Endocrine*, *Date of Systemic Therapy*, *BRM/Immunotherapy, Systemic/Surgery Sequence*, and *Date of BRM/Immunotherapy* fields. After manual entry of the text field, ensure that the text entered on both agrees with the coded values and clearly justifies the selected codes.

Other Treatment Text

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Text – Other	2670	1,000	01/10, 01/12	Required

Description

Text area for manual documentation of information regarding the treatment of the tumor being reported with treatment that cannot be defined as surgery, radiation, or systemic therapy. This includes experimental treatments (when the mechanism of action for a drug is unknown) and blinded clinical trials. If the mechanism of action for the experimental drug is known, code to the appropriate treatment field.

In RMCDS, click on the box "T" on the left of the text line to open entire text box.

Rationale

Text documentation is an essential component of a complete electronic abstract and is heavily utilized for quality control and special studies. Text is needed to justify coded values and to document supplemental information not transmitted with coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record **and should not be generated electronically from coded values**.

Coding Instructions

- Prioritize entered information in the order of the fields listed below.
- Text automatically generated from coded data is not acceptable.
- NAACCR or MCTR-approved abbreviations should be utilized.
- Do not repeat information from other text fields.
- Additional comments can be continued in empty text fields, including *Remarks Text*. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
- If information is missing from the record, state that it is missing.
- Do not include irrelevant information.
- Do not include information that the registry is not authorized to collect.

Suggestions for text:

- Date treatment was started
- Where treatment was given (e.g., at this facility, at another facility)
- Type of other treatment (e.g., blinded clinical trial, hyperthermia)
- Other treatment information (e.g., treatment cycle incomplete, unknown if other treatment was given)

Data Item(s) to be verified/validated using the text entered in this field include the *Date of First Course of Treatment*, *Other Treatment*, and *Date of Other Treatment* fields. After manual entry of the text field, ensure that the text entered on both agrees with the coded values and clearly justifies the selected codes.

Local Hospital

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Local Hospital (Facility)	540	3	04/07, 01/12	Required

Description

Identifies the facility providing this treatment. Each facility providing treatment for this case should be recorded on a separate treatment page.

In RMCDS, click on the box "First Course Treatment" to enter Local Hospital.

Rationale

The number is essential to monitor where treatment is being performed, ensuring the accuracy of data, and for identifying areas for special studies.

Coding Instructions

- Record the facility number from the list below where the treatment was performed.
- Record each facility's treatment on a separate treatment page.
- Record 999 if the treatment was performed elsewhere in Montana and facility is unknown.
- Record 888 if the treatment was performed out-of-state.
- Record 111 if the treatment was performed in an in-state physician's office or free-standing surgical center.
- Click the Next button in the First Course Treatment screen in the RMCDS system to open another treatment page.

Montana Reporting Facilities

Number Hosp	NPI Number	ACoS Number	Facility Name	City
403	1568629764	6810010	Community Hospital of Anaconda	Anaconda
411	1316965346	6810013	Fallon Medical Complex	Baker
458	1730129305	6810005	Big Sandy Medical Center	Big Sandy
412	1265478291	6810020	Billings Clinic	Billings
413	1083655997	6810030	St. Vincent Healthcare	Billings
407	1720079619	6810040	Bozeman Health	Bozeman
400	1528037215	6810055	St. James Healthcare	Butte
414	1497754782	6810085	Liberty Medical Center	Chester
415	1083602205	6810095	Teton Medical Center	Choteau
409	1054388387	6810100	Stillwater Billings Clinic	Columbus
416	1467445049	6810110	Pondera Medical Center	Conrad
417	1598874232	6810123	Roosevelt Medical Center	Culbertson
418	1831143080	6810125	Northern Rockies Medical Center	Cut Bank
419	1275560617	6810129	Deer Lodge Medical Center	Deer Lodge
420	1326042078	6810135	Barrett Hospital and Healthcare	Dillon
421	1760531404	6810150	Dahl Memorial Healthcare	Ekalaka
405	1740223882	6810155	Madison Valley Medical Center	Ennis
422	1023066081	6810160	Rosebud Healthcare Center	Forsyth
423	1356332266	6810170	Missouri River Medical Center	Fort Benton
424	1689685323	6810190	Frances Mahon Deaconess Hospital	Glasgow
425	1376552893	6810220	Glendive Medical Center	Glendive
427	1881650737	6810245	Benefis/Sletten Cancer Institute	Great Falls
480	1801897780	10000701	Great Falls Clinic	Great Falls
429	1659475846	6810260	Marcus Daly Memorial Hospital	Hamilton
430	1891713533	6810272	Big Horn County Memorial Hospital	Hardin
431	1073687406	6810285	Wheatland Memorial Healthcare	Harlowton
432	1427059070	6810290	Northern Montana Healthcare	Havre
434	1710152277	6810330	St. Peter's Health	Helena

Number	NPI Number	ACoS Number	Facility Name	City
477	1417945627	6810360	Kalispell Regional Healthcare	Kalispell
438	1790798387	6810380	Central Montana Medical Center	Lewistown
439	1952312050	6810390	Cabinet Peaks Medical Center	Libby
408	1245222306	6810395	Livingston Healthcare	Livingston
440	1255476388	6810405	Phillips County Hospital	Malta
441	1548292220	6810410	Holy Rosary Healthcare	Miles City
443	1396711396	6810415	Community Medical Center	Missoula
445	1023032588	6810225	St. Patrick Hospital	Missoula
402	1922073907	6810440	Granite County Medical Center	Philipsburg
471	1265547939	6810445	Clark Fork Valley Hospital	Plains
446	1467452102	6810450	Sheridan Memorial Hospital	Plentywood
447	1821184888	6810460	Providence St. Joseph Medical Center	Polson
448	1396766903	6810465	Northeast Montana Health Services	Poplar
410	1336119338	6810477	Beartooth Billings Clinic	Red Lodge
467	1336213446	6810481	St. Luke Community Healthcare	Ronan
449	1386751196	6810485	Roundup Memorial Healthcare	Roundup
451	1346224391	6810505	Daniels Memorial Healthcare Center	Scobey
468	1497742415	6819070	Marias Medical Center	Shelby
469	1083710651	6819075	Ruby Valley Hospital	Sheridan
452	1285719161	6810510	Sidney Health Center	Sidney
470	1093809196	6819080	Mineral Community Hospital	Superior
404	1447245857	6810530	Broadwater Health Center	Townsend
454	1396710851	6810550	North Valley Hospital	Whitefish
457	1811102270	6819100	Mountainview Medical Center	White Sulphur Springs
455	1821016536	6810560	Northeast Montana Health Services	Wolf Point
VAMC				
463	1457546384	6810180	Montana VAMC	Fort Harrison
IHS				
478	1861409955	6810050	Blackfeet Indian Health Services	Browning
462	1235302142	6810120	Crow IHS Hospital	Crow Agency
464	1942367842	6810280	Fort Belknap IHS Hospital	Harlem
474	1972694602	9999999	Fort Peck IHS Poplar Health Services	Poplar

DX/Stage Procedure

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Summ – DX/Stage Proc	1350	2	01/09, 01/12, 01/15	Required

Description

Identifies the positive surgical procedure(s) performed to diagnose and/or stage disease.

In RMCDS, click on the box "First Course Treatment" to enter Dx/Stage Procedure.

Rationale

This data item is used to track the use of surgical procedure resources that are not considered treatment.

Coding Instructions

- Record the type of procedure performed as part of the initial diagnosis and workup, whether this is done at your institution or another facility.
- Only record positive procedures. For benign and borderline reportable tumors, report the biopsies positive for those conditions. For malignant tumors, report procedures if they were positive for malignancy.
- If both an incisional biopsy of the primary site and an incisional biopsy of a metastatic site are done, use code 02 (incisional biopsy of primary site).
- If a lymph node is biopsied or removed to diagnose or stage *lymphoma*, and that node is NOT the only node involved with the lymphoma, use code 02. If there is only a single lymph node involved with lymphoma, use the data item *Surgery of Primary Site* to code these procedures.
- Do not code surgical procedures which aspirate, biopsy, or remove *regional lymph nodes* in an effort to diagnose and/or stage disease in this data item. Use the data item *Scope of Regional Lymph Node Surgery* to code these procedures. Do not record the date of surgical procedures which aspirate, biopsy or remove regional lymph nodes in the data item *Date of DX/Stage Procedure*. See instructions for *Scope of Regional Lymph Node Surgery*.
- Code brushings, washings, cell aspiration, and hematologic findings (peripheral blood smears) as positive cytologic diagnostic confirmation in the data item *Diagnostic Confirmation*. These are not considered surgical procedures and should not be coded in this item.
- Do not code excisional biopsies with clear or microscopic margins in this data item. Use the data item *Surgery of Primary Site* to code these procedures.
- If a needle biopsy preceded an excisional biopsy or more extensive surgery, and upon the excisional biopsy or more extensive surgery no tumor remains, DO NOT consider the needle biopsy to be an excisional biopsy. The needle biopsy should be recorded as such in the *Surgical Diagnostic and Staging Procedure* data item and the excisional biopsy or more extensive surgery in the *Surgical Procedure of the Primary Site* data item.
- Do not code palliative surgical procedures in this data item. Use the data item *Palliative Care* to code these procedures.

Code	Definition
00	No surgical diagnostic or staging procedure was performed.
01	A biopsy (incisional, needle, or aspiration) was done to a site other than the primary. No exploratory procedure was done.
02	A biopsy (incisional, needle, or aspiration) was done to the primary site; or biopsy or removal of a lymph node to diagnose or stage lymphoma.
03	A surgical exploration only. The patient was not biopsied or treated.
04	A surgical procedure with a bypass was performed, but no biopsy was done.
05	An exploratory procedure was performed, and a biopsy of either the primary site or another site was done.
06	A bypass procedure was performed, and a biopsy of either the primary site or another site was done.
07	A procedure was done, but the type or procedure is unknown.
09	No information of whether a diagnostic or staging procedure was performed.

DX/Stage Procedure refers solely to surgical procedures performed specifically for diagnosis and staging of the tumor and do not apply to surgical treatment. *Date of DX/Stage Procedure* refers to the date on which the surgical diagnostic and/or staging procedure was performed at any facility.

EXCEPTION: Do not code surgical procedures that aspirate, biopsy, or remove regional lymph nodes in an effort to diagnose and/or stage disease in the data item *DX/Stage Procedure*. Use the data item *Scope of Regional Lymph Node Surgery* to code these procedures. Additionally, do not record the date of surgical procedures that aspirate, biopsy, or remove regional lymph nodes in the data item *Date of DX/Stage Procedure*. Record the date of this surgical procedure in the data item *Date of First Course of Treatment*.

Examples:

Code	Reason
00	A lung cancer primary was diagnosed by CT scan. The patient expired. No surgical diagnostic or staging surgical procedure was performed.
00	A sputum sample is examined cytologically to confirm a diagnosis of suspected lung cancer. The procedure is not surgical.
01	A needle biopsy of a liver metastasis in a patient with suspected widespread colon cancer was done. Gross residual tumor is left at the biopsy site.
01	A thoracentesis is performed on a patient with suspected lung primary, and the withdrawn sample is cytologically examined for confirmation of malignant pleural effusion.
02	During a colonoscopy, a biopsy of a primary rectal mass was done. Gross residual tumor is left at the biopsy site.
03	During abdominal exploratory surgery, a gastric lesion and suspicious retroperitoneal lymph nodes were observed. No biopsy or treatment was done.
04	An abdominal exploration of a patient revealed pancreatic carcinoma with extension into surrounding organs and arteries. No attempt to treat. A bypass was performed to alleviate symptoms.
05	An exploratory procedure was performed to primary colon carcinoma with biopsy of suspicious liver lesions.
06	Esophagogastrostomy was performed for infiltrating gastric tumor following a biopsy of the primary site.
07	Stage III lung carcinoma was diagnosed and staged prior to admission.
09	A patient expires in the emergency room with recently diagnosed metastatic melanoma. It is unknown whether a diagnostic or staging procedure was done.

Date of DX/Stage Procedure

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Date – DX/Stage Proc	1280	8	01/10, 01/11	Required

Description

Records the date on which the surgical diagnostic and/or staging procedure was performed.

In RMCDS, click on the box "First Course Treatment" to enter Date of Dx/Stage Procedure.

Rationale

This data item is used to track the use of surgical procedure resources that are not considered treatment.

Coding Instructions

- Record the date on which the surgical diagnostic and/or staging procedure described in *DX/Stage Procedure* was performed at this or any facility.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this modification does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date of DX/Stage Procedure* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of DX/Stage Procedure* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *Date of DX/Stage Procedure Flag* is used to explain why *Date of DX/Stage Procedure* is not a known date. See *Date of DX/Stage Procedure Flag* for an illustration of the relationships among these items.

Date of DX/Stage Procedure Flag

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Date – DX/Stage Proc Flag	1281	2	New 01/10, 01/12	Required

Description

This flag explains why there is no appropriate value in the corresponding date field, *Date of DX/Stage Procedure*.

In RMCDS, click on the box "First Course Treatment" to enter Date of Dx/Stage Procedure Flag.

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

- Leave this item blank if *Date of DX/Stage Procedure* has a full or partial date recorded.
- Code 10 if it is unknown whether a surgical diagnostic or staging procedure was performed.
- Code 11 if no surgical diagnostic or staging procedure was performed.
- Code 12 if the *Date of DX/Stage Procedure* cannot be determined, but a surgical diagnostic or staging procedure was performed for the patient.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Definition
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any diagnostic or staging procedure performed)
11	No proper value is applicable in this context (for example, no diagnostic or staging procedure performed; autopsy only case)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (for example, diagnostic or staging procedure performed but date is unknown)
(Blank)	A valid date is provided in item *Date of DX/Stage Procedure*. Case was diagnosed prior to January 1, 2007

Surgery of Primary Site

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Summ – Surg Primary Site	1290	2	06/05, 01/10, 01/12, 01/15	Required

Description

Records the surgical procedure(s) performed to the primary site.

In RMCDS, click on the box "First Course Treatment" to enter Surgery of Primary Site.

Rationale

This data item can be used to compare the efficacy of treatment options.

Coding Instructions

- Site-specific codes for this data item are founding Appendix A.
- If registry software allows only one procedure to be collected, document the most invasive surgical procedure for the primary site.
- If registry software allows multiple procedures to be recorded, this item refers to the most invasive surgical procedure of the primary site.
- For codes 00 through 79, the response positions are hierarchical. Last-listed responses take precedence over responses written above. Code 98 takes precedence over code 00. Use codes 80 and 90 only if more precise information about the surgery is not available.
- Excisional biopsies (those that remove the entire tumor and/or leave only microscopic margins) are to be coded in this item.
- If a needle biopsy precedes an excisional biopsy or more extensive surgery, and upon the excisional biopsy or more extensive surgery no tumor remains, DO NOT consider the needle biopsy to be an excisional biopsy. The needle biopsy should be recorded in the *Surgical Diagnosis and Staging Procedure* data item and the excisional biopsy or more extensive surgery in the *Surgical Procedure of the Primary Site* data item.
- Surgery to remove regional tissue or organs is coded in this item only if the tissue/organs are removed in continuity with the primary site, except where noted in Appendix A.
- If a previous surgical procedure to remove a portion of the primary site is followed by surgery to remove the remainder of the primary site, then code the total or final results. Do not rely on registry software to perform this task for you.
- If the procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item *Palliative Care*.
- 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.

Code	Label	Definition
00	None	No surgical procedure of primary site. Diagnosed at autopsy
10-19	Site-specific codes; tumor destruction	Tumor destruction, no pathologic specimen produced. Refer to Appendix A for the correct site-specific code for the procedure
20-80	Site-specific codes; resection	Refer to Appendix A for the correct site-specific code for the procedure
90	Surgery, NOS	A surgical procedure to the primary site was done, but no information on the type of surgical procedure is provided
98	Site-specific codes; special	Special code. Refer to Appendix A for the correct site-specific code for the procedure
99	Unknown	Patient record does not state whether a surgical procedure of the primary site was performed and no information is available. Death certificate only

Date of Surgery

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Date – Surgery Date of 1st Surgical Procedure	1200	8	01/10, 01/11	Required

Description

Records the earliest date on which any first course surgical procedure was performed. Formerly called "Date of Cancer-Directed Surgery".

In RMCDS, click on the box "First Course Treatment" to enter Date of Surgery.

Rationale

This data item can be used to sequence multiple treatment modalities and to evaluate the time intervals between treatments.

Coding Instructions

- Record the date of the first surgical procedure of the types coded as *Surgery of Primary Site*, *Scope of Regional Lymph Node Surgery*, or *Surgical Procedure/Other Site* performed at this or any other facility.
- This date in this item may be the same as that in *Date of Most Definitive Surgical Resection of Primary Site*, if the patient received only one surgical procedure and it was a resection of the primary site.
- If surgery is the first or only treatment administered to the patient, then the date of surgery should be the same as the date entered into the item *Date of First Course Treatment*.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date of Surgery* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of Surgery* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *Date of Surgery Flag* is used to explain why *Date of Surgery* is not a known date. See *Date of Surgery Flag* for an illustration of the relationships among these items.

Examples:

Code	Definition
03232008	A melanoma patient had an excisional biopsy on March 23, 2008, then a wide excision on March 28, 2008.
11162009	The patient had a small (0.5 cm) lump removed from her breast on November 16, 2009.
03272007	The patient's primary tumor was treated with radiation beginning on April 16, 2007, after a distant metastasis was moved surgically on March 27, 2007.

Date of Surgery Flag

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Date – Surgery Flag	1201	2	New 01/10	Required

Description

This flag explains why there is no appropriate value in the corresponding date field, *Date of Surgery*.

In RMCDS, click on the box "First Course Treatment" to enter Date of Surgery Flag.

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

- Leave this item blank if *Date of Surgery* has a full or partial date recorded.
- Code 12 if the *Date of Surgery* cannot be determined, but the patient did receive first course surgery.
- Code 10 if it is unknown whether any surgery was performed.
- Code 11 if no surgical procedure was performed.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Definition
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any surgery performed)
11	No proper value is applicable in this context (for example, no surgery performed; autopsy only case)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (for example, surgery was performed but date is unknown)
(Blank)	A valid date is provided in item *Date of Surgery*

Date of Surgical Discharge

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Date – Surgical Discharge	3180	8	01/10, 01/11	Required by CoC

Description

Records the date the patient was discharged following primary site surgery. The date corresponds to the event recorded in *Surgery of Primary Site* and *Date of Surgery*.

In RMCDS, click on the box "First Course Treatment" to enter Date of Surgical Discharge.

Rationale

Length of stay is an important quality of care and financial measure among hospital administrations, those who fund public and private health care, and public health users. This date, in conjunction with the data item *Date of Surgery*, will allow for the calculation of a patient's length of hospitalization associated with primary site surgery.

Coding Instructions

- Record the date the patient was discharged from the hospital following the event recorded in *Surgery of Primary Site*.
- If the patient died following the event recorded in *Surgery of Primary Site*, but before being discharged from the treating facility, then the *Date of Surgical Discharge* is the same as the date recorded in the data item *Date of Last Contact or Death*.
- If the patient received out-patient surgery, then the date of surgical discharge is the same as the date recorded in the data item *Date of Surgery*.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date of Surgical Discharge* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of Surgical Discharge* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *Date of Surgical Discharge Flag* is used to explain why *Date of Surgical Discharge* is not a known date. See *Date of Surgical Discharge Flag* for an illustration of the relationships among these items.

Date of Surgical Discharge Flag

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Date – Surg Disch Flag	3181	2	New 01/10	Required by CoC

Description

This flag explains why there is no appropriate value in the corresponding date field, *Date of Surgical Discharge*.

In RMCDS, click on the box "First Course Treatment" to enter Date of Surgical Discharge Flag.

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

- Leave this item blank if *Date of Surgical Discharge* has a full or partial date recorded.
- Code 12 if the *Date of Surgical Discharge* cannot be determined, but the patient did receive first course surgery.
- Code 10 if it is unknown whether any surgery was performed.
- Code 11 if no surgical procedure was performed.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.
- Leave blank for cases diagnosed prior to January 1, 2003.

Code	Definition
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any surgery performed)
11	No proper value is applicable in this context (for example, no surgery performed; autopsy only case)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (for example, surgery was performed but date is unknown)
(Blank)	A valid date is provided in item *Date of Surgical Discharge*. The case was diagnosed prior to January 1, 2003

Date Radiation Started

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Date – Radiation	1210	8	06/05, 01/10, 01/11	Required

Description

Records the date on which radiation therapy began at any facility that is part of the first course of treatment.

In RMCDS, click on the box "First Course Treatment" to enter Date Radiation Started.

Rationale

It is important to be able to sequence the use of multiple treatment modalities and to evaluate the time intervals between the treatments. For some diseases, the sequence of radiation and surgical therapy is important when determining the analytic utility of pathologic stage information.

Coding Instructions

- If radiation therapy is the first or only treatment administered to the patient, then the date radiation started should be the same as the date entered into the item *Date of First Course of Treatment*.
- The date when treatment started will typically be found in the radiation oncologist's summary letter for the first course of treatment.
- 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.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date Radiation Started* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date Radiation Started* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *Date Radiation Started Flag* is used to explain why *Date Radiation Started* is not a known date. See *Date Radiation Started Flag* for an illustration of the relationships among these items.

Examples:

Code	Definition
12152003	A patient has external beam radiation on December 15, 2003.
10122003	A patient with a primary tumor of the brain undergoes stereotactic radiosurgery using a Gamma Knife on October 12, 2003.
06022003	A patient enters the facility for interstitial radiation boost for prostate cancer that is performed on August 6, 2003. Just prior to this, the patient had external beam therapy to the lower pelvis that was started on June 2, 2003 at another facility.

Date Radiation Started Flag

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Date – Radiation Flag	1211	2	New 01/10	Required

Description

This flag explains why there is no appropriate value in the corresponding date field, *Date Radiation Started*.

In RMCDS, click on the box "First Course Treatment" to enter Date Radiation Started Flag.

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

- Leave this item blank if *Date Radiation Started* has a full or partial date recorded.
- Code 12 if the *Date Radiation Started* cannot be determined, but the patient did receive first course radiation.
- Code 10 if it is unknown whether any radiation was performed.
- Code 11 if no radiation is planned or given.
- Code 15 if radiation is planned but has not yet started and the start date is not yet available. Follow this patient for radiation treatment and update this item, *Date Radiation Started*, and all other radiation items.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Definition
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any radiation was given)
11	No proper value is applicable in this context (for example, no radiation given)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (for example, radiation was given but date is unknown)
15	If information is not available at this time, but it is expected that it will be available later (for example, radiation therapy is planned as part of first course of therapy, but had not been started at the time of the most recent follow-up)
(Blank)	A valid date is provided in item *Date Radiation Started*

Date Radiation Ended

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Date – Radiation Ended	3220	8	06/05, 01/10, 01/11, 01/12	Required by CoC

Description

Records the date on which patient completes or receives the last radiation treatment at any facility.

In RMCDS, click on the box "First Course Treatment" to enter Date Radiation Ended.

Rationale

The length of time over which radiation therapy is administered to a patient is a factor in tumor control and treatment morbidity. It is useful to evaluate the quality of care and the success of patient support programs designed to maintain continuity of treatment.

Coding Instructions

- The date when treatment ended will typically be found in the radiation oncologist's summary letter for the first course of treatment.
- For brachytherapy if the treatment is applied only once, this date will be the same as *Date Radiation Started*.
- 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.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date Radiation Ended* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date Radiation Ended* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *Date Radiation Ended Flag* is used to explain why *Date Radiation Ended* is not a known date. See *Date Radiation Ended Flag* for an illustration of the relationships among these items.

Examples:

Code	Definition
01042005	A patient starts IMRT radiation treatment on December 15, 2004 and treatment continues until January 4, 2005.
10022009	A patient receives one radiation treatment on October 2, 2009, then refuses further treatments.
04042006	A patient with a primary tumor of the brain undergoes stereotactic radiosurgery using a Gamma Knife on April 4, 2006.

Date Radiation Ended Flag

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Date – Rad Ended Flag	3221	2	New 01/10	Required by CoC

Description

This flag explains why there is no appropriate value in the corresponding date field, *Date Radiation Ended*.

In RMCDS, click on the box "First Course Treatment" to enter Date Radiation Ended Flag.

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

- Leave this item blank if *Date Radiation Ended* has a full or partial date recorded.
- Code 12 if the *Date Radiation Ended* cannot be determined, but the patient did receive first course radiation.
- Code 10 if it is unknown whether any radiation was performed.
- Code 11 if no radiation is planned or given.
- Code 15 if radiation is ongoing. Follow this patient for radiation treatment and update this item, *Date Radiation Ended*, and all other radiation items.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Definition
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any radiation was given)
11	No proper value is applicable in this context (for example, no radiation given)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (for example, radiation was given but date is unknown)
15	If information is not available at this time, but it is expected that it will be available later (for example, radiation therapy had begun at the time of the most recent follow-up but was not yet completed)
(Blank)	A valid date is provided in item *Date Radiation Ended*

Phase I Radiation Primary Treatment Volume

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1504	2	New 01/18	Required by CoC

Description

Identifies the primary treatment volume or primary anatomic target treated during the first phase of radiation therapy during the first course of treatment.

Rationale

Radiation treatment is commonly delivered in one or more phases. Typically, in each phase, the primary tumor or tumor bed is treated. This data item should be used to indicate the primary target volume, which might include the primary tumor or tumor bed. If the primary tumor was not targeted, record the other regional or distant site that was targeted. Draining lymph nodes may also be concurrently targeted during the first phase. These will be identified in a separate data item *Phase I Radiation to Draining Lymph Nodes*.

This data item provides information describing the anatomical structure targeted by radiation therapy during the first phase of radiation treatment and can be used to determine whether the site of the primary disease was treated with radiation or if other regional or distant sites were targeted. This information is useful in evaluating the patterns of care within a facility and on a regional or national basis. The breakdown and reorganization of the sites will allow for concise reporting.

Coding Instructions

- Radiation treatment volume will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the exact treatment volume may require assistance from the radiation oncologist for consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase II, Phase III, etc., accordingly.
- If one or more discrete volumes are treated and one of those includes the primary site, record the treatment to the primary site in this data item.
- A new phase begins when there is a clinically meaningful change in target volume, treatment fraction size (i.e., dose given during a session), modality or treatment technique. Any one of these changes will generally mean that a new radiation plan will be generated in the treatment planning system, and it should be coded as a new phase of radiation therapy.
    - Note: "on-line adaptive therapy" refers to treatments where radiation treatment plans are adapted or updated while a patient is on the treatment table. When treatment plans are adapted, the shape of the target volume may change from day to day, but for registry purposes, the volume that is being targeted won't change. An adapted plan should not be coded as though a new phase of treatment has been initiated unless, as above, the radiation oncologist documents it as a new phase in the radiation treatment summary.
- Code 00 if the tumor was diagnosed at autopsy.
- Phase I of radiation treatment also commonly includes draining lymph node regions that are associated with the primary tumor or tumor bed. The draining lymph nodes are recorded in the *Phase I Radiation to Draining Lymph Nodes*. Use codes 01 to 09 only when the lymph nodes are the primary target.
    - Note: When the primary volume is lymph nodes, draining lymph nodes are not targeted. Record as 88 in the *Phase I Radiation to Draining Lymph Nodes*.
- This data item, in conjunction with *Phase I Radiation to Draining Lymph Nodes*, replaces the *Radiation Treatment Volume* and includes converted historical values. Conversion took place upon upgrade to NAACCR v18-compliant software; as of 2018, this data item is required for all cases regardless of diagnosis year.

Code	Label	Definition
00	No radiation treatment	Radiation therapy was not administered to the patient. Diagnosed at autopsy.
01	Neck lymph node regions	The primary treatment is directed at lymph node regions of the neck. Example situations include treatment of lymphoma or lymph node recurrence (in the absence of primary site failure) following definitive surgery of the primary tumor. If radiation to the neck lymph nodes includes the supraclavicular region use code 03.
02	Thoracic lymph node regions	Radiation therapy is directed to some combination of hilar, mediastinal, and supraclavicular lymph nodes without concurrent treatment of a visceral organ site. Example situations include mantle or mini-mantle for lymphomas, and treatment of lymphatic recurrence after complete surgical excision of a thoracic primary. Note that the supraclavicular region may be part of a head and neck lymph node region. Use code 03 for treatments directed at neck nodes and supraclavicular nodes with a head and neck primary. Use code 04 if supraclavicular lymph nodes are part of breast treatment.
03	Neck and thoracic lymph node regions	Treatment is directed to lymph nodes in the neck and thoracic region without concurrent treatment of a primary visceral tumor. This code might apply to some mantle or mini-mantle fields used in lymphoma treatments or some treatments for lymphatic recurrences following definitive treatment for tumors of the head and neck or thoracic regions.
04	Breast/Chest wall lymph node regions	Radiation is directed primarily to some combination of axillary, supraclavicular, and/or internal mammary lymph node sites WITHOUT concurrent treatment of the breast or chest wall. If the breast AND lymph nodes are being treated, then code the Primary Treatment Volume to Breast (codes 40 or 41) and Breast/chest wall lymph nodes (code 04) in Radiation to Draining Lymph Nodes.
05	Abdominal lymph nodes	Treatment is directed to some combination of the lymph nodes of the abdomen, including retro-crural, peri-gastric, peri-hepatic, portocaval and para-aortic nodes. Possible situations might include seminoma, lymphoma or lymph node recurrence following surgical resection of the prostate, bladder or uterus.
06	Pelvic lymph nodes	Treatment is directed to some combination of the lymph nodes of the pelvis, including the common, internal and external iliac, obturator, inguinal and peri-rectal lymph nodes. This might be done for lymphoma or lymph node recurrence following definitive surgery for a pelvic organ.
07	Abdominal and pelvic lymph nodes	Treatment is directed to a combination of lymph nodes in both the abdomen and pelvis. This code includes extended fields ("hockey stick", "dog-leg", "inverted Y", etc.) utilized to treat seminomas and lymphomas or recurrence of a solid tumor.
09	Lymph node region, NOS	This category should be used to code treatments directed at lymph node regions that are not adequately described by codes 01-07.
10	Eye/orbit/optic nerve	Treatment is directed at all or a portion of the eye, orbit and/or optic nerve.
11	Pituitary	Treatment is directed at the pituitary gland.
12	Brain	Treatment is directed at all the brain and its meninges ("Whole brain").
13	Brain (limited)	Treatment is directed at one or more sub-sites of the brain but not the whole brain. Chart may describe "SRS", "Stereotactic Radiosurgery", "Gamma Knife®".
14	Spinal cord	Treatment is directed at all or a portion of the spinal cord or its meninges.
20	Nasopharynx	Treatment is directed at all or a portion of the nasopharynx.
21	Oral Cavity	Treatment is directed at all or a portion of the oral cavity, including the lips, gingiva, alveolus, buccal mucosa, retromolar trigone, hard palate, floor of mouth and oral tongue.
22	Oropharynx	Treatment is directed at all or a portion of the oropharynx, including the soft palate, tonsils, base of tongue and pharyngeal wall.
23	Larynx (glottis) or hypopharynx	Treatment is directed at all or a portion of the larynx and/or hypopharynx.

Code	Label	Definition
24	Sinus/Nasal tract	Treatment is directed at all or a portion of the sinuses and nasal tract, including the frontal, ethmoid, sphenoid and maxillary sinuses.
25	Parotid or other salivary glands	Treatment is directed at the parotid or other salivary glands, including the submandibular, sublingual and minor salivary glands.
26	Thyroid	Treatment is directed at all or a portion of the thyroid. Code this volume when the thyroid is treated with 1-131 radioisotope.
29	Head and neck (NOS)	The treatment volume is directed at a primary tumor of the head and neck, but the primary sub-site is not a head and neck organ identified by codes 20-26 or it is an "unknown primary".
30	Lung or bronchus	Treatment is directed at all or a portion of the lung or bronchus.
31	Mesothelium	Treatment is directed to all or a portion of the mesothelium. This code should be used for mesothelioma primaries, even if a portion of the lung is included in the radiation field.
32	Thymus	Treatment is directed to all or a portion of the thymus.
39	Chest/lung (NOS)	The treatment is directed at a primary tumor of the chest, but the primary sub-site is unknown or not identified in codes 30-32. For example, this code should be used for sarcomas arising from the mediastinum.
40	Breast – whole	Treatment is directed at all the intact breast. Intact breast includes breast tissue that either was not surgically treated or received a lumpectomy or partial mastectomy.
41	Breast – partial	Treatment is directed at a portion of the intact breast but not the whole breast. The chart may have terms such as "Mammosite", "interstitial (seed) implant)", or "(accelerated) partial breast irradiation". Consider the possibility of partial breast irradiation when "IMRT" is documented in the record.
42	Chest wall	Treatment encompasses the chest wall (following mastectomy).
50	Esophagus	Treatment is directed at all or a portion of the esophagus. Include tumors of the gastro-esophageal junction.
51	Stomach	Treatment is directed at all or a portion of the stomach.
52	Small bowel	Treatment is directed at all or a portion of the small bowel.
53	Colon	Treatment is directed at all or a portion of the colon.
54	Rectum	Treatment is directed at all or a portion of the rectum.
55	Anus	Treatment is directed at all or a portion of the anus.
56	Liver	Treatment is directed at all or a portion of the liver.
57	Biliary tree or gallbladder	Treatment is directed at all or a portion of the biliary tree or gallbladder.
58	Pancreas or hepatopancreatic ampulla	Treatment is directed at all or a portion of the pancreas or the hepatopancreatic ampulla. Hepatopancreatic ampulla tumors are sometimes referred to as periampullary tumors.
59	Abdomen (NOS)	The treatment volume is directed at a primary tumor of the abdomen, but the primary sub-site is not an abdominal organ defined by codes 50-58 or it is considered to be an "unknown primary". For example, this code should be used for sarcomas arising from the abdominal retroperitoneum.
60	Bladder – whole	Treatment is directed at all the bladder.
61	Bladder – partial	Treatment is directed at a portion of the bladder but not the whole bladder.
62	Kidney	Treatment is directed at all or a portion of the kidney.
63	Ureter	Treatment is directed at all or a portion of the ureter.
64	Prostate – whole	Treatment is directed at all the prostate and/or seminal vesicles. Use this code even if seminal vesicles are not explicitly targeted.
65	Prostate – partial	Treatment is directed at a portion of the prostate but not the whole prostate.
66	Urethra	Treatment is directed at all or a portion of the urethra.
67	Penis	Treatment is directed at all or a portion of the penis. Treatments of urethral primaries should be coded as 'urethra' (code 66).
68	Testicle or Scrotum	Treatment is directed at all or a portion of the testicle and/or scrotum.

Code	Label	Definition
70	Ovaries or fallopian tubes	Treatment is directed at all or a portion of the ovaries or fallopian tubes.
71	Uterus or Cervix	Treatment is directed at all or a portion of the uterus, endometrium or cervix.
72	Vagina	Treatment is directed at all or a portion of the vagina. Treatments of urethral primaries should be coded as 'urethra' (code 66).
73	Vulva	Treatment is directed at all or a portion of the vulva. Treatments of urethral primaries should be coded as 'urethra' (code 66).
80	Skull	Treatment is directed at all or a portion of the bones of the skull. Any brain irradiation is a secondary consequence.
81	Spine/vertebral bodies	Treatment is directed at all or a portion of the bones of the spine/vertebral bodies, including the sacrum. Spinal cord malignancies should be coded using 'spinal cord' (code 14).
82	Shoulder	Treatment is directed to all or a portion of the proximal humerus, scapula, clavicle, or other components of the shoulder complex.
83	Ribs	Treatment is directed at all or a portion of one or more ribs.
84	Hip	Treatment is directed at all or a portion of the proximal femur or acetabulum.
85	Pelvic bones	Treatment is directed at all or a portion of the bones of the pelvis other than the hip or sacrum.
86	Pelvis (NOS, non-visceral)	The treatment volume is directed at a primary tumor of the pelvis, but the primary sub-site is not a pelvic organ or is not known or indicated. For example, this code should be used for sarcomas arising from the pelvis.
88	Extremity bone, NOS	Treatment is directed at all or a portion of the bones of the arms or legs. This excludes the proximal femur (Hip, code 84). This excludes the proximal humerus (Shoulder, code 82).
90	Skin	Treatment is directed at all or a portion of the skin. The primary malignancy originates in the skin and the skin is the primary target. So-called skin metastases are usually subcutaneous and should be coded as a soft tissue site.
91	Soft tissue	This category should be used to code primary or metastatic soft tissue malignancies not fitting other categories.
92	Hemibody	A single treatment volume encompassing either all structures above the diaphragm, or all structures below the diaphragm. This is almost always administered for palliation of widespread bone metastasis in patients with prostate or breast cancer.
93	Whole body	Treatment is directed to the entire body included in a single treatment.
94	Mantle, mini-mantle (obsolete after 2017)	For conversion of historical data only
95	Lower extended field (obsolete after 2017)	For conversion of historical data only
96	Inverted Y (obsolete after 2017)	For conversion of historical data only
97	Invalid historical value	Conversion to new STORE data item could not take place due to an invalid FORDS Volume code
98	Other	Radiation therapy administered; treatment volume other than those previously categorized by codes 01-93.
99	Unknown	This category should be used to code treatments for which there is no information available about the treatment volume, or it is unknown if radiation treatment was administered.

Phase I Radiation to Draining Lymph Nodes

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1505	2	New 01/18	Required by CoC

Description

Identifies the draining lymph nodes treated (if any) during the first phase of radiation therapy delivered to the patient during the first course of treatment.

Rationale

The first phase of radiation treatment commonly targets both the primary tumor (or tumor bed) and draining lymph nodes as a secondary site. This data item should be used to indicate the draining regional lymph nodes, if any, that were irradiated during the first phase of radiation to the primary site.

Coding Instructions

- Radiation treatment to draining lymph nodes will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the exact draining lymph nodes may require assistance from the radiation oncologist for consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase II, Phase III, etc., accordingly.
- Code 00 if the tumor was diagnosed at autopsy.
- Phase I of radiation treatment includes primary tumor or tumor bed in addition to the draining lymph node regions that are associated with the primary tumor or tumor bed. The primary tumor or tumor bed is recorded in the *Phase I Radiation Primary Treatment Volume*.
    - Note: When the Primary Treatment Volume is lymph nodes, draining lymph nodes are not targeted. Record code 88 in this data item.
- This data item, in conjunction with *Phase I Radiation Primary Treatment Volume*, replaces the *Radiation Treatment Volume* and includes converted historical values. Conversion took place upon upgrade to NAACCR v18-compliant software; as of 2018 this data item is required for all cases regardless of diagnosis year.

Code	Label
00	No radiation treatment to draining lymph nodes. Diagnosed at autopsy.
01	Neck lymph node regions
02	Thoracic lymph node regions
03	Neck and thoracic lymph node regions
04	Breast/Chest wall lymph node regions
05	Abdominal lymph nodes
06	Pelvic lymph nodes
07	Abdominal and pelvic lymph nodes
08	Lymph node region, NOS
88	Not applicable; Phase I Radiation Primary Treatment Volume is lymph nodes
99	Unknown if any radiation treatment to draining lymph nodes; Unknown if radiation treatment administered

Phase I Radiation Treatment Modality

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1506	2	New 01/18	Required

Description

Identifies the radiation modality administered during the first phase of radiation treatment delivered during the first course of treatment.

Rationale

Radiation modality reflects whether a treatment was external beam, brachytherapy, a radioisotope as well as their major subtypes, or a combination of modalities. This data item should be used to indicate the radiation modality administered during the first phase of radiation.

Historically, the previously-named *Regional Treatment Modality* utilized codes that were not mutually exclusive. Rather, it included codes describing a mix of modalities, treatment planning techniques, and delivery techniques that are commonly utilized by radiation oncologists. However, every phase of radiation treatment will include a specified modality, planning technique, and delivery technique. The goal of the 2018 implementation of separate phase-specific data items for the recording of radiation modality and external beam radiation treatment planning techniques is to clarify this information and implement mutually exclusive categories. A separate data item for delivery technique has not been implemented because this information is not consistently reported in end of treatment summaries.

Coding Instructions

- Radiation treatment modality will typically be found in the radiation oncologist's summary letter for the first course of treatment. Segregation of treatment components into Phases and determination of the respective treatment modality may require assistance from the radiation oncologist to ensure consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase II, Phase III, etc., accordingly.
- A new phase begins when there is a clinically meaningful change in target volume, treatment fraction size (i.e. dose given during a session), modality or treatment technique. Any one of these changes will mean that a new radiation plan will be generated in the treatment planning system, and it should be coded as a new phase of radiation therapy.
- For purposes of this data item, photons, x-rays and gamma-rays are equivalent.
- Use code 13 - Radioisotopes, NOS for radioembolization procedures, e.g. intravascular Yttrium-90.
- This data item intentionally does not include reference to various MV energies because this is not a clinically important aspect of technique. A change in MV energy (e.g., 6MV to 12MV) is not clinically relevant and does not represent a change in treatment technique. It is rare for change in MV energy to occur during any phase of radiation therapy.
- A new phase begins when there is a clinically meaningful change in target volume, treatment fraction size (i.e., dose given during a session), modality or treatment technique. Any one of these changes will generally mean that a new radiation plan will be generated in the treatment planning system and should be coded as a new phase of radiation therapy.
- If this data item is coded to any of the External beam codes (01-06), the planning technique must be recorded in the data item *Phase I External Beam Radiation Planning Technique*.
- If this data item is coded to any of the Brachytherapy or Radioisotopes codes (07-16) the code of 88 must be recorded in the data item *Phase I External Beam Radiation Planning Technique*.
    - Note: Do not confuse a radioiodine scan with treatment. Only treatment is recorded in this item.
- This data item, in conjunction with *Phase I Radiation External Beam Planning Technique*, replaces the *Rad--Regional RX Modality* and includes converted historical values. Conversion took place upon upgrade to NAACCR v18-compliant software; as of 2018 this data item is required for all cases regardless of diagnosis year.

Code	Label
00	No radiation treatment
01	External beam, NOS
02	External beam, photons
03	External beam, protons
04	External beam, electrons
05	External beam, neutrons
06	External beam, carbon ions
07	Brachytherapy, NOS
08	Brachytherapy, intracavitary, LDR
09	Brachytherapy, intracavitary, HDR
10	Brachytherapy, Interstitial, LDR
11	Brachytherapy, Interstitial, HDR
12	Brachytherapy, electronic
13	Radioisotopes, NOS
14	Radioisotopes, Radium-223
15	Radioisotopes, Strontium-89
16	Radioisotopes, Strontium-90
99	Radiation treatment modality unknown; Unknown if radiation treatment administered

Phase I External Beam Radiation Planning Technique

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1502	2	New 01/18	Required by CoC

Description

Identifies the external beam radiation planning technique used to administer the first phase of radiation treatment during the first course of treatment.

Rationale

External beam radiation is the most commonly-used radiation modality in North America. In this data item we specified the planning technique for external beam treatment. Identifying the radiation technique is of interest for patterns of care and comparative effectiveness studies.

Historically, the previously-named *Regional Treatment Modality* utilized codes that were not mutually exclusive. Rather, it included codes describing a mix of modalities, treatment planning techniques, and delivery techniques that are commonly utilized by radiation oncologists. However, every phase of radiation treatment will include a specified modality, planning technique, and delivery technique. The goal of the 2018 implementation of separate phase-specific data items for the recording of radiation modality and external beam radiation treatment planning techniques is to clarify this information and implement mutually exclusive categories. A separate data item for delivery technique has not been implemented because this information is not consistently reported in end of treatment summaries.

Coding Instructions

- Radiation external beam treatment planning technique will typically be found in the radiation oncologist' s summary letter for the first course of treatment. Determination of the external beam planning technique may require assistance from the radiation oncologist to ensure consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase II, Phase III, etc., accordingly.
- A new phase begins when there is a clinically meaningful change in target volume, treatment fraction size (i.e., dose given during a session), modality or treatment technique. Any one of these changes will generally mean that a new radiation plan will be generated in the treatment planning system and should be coded as a new phase of radiation therapy.
    - Note: "on-line adaptive therapy" refers to treatments where radiation treatment plans are adapted or updated while a patient is on the treatment table. When treatment plans are adapted, the shape of the target volume may change from day to day but, for registry purposes, the volume that is being targeted won't change. An adapted plan should not be coded as though a new phase of treatment has been initiated unless, as above, the radiation oncologist documents it as a new phase in the radiation treatment summary. Two new technique codes have been added to capture when online adaptive therapy is occurring: CT guided and MR guided adaptive therapy.
- Code 00, no radiation treatment, when diagnosed at autopsy.
- Code 05 for Intensity Modulated Therapy (IMT) or Intensity Modulated Radiation Therapy {IMRT).
- Code 04 for Conformal or 3-0 Conformal Therapy whenever either is explicitly mentioned.
- When code 98 is recorded, document the planning technique in the appropriate text data item.
- This data item, in conjunction with *Phase I Radiation Treatment Modality*, replaces the *Rad--Regional RX Modality* and includes converted historical values. Conversion took place upon upgrade to NAACCR v18-compliant software; as of 2018 this data item is required for all cases regardless of diagnosis year.

Code	Label	Definition
00	No radiation treatment	Radiation therapy was not administered to the patient. Diagnosed at autopsy.
01	External beam, NOS	The treatment is known to be by external beam, but there is insufficient information to determine the specific planning technique.
02	Low energy x-ray/photon therapy	External beam therapy administered using equipment with a maximum energy of less than one (1) million volts (MV). Energies are typically expressed in units of kilovolts (kV). These types of treatments are sometimes referred to as electronic brachytherapy or orthovoltage or superficial therapy. Clinical notes may refer to the brand names of low energy x-ray delivery devices, e.g. Axxent®, INTRABEAM®, or Esteya®.
03	2-D therapy	An external beam planning technique using 2-D imaging, such as plain film x-rays or fluoroscopic images, to define the location and size of the treatment beams. Should be dearly described as 2-D therapy. This planning modality is typically used only for palliative treatments.
04	Conformal or 3-D conformal therapy	An external beam planning technique using multiple, fixed beams shaped to conform to a defined target volume. Should be dearly described as conformal or 3-D therapy in patient record.
05	Intensity modulated therapy	An external beam planning technique where the shape or energy of beams is optimized using software algorithms. Any external beam modality can be modulated but these generally refer to photon or proton beams. Intensity modulated therapy can be described as intensity modulated radiation therapy (IMRT), intensity modulated x-ray or proton therapy (IMXT /IMPT), volumetric arc therapy (VMAT) and other ways. If a treatment is described as IMRT with online re-optimization/re-planning, then it should be categorized as online re-optimization or re-planning.
06	Stereotactic radiotherapy or radiosurgery, NOS	Treatment planning using stereotactic radiotherapy/radiosurgery techniques, but the treatment is not described as Cyberknife® or Gamma Knife®. These approaches are sometimes described as SBRT (stereotactic body radiation), SABR (stereotactic ablative radiation), SRS (stereotactic radiosurgery), or SRT (stereotactic radiotherapy). If the treatment is described as robotic radiotherapy (e.g. Cyberknife®) or Gamma Knife® , use stereotactic radiotherapy subcodes below. If a treatment is described as stereotactic radiotherapy or radiosurgery with online re-optimization/re-planning, then it should be categorized as online re-optimization or re-planning.
07	Stereotactic radiotherapy or radiosurgery, robotic	Treatment planning using stereotactic radiotherapy/radiosurgery techniques which is specifically described as robotic (e.g. Cyberknife®).
08	Stereotactic radiotherapy or radiosurgery, Gamma Knife	Treatment planning using stereotactic radiotherapy/radiosurgery techniques which uses a Cobalt-60 gamma ray source and is specifically described as Gamma Knife®. This is most commonly used for treatments in the brain.
09	CT-guided online adaptive therapy	An external beam technique in which the treatment plan is adapted over the course of radiation to reflect changes in the patient's tumor or normal anatomy radiation using a CT scan obtained at the treatment machine (online). These approaches are sometimes described as CT-guided online re-optimization or online re-planning. If a treatment technique is described as both CT-guided online adaptive therapy as well as another external beam technique (IMRT, SBRT, etc.), then it should be categorized as CT-guided online adaptive therapy. If a treatment is described as "adaptive" but does not include the descriptor "online", this code should not be used.

Code	Label	Definition
10	MR-guided online adaptive therapy	An external beam technique in which the treatment plan is adapted over the course of radiation to reflect changes in the patient's tumor or normal anatomy radiation using an MRI scan obtained at the treatment machine (online). These approaches are sometimes described as MR-guided online re-optimization or online re-planning. If a treatment technique is described as both MR-guided online adaptive therapy as well as another external beam technique (IMRT, SBRT, etc.), then it should be categorized as MR-guided online adaptive therapy. If a treatment is described as "adaptive" but does not include the descriptor "online", this code should not be used.
88	Not applicable	Treatment not by external beam.
98	Other, NOS	Other radiation, NOS; Radiation therapy administered, but the treatment modality is not specified or is unknown.
99	Unknown	It is unknown whether radiation therapy was administered.

Phase I Dose per Fraction

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1501	5	New 01/18	Required by CoC

Description

Records the dose per fraction (treatment session) delivered to the patient in the first phase of radiation during the first course of treatment. The unit of measure is centi-Gray (cGy).

Rationale

Radiation therapy is delivered in one or more phases with identified dose per fraction. It is necessary to capture information describing the dose per fraction to evaluate patterns of radiation oncology care. Outcomes are strongly related to the dose delivered.

Coding Instructions

- The International Council for Radiation Protection (ICRP) recommends recording doses at the axis point where applicable (opposed fields, four field box, wedged pair, and so on). For maximum consistency in this data item, the ICRP recommendations should be followed whenever possible. Where there is no clear axis point, record the total dose as indicated in the summary chart.
- Radiation treatment Phase I dose will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the Phase I dose of radiation therapy may require assistance from the radiation oncologist for consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase II, Phase III, etc., accordingly.
- Record the actual dose delivered (NOT the initially prescribed dose) as documented in the treatment summary.
- For proton treatment, dosage may occasionally be specified as in cGe units (Cobalt Gray Equivalent) rather than cGy. 1 cGe = 100 cGy (for the Phase I Total Dose multiply cGe by 100).
- Note that dose is still occasionally specified in "rads". One rad is equivalent to one centi-Gray (cGy).
- 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.
- Code 99998 when radioisotopes were administered to the patient (codes 13-16 for *Phase I Treatment Modality*.
- This data item replaces the *Rad--Regional Dose: cGy* and includes mapped historical values. 1-1 mapping took place upon upgrade to NAACCR v18-compliant software; as of 2018 this data item is required for all cases regardless of diagnosis year.

Code	Label
00000	No radiation treatment
00001-99997	Record the actual Phase I dose delivered in cGy
99998	Not applicable, radioisotopes administered to the patient
99999	Regional radiation therapy was administered but dose is unknown; unknown whether radiation therapy was administered; death certificate only

Examples:

Code	Reason
00200	A patient with Stage Ill prostate carcinoma received pelvic irradiation to 5,000 cGy over 25 fractions followed by a Phase II (boost) prostate irradiation to 7,000 cGy. Record the Phase I dose per fraction as 00200 (5000/25).
00150	A patient with a left supraclavicular metastasis from a gastric carcinoma received 6,000 cGy to the left supraclavicular region over 40 fractions. The dose is calculated at the prescribed depth of 3cm. A secondary calculation shows a Dmax dose of 6,450 cGy. Record the Phase I dose per fraction as 00150 (6000/40).
00220	A patient with a Stage II breast carcinoma is treated with the breast intact. Tangent fields are utilized to bring the dose of the breast to 5,500 cGy over 25 fractions. Phase II (boost) in the primary tumor bed delivered to a small volume in the breast. Record phase I dose per fraction as 00220 (5500/25).

Phase I Number of Fractions

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1503	3	New 01/18	Required by CoC

Description

Records the total number of fractions (treatment sessions) delivered to the patient in the first phase of radiation during the first course of treatment.

Rationale

Radiation therapy is delivered in one or more phases with each phase spread out over a number of fractions (treatment sessions). It is necessary to capture information describing the number of fraction(s) to evaluate patterns of radiation oncology care.

Coding Instructions

- The number of fractions or treatments will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the exact number of treatments or fractions delivered to the patient may require assistance from the radiation oncologist for consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase II, Phase III, etc., accordingly.
- Although a fraction or treatment session may include several treatment portals delivered within a relatively confined period of time-usually a few minutes-it is still considered one session.
- Count each separate administration of brachytherapy or implants as a single fraction or treatment.
- Record the actual number of fractions delivered (NOT initially prescribed), as documented in the treatment summary.
- Code 999 for Death Certificate Only (DCO) cases.
- 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.
- This data item replaces the *Rad--No of Treatment Vol* and includes mapped values for historical cases. 1-1 mapping took place upon upgrade to NAACCR v18-compliant software; as of 2018 this data item is required for all cases regardless of diagnosis year.

Code	Label
000	No radiation treatment
001-998	Number of fractions administered to the patient during the first phase of radiation therapy
999	Phase I Radiation therapy was administered, but the number of fractions is unknown; It is unknown whether radiation therapy was administered

Examples:

Code	Reason
025	A patient with breast carcinoma had treatment sessions in which treatment was delivered to the chest wall and encompassing the ipsilateral supraclavicular region for a total of three fraction portals. Twenty-five treatment sessions were given. Record 25 fractions as 025.
025	A patient with Stage 1118 bronchogenic carcinoma received 25 treatments to the left hilum and mediastinum, given in 25 daily fractions over five weeks.
050	A patient with advanced head and neck cancer was treated using "hyper-fractionation." Three fields were delivered in each session; two sessions were given each day, six hours apart, with each session delivering a total dose of 150 cGy. Treatment was given for a total of 25 days. Record 50 fractions as 050.
010	The patient was given Mammosite® brachytherapy, repeated in 10 separate sessions. Record 10 fractions as 010.
001	Prostate cancer patient treated with a single administration of seeds. Record 1 fraction as 001.

Phase I Total Dose

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1507	6	New 01/18	Required by CoC

Description

Identifies the total radiation dose delivered to the patient in the first phase of radiation treatment during the first course of treatment. The unit of measure is centi-Gray (cGy).

Rationale

To evaluate the patterns of radiation care, it is necessary to capture information describing the prescribed dose of Phase I radiation to the patient during the first course of treatment. Outcomes are strongly related to the total dose delivered.

Coding Instructions

- The International Council for Radiation Protection {ICRP) recommends recording doses at the axis point where applicable (opposed fields, four field box, wedged pair, and so on). For maximum consistency in this data item, the ICRP recommendations should be followed whenever possible. Where there is no clear axis point, record the total dose as indicated in the summary chart. Determining the exact dose may require assistance from the radiation oncologist for consistent coding.
- Phase I radiation treatment dose will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the Phase I dose of radiation therapy may require assistance from the radiation oncologist for consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase II, Phase Ill, etc., accordingly.
- Record the actual total dose delivered (NOT initially prescribed), as documented in the treatment summary. The value recorded for this data item should NOT be auto-calculated within the registry abstraction software.
- For proton treatment, dosage may occasionally be specified as in cGe units (Cobalt Gray Equivalent) rather than cGy. 1 cGe = 100 cGy (for the Phase I Total Dose, you would need to multiply cGe by 100).
- Note that dose is still occasionally specified in "rads". One rad is equivalent to one centi-Gray (cGy).
- Code 000000, radiation therapy not administered, when diagnosed at autopsy.
- Code 999998 when radioisotopes are administered to the patient (codes 13-16 recorded in the *Phase I Treatment Modality*.
- Code 999999 for Death Certificate Only (DCO) cases.
- 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.
- This data item is an all new data item in 2018 includes mapped values for historical cases. Mapping took place upon upgrade to NAACCR v18-compliant software; as of 2018 this data item is required for all cases regardless of diagnosis year.

Code	Label
00000	No radiation treatment. Diagnosed at autopsy
000001-999997	Record the actual total dose delivered in cGy
999998	Not applicable, radioisotopes administered to the patient
999999	Radiation therapy was administered, but the total dose is unknown; it is unknown whether radiation therapy was administered, or diagnosed by death certificate only

Examples:

Code	Reason
005000	A patient with Stage Ill prostate carcinoma received pelvic irradiation of 5,000 cGy during Phase I Radiation Treatment. Record the Phase I Total Dose of 5,000 cGy as 005000.
006000	A patient with a left supraclavicular metastasis from a gastric carcinoma received 6,000 cGy to the left supraclavicular region. Record the Phase I Total Dose of 6,000 cGy as 006000.
005500	A patient with a Stage II breast carcinoma is treated with the breast intact. Tangent fields are utilized to bring the dose of the breast to 5,500 cGy. The supraclavicular (draining) lymph nodes are treated 4,500 cGy, calculated to a depth of 3 cm, and Phase II radiation treatment in the primary tumor bed is delivered to a small volume in the breast. Record the Phase I Total Dose of 5,500cGy as 005500. Ignore the fact that a sub-region (supraclavicular nodes) received a lower dose than the breast in Phase I. Planned or otherwise, dose variations in the target volume may vary up to about 10%.

Phase II Radiation Primary Treatment Volume

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1514	2	New 01/18	Required by CoC

Description

Identifies the primary treatment volume or primary anatomic target treated during the second phase of radiation therapy during the first course of treatment.

Rationale

Radiation treatment is commonly delivered in one or more phases. Typically, in each phase, the primary tumor or tumor bed is treated. This data item should be used to indicate the primary target volume, which might include the primary tumor or tumor bed. If the primary tumor was not targeted, record the other regional or distant site that was targeted. Draining lymph nodes may also be concurrently targeted during the first phase. These will be identified in a separate data item *Phase II Radiation to Draining Lymph Nodes.*

This data item provides information describing the anatomical structure targeted by radiation therapy during the second phase of radiation treatment and can be used to determine whether the site of the primary disease was treated with radiation or if other regional or distant sites were targeted. This information is useful in evaluating the patterns of care within a facility and on a regional or national basis. The breakdown and reorganization of the sites will allow for concise reporting.

Coding Instructions

- Radiation treatment volume will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the exact treatment volume may require assistance from the radiation oncologist for consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase II, Phase III, etc., accordingly.
- If one or more discrete volumes are treated and one of those includes the primary site, record the Phase II treatment to the primary site in this data item.
- A new phase begins when there is a clinically meaningful change in target volume, treatment fraction size (i.e., dose given during a session), modality or treatment technique. Any one of these changes will generally mean that a new radiation plan will be generated in the treatment planning system, and it should be coded as a new phase of radiation therapy.
    - Note: "on-line adaptive therapy" refers to treatments where radiation treatment plans are adapted or updated while a patient is on the treatment table. When treatment plans are adapted, the shape of the target volume may change from day to day, but for registry purposes, the volume that is being targeted won't change. An adapted plan should not be coded as though a new phase of treatment has been initiated unless, as above, the radiation oncologist documents it as a new phase in the radiation treatment summary.
- Code 00 if the tumor was diagnosed at autopsy.
- Phase II of radiation treatment also commonly includes draining lymph node regions that are associated with the primary tumor or tumor bed. The draining lymph nodes are recorded in the *Phase II Radiation to Draining Lymph Nodes*.
    - Note: When the primary volume is lymph nodes, draining lymph nodes are not targeted. Record as 88 in the *Phase II Radiation to Draining Lymph Nodes*.
- This data item may include converted historical values. It was converted *Radiation Treatment Volume* when *Rad—Boost RX Modality* was administered. Conversion took place upon upgrade to NAACCR v18-compliant software; as of 2018, this data item is required for all cases regardless of diagnosis year.
- Blanks allowed if no Phase II radiation treatment administered.

Code	Label	Definition
00	No radiation treatment	Phase II radiation therapy was not administered to the patient. Diagnosed at autopsy.
01	Neck lymph node regions	The primary treatment is directed at lymph node regions of the neck. Example situations include treatment of lymphoma or lymph node recurrence (in the absence of primary site failure) following definitive surgery of the primary tumor. If radiation to the neck lymph nodes includes the supraclavicular region use code 03.
02	Thoracic lymph node regions	Radiation therapy is directed to some combination of hilar, mediastinal, and supraclavicular lymph nodes without concurrent treatment of a visceral organ site. Example situations include mantle or mini-mantle for lymphomas, and treatment of lymphatic recurrence after complete surgical excision of a thoracic primary. Note that the supraclavicular region may be part of a head and neck lymph node region. Use code 03 for treatments directed at neck nodes and supraclavicular nodes with a head and neck primary. Use code 04 if supraclavicular lymph nodes are part of breast treatment.
03	Neck and thoracic lymph node regions	Treatment is directed to lymph nodes in the neck and thoracic region without concurrent treatment of a primary visceral tumor. This code might apply to some mantle or mini-mantle fields used in lymphoma treatments or some treatments for lymphatic recurrences following definitive treatment for tumors of the head and neck or thoracic regions.
04	Breast/Chest wall lymph node regions	Radiation is directed primarily to some combination of axillary, supraclavicular, and/or internal mammary lymph node sites WITHOUT concurrent treatment of the breast or chest wall. If the breast AND lymph nodes are being treated, then code the Primary Treatment Volume to Breast (codes 40 or 41) and Breast/chest wall lymph nodes (code 04) in Radiation to Draining Lymph Nodes.
05	Abdominal lymph nodes	Treatment is directed to some combination of the lymph nodes of the abdomen, including retro-crural, peri-gastric, peri-hepatic, portocaval and para-aortic nodes. Possible situations might include seminoma, lymphoma or lymph node recurrence following surgical resection of the prostate, bladder or uterus.
06	Pelvic lymph nodes	Treatment is directed to some combination of the lymph nodes of the pelvis, including the common, internal and external iliac, obturator, inguinal and peri-rectal lymph nodes. This might be done for lymphoma or lymph node recurrence following definitive surgery for a pelvic organ.
07	Abdominal and pelvic lymph nodes	Treatment is directed to a combination of lymph nodes in both the abdomen and pelvis. This code includes extended fields ("hockey stick", "dog-leg", "inverted Y", etc.) utilized to treat seminomas and lymphomas or recurrence of a solid tumor.
09	Lymph node region, NOS	This category should be used to code treatments directed at lymph node regions that are not adequately described by codes 01-07.
10	Eye/orbit/optic nerve	Treatment is directed at all or a portion of the eye, orbit and/or optic nerve.
11	Pituitary	Treatment is directed at the pituitary gland.
12	Brain	Treatment is directed at all the brain and its meninges ("Whole brain").
13	Brain (limited)	Treatment is directed at one or more sub-sites of the brain but not the whole brain. Chart may describe "SRS", "Stereotactic Radiosurgery", "Gamma Knife®".
14	Spinal cord	Treatment is directed at all or a portion of the spinal cord or its meninges.
20	Nasopharynx	Treatment is directed at all or a portion of the nasopharynx.
21	Oral Cavity	Treatment is directed at all or a portion of the oral cavity, including the lips, gingiva, alveolus, buccal mucosa, retromolar trigone, hard palate, floor of mouth and oral tongue.
22	Oropharynx	Treatment is directed at all or a portion of the oropharynx, including the soft palate, tonsils, base of tongue and pharyngeal wall.

Code	Label	Definition
23	Larynx (glottis) or hypopharynx	Treatment is directed at all or a portion of the larynx and/or hypopharynx.
24	Sinus/Nasal tract	Treatment is directed at all or a portion of the sinuses and nasal tract, including the frontal, ethmoid, sphenoid and maxillary sinuses.
25	Parotid or other salivary glands	Treatment is directed at the parotid or other salivary glands, including the submandibular, sublingual and minor salivary glands.
26	Thyroid	Treatment is directed at all or a portion of the thyroid. Code this volume when the thyroid is treated with 1-131 radioisotope.
29	Head and neck (NOS)	The treatment volume is directed at a primary tumor of the head and neck, but the primary sub-site is not a head and neck organ identified by codes 20-26 or it is an "unknown primary".
30	Lung or bronchus	Treatment is directed at all or a portion of the lung or bronchus.
31	Mesothelium	Treatment is directed to all or a portion of the mesothelium. This code should be used for mesothelioma primaries, even if a portion of the lung is included in the radiation field.
32	Thymus	Treatment is directed to all or a portion of the thymus.
39	Chest/lung (NOS)	The treatment is directed at a primary tumor of the chest, but the primary sub-site is unknown or not identified in codes 30-32. For example, this code should be used for sarcomas arising from the mediastinum.
40	Breast – whole	Treatment is directed at all the intact breast. Intact breast includes breast tissue that either was not surgically treated or received a lumpectomy or partial mastectomy.
41	Breast – partial	Treatment is directed at a portion of the intact breast but not the whole breast. The chart may have terms such as "Mammosite", "interstitial (seed) implant)", or "(accelerated) partial breast irradiation". Consider the possibility of partial breast irradiation when "IMRT" is documented in the record.
42	Chest wall	Treatment encompasses the chest wall (following mastectomy).
50	Esophagus	Treatment is directed at all or a portion of the esophagus. Include tumors of the gastro-esophageal junction.
51	Stomach	Treatment is directed at all or a portion of the stomach.
52	Small bowel	Treatment is directed at all or a portion of the small bowel.
53	Colon	Treatment is directed at all or a portion of the colon.
54	Rectum	Treatment is directed at all or a portion of the rectum.
55	Anus	Treatment is directed at all or a portion of the anus.
56	Liver	Treatment is directed at all or a portion of the liver.
57	Biliary tree or gallbladder	Treatment is directed at all or a portion of the biliary tree or gallbladder.
58	Pancreas or hepatopancreatic ampulla	Treatment is directed at all or a portion of the pancreas or the hepatopancreatic ampulla. Hepatopancreatic ampulla tumors are sometimes referred to as periampullary tumors.
59	Abdomen (NOS)	The treatment volume is directed at a primary tumor of the abdomen, but the primary sub-site is not an abdominal organ defined by codes 50-58 or it is considered to be an "unknown primary". For example, this code should be used for sarcomas arising from the abdominal retroperitoneum.
60	Bladder – whole	Treatment is directed at all the bladder.
61	Bladder – partial	Treatment is directed at a portion of the bladder but not the whole bladder.
62	Kidney	Treatment is directed at all or a portion of the kidney.
63	Ureter	Treatment is directed at all or a portion of the ureter.
64	Prostate – whole	Treatment is directed at all the prostate and/or seminal vesicles. Use this code even if seminal vesicles are not explicitly targeted.
65	Prostate – partial	Treatment is directed at a portion of the prostate but not the whole prostate.
66	Urethra	Treatment is directed at all or a portion of the urethra.

Code	Label	Definition
67	Penis	Treatment is directed at all or a portion of the penis. Treatments of urethral primaries should be coded as 'urethra' (code 66).
68	Testicle or Scrotum	Treatment is directed at all or a portion of the testicle and/or scrotum.
70	Ovaries or fallopian tubes	Treatment is directed at all or a portion of the ovaries or fallopian tubes.
71	Uterus or Cervix	Treatment is directed at all or a portion of the uterus, endometrium or cervix.
72	Vagina	Treatment is directed at all or a portion of the vagina. Treatments of urethral primaries should be coded as 'urethra' (code 66).
73	Vulva	Treatment is directed at all or a portion of the vulva. Treatments of urethral primaries should be coded as 'urethra' (code 66).
80	Skull	Treatment is directed at all or a portion of the bones of the skull. Any brain irradiation is a secondary consequence.
81	Spine/vertebral bodies	Treatment is directed at all or a portion of the bones of the spine/vertebral bodies, including the sacrum. Spinal cord malignancies should be coded using 'spinal cord' (code 14).
82	Shoulder	Treatment is directed to all or a portion of the proximal humerus, scapula, clavicle, or other components of the shoulder complex.
83	Ribs	Treatment is directed at all or a portion of one or more ribs.
84	Hip	Treatment is directed at all or a portion of the proximal femur or acetabulum.
85	Pelvic bones	Treatment is directed at all or a portion of the bones of the pelvis other than the hip or sacrum.
86	Pelvis (NOS, non-visceral)	The treatment volume is directed at a primary tumor of the pelvis, but the primary sub-site is not a pelvic organ or is not known or indicated. For example, this code should be used for sarcomas arising from the pelvis.
88	Extremity bone, NOS	Treatment is directed at all or a portion of the bones of the arms or legs. This excludes the proximal femur (Hip, code 84). This excludes the proximal humerus (Shoulder, code 82).
90	Skin	Treatment is directed at all or a portion of the skin. The primary malignancy originates in the skin and the skin is the primary target. So-called skin metastases are usually subcutaneous and should be coded as a soft tissue site.
91	Soft tissue	This category should be used to code primary or metastatic soft tissue malignancies not fitting other categories.
92	Hemibody	A single treatment volume encompassing either all structures above the diaphragm, or all structures below the diaphragm. This is almost always administered for palliation of widespread bone metastasis in patients with prostate or breast cancer.
93	Whole body	Treatment is directed to the entire body included in a single treatment.
94	Mantle, mini-mantle (obsolete after 2017)	For conversion of historical data only
95	Lower extended field (obsolete after 2017)	For conversion of historical data only
96	Inverted Y (obsolete after 2017)	For conversion of historical data only
97	Invalid historical value	Conversion to new STORE data item could not take place due to an invalid FORDS Volume code
98	Other	Radiation therapy administered; treatment volume other than those previously categorized by codes 01-93.
99	Unknown	This category should be used to code treatments for which there is no information available about the treatment volume, or it is unknown if radiation treatment was administered.

Phase II Radiation to Draining Lymph Nodes

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1515	2	New 01/18	Required by CoC

Description

Identifies the draining lymph nodes treated (if any) during the second phase of radiation therapy delivered to the patient during the first course of treatment.

Rationale

The second phase of radiation treatment commonly targets both the primary tumor (or tumor bed) and draining lymph nodes as a secondary site. This data item should be used to indicate the draining regional lymph nodes, if any, that were irradiated during the second phase of radiation to the primary site.

Coding Instructions

- Radiation treatment to draining lymph nodes will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the exact draining lymph nodes may require assistance from the radiation oncologist for consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase be referred to as a boost or cone down, and would be recorded as Phase II, Phase III, etc., accordingly.
- Code 00 if the tumor was diagnosed at autopsy.
- The second phase of radiation treatment includes primary tumor or tumor bed in addition to the draining lymph node regions that are associated with the primary tumor or tumor bed. The primary tumor or tumor bed is recorded in the *Phase II Radiation Primary Treatment Volume*.
    - Note: When the *Phase II Primary Treatment Volume* is lymph nodes, draining lymph nodes are not targeted. Record code 88 in this data item.
- This data item may include converted historical values. For conversion of historical values, this data item includes a mapped value of 99 when *Rad--Boost RX Modality* was administered. Conversion took place upon upgrade to NAACCR v18-compliant software; as of 2018 this data item is required for all cases regardless of diagnosis year.
- Blanks allowed if no Phase II radiation treatment administered.

Code	Label
00	No radiation treatment to draining lymph nodes. Diagnosed at autopsy.
01	Neck lymph node regions
02	Thoracic lymph node regions
03	Neck and thoracic lymph node regions
04	Breast/Chest wall lymph node regions
05	Abdominal lymph nodes
06	Pelvic lymph nodes
07	Abdominal and pelvic lymph nodes
08	Lymph node region, NOS
88	Not applicable; Phase I Radiation Primary Treatment Volume is lymph nodes
99	Unknown if any radiation treatment to draining lymph nodes; Unknown if radiation treatment administered

Phase II Radiation Treatment Modality

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1516	2	New 01/18	Required by CoC

Description

Identifies the radiation modality administered during the second phase of radiation treatment delivered during the first course of treatment.

Rationale

Radiation modality reflects whether a treatment was external beam, brachytherapy, a radioisotope as well as their major subtypes, or a combination of modalities. This data item should be used to indicate the radiation modality administered during the second phase of radiation.

Historically, the previously-named *Radiation Treatment Modality* utilized codes that were not mutually exclusive. Rather, it included codes describing a mix of modalities, treatment planning techniques, and delivery techniques that are commonly utilized by radiation oncologists. However, every phase of radiation treatment will include a specified modality, planning technique, and delivery technique. The goal of the 2018 implementation of separate phase-specific data items for the recording of radiation modality and external beam radiation treatment planning techniques is to clarify this information and implement mutually exclusive categories. A separate data item for delivery technique has not been implemented because this information is not consistently reported in end of treatment summaries.

Coding Instructions

- Radiation treatment modality will typically be found in the radiation oncologist's summary letter for the first course of treatment. Segregation of treatment components into Phases and determination of the respective treatment modality may require assistance from the radiation oncologist to ensure consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase II, Phase III, etc., accordingly.
- A new phase begins when there is a clinically meaningful change in target volume, treatment fraction size (I.e. dose given during a session), modality or treatment technique. Any one of these changes will mean that a new radiation plan will be generated in the treatment planning system, and it should be coded as a new phase of radiation therapy.
- For purposes of this data item, photons, x-rays and gamma-rays are equivalent.
- Use code 13 - Radioisotopes, NOS for radioembolization procedures, e.g. intravascular Yttrium-90.
- This data item intentionally does not include reference to various MV energies because this is not a clinically important aspect of technique. A change in MV energy (e.g., 6MV to 12MV) is not clinically relevant and does not represent a change in treatment technique. It is rare for change in MV energy to occur during any phase of radiation therapy.
- A new phase begins when there is a clinically meaningful change in target volume, treatment fraction size (i.e., dose given during a session), modality or treatment technique. Any one of these changes will generally mean that a new radiation plan will be generated in the treatment planning system and should be coded as a new phase of radiation therapy.
- If this data item is coded to any of the External beam codes (01-06), the planning technique must be recorded in the data item *Phase II External Beam Radiation Planning Technique*.
- If this data item is coded to any of the Brachytherapy or Radioisotopes codes (07-16) the code of 88 must be recorded in the data item *Phase II External Beam Radiation Planning Technique*.
    - Note: Do not confuse a radioiodine scan with treatment. Only treatment is recorded in this item.
- This data item, in conjunction with *Phase II Radiation External Beam Planning Technique*, replaces the *Rad--Boost RX Modality* and may include converted historical values. Conversion took place upon upgrade to NAACCR v18-compliant software; as of 2018 this data item is required for all cases regardless of diagnosis year.
- Blanks allowed if no Phase II radiation treatment administered.

Code	Label
00	No radiation treatment
01	External beam, NOS
02	External beam, photons
03	External beam, protons
04	External beam, electrons
05	External beam, neutrons
06	External beam, carbon ions
07	Brachytherapy, NOS
08	Brachytherapy, intracavitary, LDR
09	Brachytherapy, intracavitary, HDR
10	Brachytherapy, Interstitial, LDR
11	Brachytherapy, Interstitial, HDR
12	Brachytherapy, electronic
13	Radioisotopes, NOS
14	Radioisotopes, Radium-223
15	Radioisotopes, Strontium-89
16	Radioisotopes, Strontium-90
99	Radiation treatment modality unknown; Unknown if radiation treatment administered

Phase II External Beam Radiation Planning Technique

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1512	2	New 01/18	Required by CoC

Description

Identifies the external beam radiation planning technique used to administer the second phase of radiation treatment during the first course of treatment.

Rationale

External beam radiation is the most commonly-used radiation modality in North America. In this data item we specified the planning technique for external beam treatment. Identifying the radiation technique is of interest for patterns of care and comparative effectiveness studies.

Historically, the previously-named *Regional Treatment Modality* utilized codes that were not mutually exclusive. Rather, it included codes describing a mix of modalities, treatment planning techniques, and delivery techniques that are commonly utilized by radiation oncologists. However, every phase of radiation treatment will include a specified modality, planning technique, and delivery technique. The goal of the 2018 implementation of separate phase-specific data items for the recording of *Phase II Radiation Treatment Modality* and *Phase II External Beam Radiation Planning Technique* is to clarify this information and implement mutually exclusive categories. Note that Planning Technique details are not being captured for non-External Beam modalities. A separate data item for delivery technique has not been implemented because this information is not consistently reported in end treatment summaries.

Coding Instructions

- Radiation external beam treatment planning technique will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the external beam planning technique may require assistance from the radiation oncologist to ensure consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase II, Phase Ill, etc., accordingly.
- A new phase begins when there is a clinically meaningful change in target volume, treatment fraction size (i.e., dose given during a session), modality or treatment technique. Any one of these changes will generally mean that a new radiation plan will be generated in the treatment planning system and should be coded as a new phase of radiation therapy.
    - Note: "on-line adaptive therapy'' refers to treatments where radiation treatment plans are adapted or updated while a patient is on the treatment table. When treatment plans are adapted, the shape of the target volume may change from day to day but, for registry purposes, the volume that is being targeted won't change. An adapted plan should not be coded as though a new phase of treatment has been initiated unless, as above, the radiation oncologist documents it as a new phase in the radiation treatment summary. Two new technique codes have been added to capture when online adaptive therapy is occurring: CT guided and MR guided adaptive therapy.
- Code 00, no radiation treatment, when diagnosed at autopsy.
- Code 05 for Intensity Modulated Therapy (IMT) or Intensity Modulated Radiation Therapy (IMRT).
- Code 04 for Conformal or 3-0 Conformal Therapy whenever either is explicitly mentioned.
- When code 98 is recorded, document the planning technique in the appropriate text data item.
- This data item, in conjunction with *Phase II Radiation Treatment Modality*, replaces the *Rad--Boost RX Modality* and may include converted historical values. Conversion took place upon upgrade to NAACCR v18-compliant software; as of 2018 this data item is required for all cases regardless of diagnosis year.
- Blanks allowed if no Phase II radiation treatment administered.

Code	Label	Definition
00	No radiation treatment	Radiation therapy was not administered to the patient. Diagnosed at autopsy.
01	External beam, NOS	The treatment is known to be by external beam, but there is insufficient information to determine the specific planning technique.
02	Low energy x-ray/photon therapy	External beam therapy administered using equipment with a maximum energy of less than one (1) million volts (MV). Energies are typically expressed in units of kilovolts (kV). These types of treatments are sometimes referred to as electronic brachytherapy or orthovoltage or superficial therapy. Clinical notes may refer to the brand names of low energy x-ray delivery devices, e.g. Axxent®, INTRABEAM®, or Esteya®.
03	2-D therapy	An external beam planning technique using 2-D imaging, such as plain film x-rays or fluoroscopic images, to define the location and size of the treatment beams. Should be dearly described as 2-D therapy. This planning modality is typically used only for palliative treatments.
04	Conformal or 3-D conformal therapy	An external beam planning technique using multiple, fixed beams shaped to conform to a defined target volume. Should be dearly described as conformal or 3-D therapy in patient record.
05	Intensity modulated therapy	An external beam planning technique where the shape or energy of beams is optimized using software algorithms. Any external beam modality can be modulated but these generally refer to photon or proton beams. Intensity modulated therapy can be described as intensity modulated radiation therapy (IMRT), intensity modulated x-ray or proton therapy (IMXT /IMPT), volumetric arc therapy (VMAT) and other ways. If a treatment is described as IMRT with online re-optimization/re-planning, then it should be categorized as online re-optimization or re-planning.
06	Stereotactic radiotherapy or radiosurgery, NOS	Treatment planning using stereotactic radiotherapy/radiosurgery techniques, but the treatment is not described as Cyberknife® or Gamma Knife®. These approaches are sometimes described as SBRT (stereotactic body radiation), SABR (stereotactic ablative radiation), SRS (stereotactic radiosurgery), or SRT (stereotactic radiotherapy). If the treatment is described as robotic radiotherapy (e.g. Cyberknife®) or Gamma Knife® , use stereotactic radiotherapy subcodes below. If a treatment is described as stereotactic radiotherapy or radiosurgery with online re-optimization/re-planning, then it should be categorized as online re-optimization or re-planning.
07	Stereotactic radiotherapy or radiosurgery, robotic	Treatment planning using stereotactic radiotherapy/radiosurgery techniques which is specifically described as robotic (e.g. Cyberknife®).
08	Stereotactic radiotherapy or radiosurgery, Gamma Knife	Treatment planning using stereotactic radiotherapy/radiosurgery techniques which uses a Cobalt-60 gamma ray source and is specifically described as Gamma Knife®. This is most commonly used for treatments in the brain.
09	CT-guided online adaptive therapy	An external beam technique in which the treatment plan is adapted over the course of radiation to reflect changes in the patient's tumor or normal anatomy radiation using a CT scan obtained at the treatment machine (online). These approaches are sometimes described as CT-guided online re-optimization or online re-planning. If a treatment technique is described as both CT-guided online adaptive therapy as well as another external beam technique (IMRT, SBRT, etc.), then it should be categorized as CT-guided online adaptive therapy. If a treatment is described as "adaptive" but does not include the descriptor "online", this code should not be used.

Code	Label	Definition
10	MR-guided online adaptive therapy	An external beam technique in which the treatment plan is adapted over the course of radiation to reflect changes in the patient's tumor or normal anatomy radiation using an MRI scan obtained at the treatment machine (online). These approaches are sometimes described as MR-guided online re-optimization or online re-planning. If a treatment technique is described as both MR-guided online adaptive therapy as well as another external beam technique (IMRT, SBRT, etc.), then it should be categorized as MR-guided online adaptive therapy. If a treatment is described as "adaptive" but does not include the descriptor "online", this code should not be used.
88	Not applicable	Treatment not by external beam.
98	Other, NOS	Other radiation, NOS; Radiation therapy administered, but the treatment modality is not specified or is unknown.
99	Unknown	It is unknown whether radiation therapy was administered.

Phase II Dose per Fraction

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1511	5	New 01/18	Required by CoC

Description

Records the dose per fraction (treatment session) delivered to the patient in the second phase of radiation during the first course of treatment. The unit of measure is centi-Gray (cGy).

Rationale

Radiation therapy is delivered in one or more phases with identified dose per fraction. It is necessary to capture information describing the dose per fraction to evaluate patterns of radiation oncology care. Outcomes are strongly related to the dose delivered.

Coding Instructions

- The International Council for Radiation Protection (ICRP) recommends recording doses at the axis point where applicable (opposed fields, four field box, wedged pair, and so on). For maximum consistency in this data item, the ICRP recommendations should be followed whenever possible. Where there is no clear axis point, record the total dose as indicated in the summary chart. Determining the exact dose may require assistance from the radiation oncologist for consistent coding.
- Radiation treatment Phase II dose will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the Phase II dose of radiation therapy may require assistance from the radiation oncologist for consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred as a boost or cone down, and would be recorded as Phase II, Phase III, etc., accordingly.
- Record the actual dose delivered (NOT the initially prescribed dose) as documented in the treatment summary.
- For proton treatment, dosage may occasionally be specified as in cGe units (Cobalt Gray Equivalent) rather than cGy. 1 cGe = 100 cGy (for the Phase I Total Dose, you would need to multiply cGe by 100).
    - Note that dose is still occasionally specified in "rads". One rad is equivalent to one centi-Gray (cGy).
- 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.
- Code 99998 when radioisotopes were administered to the patient (codes 13-16 for *Phase II Radiation Treatment Modality*).
- This data item replaces the *Rad--Boost Dose cGy* and may include mapped values for historical cases. 1-1 mapping took place upon upgrade to NAACCR v18-compliant software; as of 2018 this data item is required for all cases regardless of diagnosis year.
- Blanks allowed if no Phase II radiation treatment administered.

Code	Label
00000	No radiation treatment
00001-99997	Record the actual Phase II dose delivered in cGy
99998	Not applicable, radioisotopes administered to the patient
99999	Phase II (Boost) radiation therapy was administered but dose is unknown; It is unknown whether Phase II radiation therapy was administered. Death Certificate only.

Examples:

Code	Reason
00200	A patient with Stage Ill prostate carcinoma received pelvic irradiation to 5,000 cGy over 25 fractions followed by a Phase II (boost) prostate irradiation to 7,000 cGy. Record the prescribed (and delivered) Phase II dose per fractions as 00200 (2000/10).
Blank	A patient with a left supraclavicular metastasis from a gastric carcinoma receives 6,000 cGy to the left supraclavicular region. The dose is calculated at a prescribed depth of 3 cm. A secondary calculation shows a D max dose (dose at depth of maximum dose) of 6,450 cGy. Do not confuse D max doses with Phase II doses. In this case, there is no planned Phase II dose. Leave Phase II Dose per Fraction blank.
99999	A patient with a Stage II breast carcinoma is treated with the breast intact. Tangent fields are utilized to bring the central axis dose in the breast to 5,040 cGy encompassing the supraclavicular nodes, and an intracavitary boost in the primary tumor bed is delivered to a small volume in the breast in a single session. Record the Phase II dose per fraction as 99999. Dosage (brachytherapy) unknown.

Phase II Number of Fractions

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1513	3	New 01/18	Required by CoC

Description

Records the total number of fractions (treatment sessions) administered to the patient in the second phase of radiation during the first course of treatment.

Rationale

Radiation therapy is delivered in one or more phases with each phase spread out over a number of fractions (treatment sessions). It is necessary to capture information describing the number of fraction(s) to evaluate patterns of radiation oncology care.

Coding Instructions

- The number of fractions or treatments will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the exact number of treatments or fractions delivered to the patient may require assistance from the radiation oncologist for consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase II, Phase III, etc., accordingly.
- Although a fraction or treatment session may include several treatment portals delivered within a relatively confined period of time-usually a few minutes-it is still considered one session.
- Count each separate administration of brachytherapy or implants as a single fraction or treatment.
- Record the actual number of fractions delivered (NOT initially prescribed), as documented in the treatment summary.
- Code 999 for Death Certificate Only (DCO) cases.
- 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.
- This data item may include mapped values for historical cases. This data item includes a mapped value of 999 when *Rad--Boost RX Modality* was administered. Mapping took place upon upgrade to NAACCR v18-compliant software; as of 2018 this data item is required for all cases regardless of diagnosis year.
- Blanks allowed if no Phase II radiation treatment administered.

Code	Label
000	No radiation treatment
001-998	Number of fractions administered to the patient during the second phase of radiation therapy
999	Phase II Radiation therapy was administered, but the number of fractions is unknown; It is unknown whether radiation therapy was administered

Examples:

Code	Reason
005	A patient with breast carcinoma had treatment sessions in which treatment was delivered to the chest wall encompassing the ipsilateral supradavicular region for a total of three fraction portals. Twenty-five treatment sessions were given. Additional 1000 cGy external beam boost to the tumor bed given in 5 fractions. Code 005 for 5 fractions for phase II.
Blank	A patient with Stage 111B bronchogenic carcinoma received 25 treatments to the left hilum and mediastinum, given in 25 daily fractions over five weeks. No Phase II treatment, leave blank.
010	A patient with advanced head and neck cancer was treated with 6000 cGy in 25 fractions encompassing the primary site and draining nodes with a boost of 1200 cGy in 10 fractions to the tumor bed. Record 010 for 10 fractions for phase II.
005	The patient was given a course of external beam to the prostate followed by 5 HOR brachytherapy treatments. Record 005 for 5 fractions for phase II.
030	Prostate cancer patient treated with a single administration of seeds followed by 4500 cGy IMRT in 30 fractions. Code 030 for 30 fractions for phase II.

Phase II Total Dose

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1517	6	New 01/18	Required by CoC

Description

Identifies the total radiation dose administered in the second phase of radiation treatment delivered to the patient during the first course of treatment. The unit of measure is centi-Gray (cGy).

Rationale

To evaluate the patterns of radiation care, it is necessary to capture information describing the prescribed dose of Phase II radiation to the patient during the first course of treatment. Outcomes are strongly related to the total dose delivered.

Coding Instructions

- The International Council for Radiation Protection (ICRP) recommends recording doses at the axis point where applicable (opposed fields, four field box, wedged pair, and so on). For maximum consistency in this data item, the ICRP recommendations should be followed whenever possible. Where there is no clear axis point, record the total dose as indicated in the summary chart. Determining the exact dose may be highly subjective and require assistance from the radiation oncologist for consistent coding.
- Phase II radiation treatment dose will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the Phase II dose of radiation therapy may require assistance from the radiation oncologist for consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase II, Phase III, etc., accordingly.
- Record the actual total dose delivered (NOT initially prescribed), as documented in the treatment summary. The value recorded for this data item should NOT be auto-calculated within the registry abstraction software.
- For proton treatment, dosage may occasionally be specified as in cGe units (Cobalt Gray Equivalent) rather than cGy. 1 cGe = 100 cGy {for the Phase II Total Dose, you would need to multiply cGe by 100).
- Note that dose is still occasionally specified in "rads". One rad is equivalent to one centi-Gray (cGy).
- Code 000000, radiation therapy not administered, when diagnosed at autopsy.
- Code 999998 when radioisotopes are administered to the patient (codes 13-16 recorded in the P*hase II Treatment Modality*).
- Code 999999 for Death Certificate Only (DCO) cases.
- 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.
- This data item may include mapped values for historical cases. This data item includes a mapped value of 999999 when *Rad--Boost RX Modality* was administered. Mapping took place upon upgrade to NAACCR v18-compliant software; as of 2018 this data item is required for all cases regardless of diagnosis year.
- Blanks allowed if no Phase II radiation treatment administered.

Code	Label
00000	No radiation treatment. Diagnosed at autopsy
000001-999997	Record the actual total dose delivered in cGy
999998	Not applicable, radioisotopes administered to the patient
999999	Radiation therapy was administered, but the total dose is unknown; it is unknown whether radiation therapy was administered, or diagnosed by death certificate only

Examples:

Code	Reason
005000	A patient with Stage Ill prostate carcinoma received pelvic irradiation of 5,000 cGy during Phase II Radiation Treatment. Record the Phase II Total Dose of 5,000 cGy as 005000.
006000	A patient with a left supraclavicular metastasis from a gastric carcinoma received 6,000 cGy to the left supraclavicular region during Phase II Radiation Treatment. Record the Phase II Total Dose of 6,000 cGy as 006000.
005500	A patient with a Stage II breast carcinoma is treated with the breast intact. During Phase II treatment tangent fields are utilized to bring the dose of the breast to 5,500 cGy. The supraclavicular (draining) lymph nodes are treated 4,500 cGy, calculated to a depth of 3 cm. Record the Phase II Total Dose of 5,500cGy as 005500.

Phase III Radiation Primary Treatment Volume

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1524	2	New 01/18	Required by CoC

Description

Identifies the primary treatment volume or primary anatomic target treated during the third phase of radiation therapy during the first course of treatment.

Rationale

Radiation treatment is commonly delivered in one or more phases. Typically, in each phase, the primary tumor or tumor bed is treated. This data item should be used to indicate the primary target volume, which might include the primary tumor or tumor bed. If the primary tumor was not targeted, record the other regional or distant site that was targeted. Draining lymph nodes may also be targeted during the first phase. These will be identified in a separate data item Phase Ill Radiation to Draining Lymph Nodes (1525].

This data item provides information describing the anatomical structure targeted by radiation therapy during the third phase of radiation treatment and can be used to determine whether the site of the primary disease was treated with radiation or if other regional or distant sites were targeted. This information is useful in evaluating the patterns of care within a facility and on a regional or national basis. The breakdown and reorganization of the ·sites will allow for concise reporting.

Coding Instructions

- Radiation treatment volume will typically be found in the radiation oncologist' s summary letter for the first course of treatment. Determination of the exact treatment volume may require assistance from the radiation oncologist for consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase II, Phase III, etc., accordingly.
- If one or more discrete volumes are treated and one of those includes the primary site, record the treatment to the primary site in this data item.
- A new phase begins when there is a clinically meaningful change in target volume, treatment fraction size (i.e., dose given during a session), modality or treatment technique. Any one of these changes will generally mean that a new radiation plan will be generated in the treatment planning system, and it should be coded as a new phase of radiation therapy.
    - Note: "on-line adaptive therapy'' refers to treatments where radiation treatment plans are adapted or updated while a patient is on the treatment table. When treatment plans are adapted, the shape of the target volume may change from day to day, but for registry purposes, the volume that is being targeted won't change. An adapted plan should not be coded as though a new phase of treatment has been initiated unless, as above, the radiation oncologist documents it as a new phase in the radiation treatment summary.
- Code 00 if the tumor was diagnosed at autopsy.
- Phase Ill of radiation treatment also commonly includes draining lymph node regions that are associated with the primary tumor or tumor bed. The draining lymph nodes are recorded in the *Phase Ill Radiation to Draining Lymph Nodes*.
    - Note: When the Primary Treatment Volume is lymph nodes draining lymph nodes are not targeted. Record code 88 in the *Phase Ill Radiation to Draining Lymph Nodes*.
- Blanks allowed if no Phase II radiation treatment administered

Code	Label	Definition
00	No radiation treatment	Radiation therapy was not administered to the patient. Diagnosed at autopsy.

Code	Label	Definition
01	Neck lymph node regions	The primary treatment is directed at lymph node regions of the neck. Example situations include treatment of lymphoma or lymph node recurrence (in the absence of primary site failure) following definitive surgery of the primary tumor. If radiation to the neck lymph nodes includes the supraclavicular region use code 03.
02	Thoracic lymph node regions	Radiation therapy is directed to some combination of hilar, mediastinal, and supraclavicular lymph nodes without concurrent treatment of a visceral organ site. Example situations include mantle or mini-mantle for lymphomas, and treatment of lymphatic recurrence after complete surgical excision of a thoracic primary. Note that the supraclavicular region may be part of a head and neck lymph node region. Use code 03 for treatments directed at neck nodes and supraclavicular nodes with a head and neck primary. Use code 04 if supraclavicular lymph nodes are part of breast treatment.
03	Neck and thoracic lymph node regions	Treatment is directed to lymph nodes in the neck and thoracic region without concurrent treatment of a primary visceral tumor. This code might apply to some mantle or mini-mantle fields used in lymphoma treatments or some treatments for lymphatic recurrences following definitive treatment for tumors of the head and neck or thoracic regions.
04	Breast/Chest wall lymph node regions	Radiation is directed primarily to some combination of axillary, supraclavicular, and/or internal mammary lymph node sites WITHOUT concurrent treatment of the breast or chest wall. If the breast AND lymph nodes are being treated, then code the Primary Treatment Volume to Breast (codes 40 or 41) and Breast/chest wall lymph nodes (code 04) in Radiation to Draining Lymph Nodes.
05	Abdominal lymph nodes	Treatment is directed to some combination of the lymph nodes of the abdomen, including retro-crural, peri-gastric, peri-hepatic, portocaval and para-aortic nodes. Possible situations might include seminoma, lymphoma or lymph node recurrence following surgical resection of the prostate, bladder or uterus.
06	Pelvic lymph nodes	Treatment is directed to some combination of the lymph nodes of the pelvis, including the common, internal and external iliac, obturator, inguinal and peri-rectal lymph nodes. This might be done for lymphoma or lymph node recurrence following definitive surgery for a pelvic organ.
07	Abdominal and pelvic lymph nodes	Treatment is directed to a combination of lymph nodes in both the abdomen and pelvis. This code includes extended fields ("hockey stick", "dog-leg", "inverted Y", etc.) utilized to treat seminomas and lymphomas or recurrence of a solid tumor.
09	Lymph node region, NOS	This category should be used to code treatments directed at lymph node regions that are not adequately described by codes 01-07.
10	Eye/orbit/optic nerve	Treatment is directed at all or a portion of the eye, orbit and/or optic nerve.
11	Pituitary	Treatment is directed at the pituitary gland.
12	Brain	Treatment is directed at all the brain and its meninges ("Whole brain").
13	Brain (limited)	Treatment is directed at one or more sub-sites of the brain but not the whole brain. Chart may describe "SRS", "Stereotactic Radiosurgery", "Gamma Knife®".
14	Spinal cord	Treatment is directed at all or a portion of the spinal cord or its meninges.
20	Nasopharynx	Treatment is directed at all or a portion of the nasopharynx.
21	Oral Cavity	Treatment is directed at all or a portion of the oral cavity, including the lips, gingiva, alveolus, buccal mucosa, retromolar trigone, hard palate, floor of mouth and oral tongue.
22	Oropharynx	Treatment is directed at all or a portion of the oropharynx, including the soft palate, tonsils, base of tongue and pharyngeal wall.
23	Larynx (glottis) or hypopharynx	Treatment is directed at all or a portion of the larynx and/or hypopharynx.

Code	Label	Definition
24	Sinus/Nasal tract	Treatment is directed at all or a portion of the sinuses and nasal tract, including the frontal, ethmoid, sphenoid and maxillary sinuses.
25	Parotid or other salivary glands	Treatment is directed at the parotid or other salivary glands, including the submandibular, sublingual and minor salivary glands.
26	Thyroid	Treatment is directed at all or a portion of the thyroid. Code this volume when the thyroid is treated with 1-131 radioisotope.
29	Head and neck (NOS)	The treatment volume is directed at a primary tumor of the head and neck, but the primary sub-site is not a head and neck organ identified by codes 20-26 or it is an "unknown primary".
30	Lung or bronchus	Treatment is directed at all or a portion of the lung or bronchus.
31	Mesothelium	Treatment is directed to all or a portion of the mesothelium. This code should be used for mesothelioma primaries, even if a portion of the lung is included in the radiation field.
32	Thymus	Treatment is directed to all or a portion of the thymus.
39	Chest/lung (NOS)	The treatment is directed at a primary tumor of the chest, but the primary sub-site is unknown or not identified in codes 30-32. For example, this code should be used for sarcomas arising from the mediastinum.
40	Breast – whole	Treatment is directed at all the intact breast. Intact breast includes breast tissue that either was not surgically treated or received a lumpectomy or partial mastectomy.
41	Breast – partial	Treatment is directed at a portion of the intact breast but not the whole breast. The chart may have terms such as "Mammosite", "interstitial (seed) implant)", or "(accelerated) partial breast irradiation". Consider the possibility of partial breast irradiation when "IMRT" is documented in the record.
42	Chest wall	Treatment encompasses the chest wall (following mastectomy).
50	Esophagus	Treatment is directed at all or a portion of the esophagus. Include tumors of the gastro-esophageal junction.
51	Stomach	Treatment is directed at all or a portion of the stomach.
52	Small bowel	Treatment is directed at all or a portion of the small bowel.
53	Colon	Treatment is directed at all or a portion of the colon.
54	Rectum	Treatment is directed at all or a portion of the rectum.
55	Anus	Treatment is directed at all or a portion of the anus.
56	Liver	Treatment is directed at all or a portion of the liver.
57	Biliary tree or gallbladder	Treatment is directed at all or a portion of the biliary tree or gallbladder.
58	Pancreas or hepatopancreatic ampulla	Treatment is directed at all or a portion of the pancreas or the hepatopancreatic ampulla. Hepatopancreatic ampulla tumors are sometimes referred to as periampullary tumors.
59	Abdomen (NOS)	The treatment volume is directed at a primary tumor of the abdomen, but the primary sub-site is not an abdominal organ defined by codes 50-58 or it is considered to be an "unknown primary". For example, this code should be used for sarcomas arising from the abdominal retroperitoneum.
60	Bladder – whole	Treatment is directed at all the bladder.
61	Bladder – partial	Treatment is directed at a portion of the bladder but not the whole bladder.
62	Kidney	Treatment is directed at all or a portion of the kidney.
63	Ureter	Treatment is directed at all or a portion of the ureter.
64	Prostate – whole	Treatment is directed at all the prostate and/or seminal vesicles. Use this code even if seminal vesicles are not explicitly targeted.
65	Prostate – partial	Treatment is directed at a portion of the prostate but not the whole prostate.
66	Urethra	Treatment is directed at all or a portion of the urethra.
67	Penis	Treatment is directed at all or a portion of the penis. Treatments of urethral primaries should be coded as 'urethra' (code 66).

Code	Label	Definition
68	Testicle or Scrotum	Treatment is directed at all or a portion of the testicle and/or scrotum.
70	Ovaries or fallopian tubes	Treatment is directed at all or a portion of the ovaries or fallopian tubes.
71	Uterus or Cervix	Treatment is directed at all or a portion of the uterus, endometrium or cervix.
72	Vagina	Treatment is directed at all or a portion of the vagina. Treatments of urethral primaries should be coded as 'urethra' (code 66).
73	Vulva	Treatment is directed at all or a portion of the vulva. Treatments of urethral primaries should be coded as 'urethra' (code 66).
80	Skull	Treatment is directed at all or a portion of the bones of the skull. Any brain irradiation is a secondary consequence.
81	Spine/vertebral bodies	Treatment is directed at all or a portion of the bones of the spine/vertebral bodies, including the sacrum. Spinal cord malignancies should be coded using 'spinal cord' (code 14).
82	Shoulder	Treatment is directed to all or a portion of the proximal humerus, scapula, clavicle, or other components of the shoulder complex.
83	Ribs	Treatment is directed at all or a portion of one or more ribs.
84	Hip	Treatment is directed at all or a portion of the proximal femur or acetabulum.
85	Pelvic bones	Treatment is directed at all or a portion of the bones of the pelvis other than the hip or sacrum.
86	Pelvis (NOS, non-visceral)	The treatment volume is directed at a primary tumor of the pelvis, but the primary sub-site is not a pelvic organ or is not known or indicated. For example, this code should be used for sarcomas arising from the pelvis.
88	Extremity bone, NOS	Treatment is directed at all or a portion of the bones of the arms or legs. This excludes the proximal femur (Hip, code 84). This excludes the proximal humerus (Shoulder, code 82).
90	Skin	Treatment is directed at all or a portion of the skin. The primary malignancy originates in the skin and the skin is the primary target. So-called skin metastases are usually subcutaneous and should be coded as a soft tissue site.
91	Soft tissue	This category should be used to code primary or metastatic soft tissue malignancies not fitting other categories.
92	Hemibody	A single treatment volume encompassing either all structures above the diaphragm, or all structures below the diaphragm. This is almost always administered for palliation of widespread bone metastasis in patients with prostate or breast cancer.
93	Whole body	Treatment is directed to the entire body included in a single treatment.
94	Mantle, mini-mantle (obsolete after 2017)	For conversion of historical data only
95	Lower extended field (obsolete after 2017)	For conversion of historical data only
96	Inverted Y (obsolete after 2017)	For conversion of historical data only
97	Invalid historical value	Conversion to new STORE data item could not take place due to an invalid FORDS Volume code
98	Other	Radiation therapy administered; treatment volume other than those previously categorized by codes 01-93.
99	Unknown	This category should be used to code treatments for which there is no information available about the treatment volume, or it is unknown if radiation treatment was administered.

Phase III Radiation to Draining Lymph Nodes

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1525	2	New 01/18	Required by CoC

Description

Identifies the draining lymph nodes treated (if any) during the third phase of radiation therapy delivered to the patient during the first course of treatment.

Rationale

The third phase of radiation treatment commonly targets both the primary tumor (or tumor bed) and draining lymph nodes as a secondary site. This data item should be used to indicate the draining regional lymph nodes, if any, that were irradiated during the third phase of radiation to the primary site.

Coding Instructions

- Radiation treatment to draining lymph nodes will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the exact draining lymph nodes may require assistance from the radiation oncologist for consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase III, Phase III, etc. accordingly.
- Code 00 if the tumor was diagnosed at autopsy.
- Phase III of radiation treatment includes primary tumor or tumor bed in addition to the draining lymph node regions that are associated with the primary tumor or tumor bed. The primary tumor or tumor bed is recorded in the Phase III Radiation Primary Treatment Volume [1524].
    - Note: When the Primary Treatment Volume is lymph nodes, draining lymph nodes are not targeted. Record code 88 in this data item.
- Blanks allowed if no Phase III radiation treatment administered.

Code	Label
00	No radiation treatment to draining lymph nodes. Diagnosed at autopsy.
01	Neck lymph node regions
02	Thoracic lymph node regions
03	Neck and thoracic lymph node regions
04	Breast/Chest wall lymph node regions
05	Abdominal lymph nodes
06	Pelvic lymph nodes
07	Abdominal and pelvic lymph nodes
08	Lymph node region, NOS
88	Not applicable; Phase I Radiation Primary Treatment Volume is lymph nodes
99	Unknown if any radiation treatment to draining lymph nodes; Unknown if radiation treatment administered

Phase III Radiation Treatment Modality

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1526	2	New 01/18	Required by CoC

Description

Identifies the radiation modality administered during the third phase of radiation treatment delivered during the first course of treatment.

Rationale

Radiation modality reflects whether a treatment was external beam, brachytherapy, a radioisotope as well as their major subtypes, or a combination of modalities. This data item should be used to indicate the radiation modality administered during the third phase of radiation.

Historically, the previously-named *Radiation Treatment Modality* utilized codes that were not mutually exclusive. Rather, it included codes describing a mix of modalities, treatment planning techniques, and delivery techniques that are commonly utilized by radiation oncologists. However, every phase of radiation treatment will include a specified modality, planning technique, and delivery technique. The goal of the 2018 implementation of separate phase-specific data items for the recording of radiation modality and external beam radiation treatment planning techniques is to clarify this information and implement mutually exclusive categories. A separate data item for delivery technique has not been implemented because this information is not consistently reported in end of treatment summaries.

Coding Instructions

- Radiation treatment modality will typically be found in the radiation oncologist's summary letter for the first course of treatment. Segregation of treatment components into Phases and determination of the respective treatment modality may require assistance from the radiation oncologist to ensure consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase II, Phase III, etc., accordingly.
- A new phase begins when there is a clinically meaningful change in target volume, treatment fraction size (I.e. dose given during a session), modality or treatment technique. Any one of these changes will mean that a new radiation plan will be generated in the treatment planning system, and it should be coded as a new phase of radiation therapy.
- For purposes of this data item, photons, x-rays and gamma-rays are equivalent.
- Use code 13 - Radioisotopes, NOS for radioembolization procedures, e.g. intravascular Yttrium-90.
- This data item intentionally does not include reference to various MV energies because this is not a clinically important aspect of technique. A change in MV energy (e.g., 6MV to 12MV) is not clinically relevant and does not represent a change in treatment technique. It is rare for change in MV energy to occur during any phase of radiation therapy.
- A new phase begins when there is a clinically meaningful change in target volume, treatment fraction size (i.e., dose given during a session), modality or treatment technique. Any one of these changes will generally mean that a new radiation plan will be generated in the treatment planning system and should be coded as a new phase of radiation therapy.
- If this data item is coded to any of the External beam codes (01-06), the planning technique must be recorded in the data item *Phase Ill External Beam Radiation Planning Technique*.
- If this data item is coded to any of the radioisotopes codes (13-16) the code of 88 must be recorded in the data item *Phase Ill External Beam Radiation Planning Technique*.
    - Note: Do not confuse a radioiodine scan with treatment. Only treatment is recorded in this item.
- Blanks allowed if no Phase Ill radiation treatment administered.

Code	Label
00	No radiation treatment
01	External beam, NOS
02	External beam, photons
03	External beam, protons
04	External beam, electrons
05	External beam, neutrons
06	External beam, carbon ions
07	Brachytherapy, NOS
08	Brachytherapy, intracavitary, LDR
09	Brachytherapy, intracavitary, HDR
10	Brachytherapy, Interstitial, LDR
11	Brachytherapy, Interstitial, HDR
12	Brachytherapy, electronic
13	Radioisotopes, NOS
14	Radioisotopes, Radium-223
15	Radioisotopes, Strontium-89
16	Radioisotopes, Strontium-90
99	Radiation treatment modality unknown; Unknown if radiation treatment administered

Phase III External Beam Radiation Planning Technique

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1512	2	New 01/18	Required by CoC

Description

Identifies the external beam radiation planning technique used to administer the third phase of radiation treatment during the first course of treatment.

Rationale

External beam radiation is the most commonly-used radiation modality in North America. In this data item we specified the planning technique for external beam treatment. Identifying the radiation technique is of interest for patterns of care and comparative effectiveness studies.

Historically, the previously-named *Regional Treatment Modality* utilized codes that were not mutually exclusive. Rather, it included codes describing a mix of modalities, treatment planning techniques, and delivery techniques that are commonly utilized by radiation oncologists. However, every phase of radiation treatment will include a specified modality, planning technique, and delivery technique. The goal of the 2018 implementation of separate phase-specific data items for the recording of *Phase III Radiation Treatment Modality* and *Phase III External Beam Radiation Planning Technique* is to clarify this information and implement mutually exclusive categories. Note that Planning Technique details are not being captured for non-External Beam modalities. A separate data item for delivery technique has not been implemented because this information is not consistently reported in end treatment summaries.

Coding Instructions

- Radiation external beam treatment planning technique will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the external beam planning technique may require assistance from the radiation oncologist to ensure consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase II, Phase III, etc., accordingly.
- A new phase begins when there is a clinically meaningful change in target volume, treatment fraction size (i.e., dose given during a session), modality or treatment technique. Any one of these changes will generally mean that a new radiation plan will be generated in the treatment planning system and should be coded as a new phase of radiation therapy.
    - Note: "on-line adaptive therapy" refers to treatments where radiation treatment plans are adapted or updated while a patient is on the treatment table. When treatment plans are adapted, the shape of the target volume may change from day to day but, for registry purposes, the volume that is being targeted won't change. An adapted plan should not be coded as though a new phase of treatment has been initiated unless, as above, the radiation oncologist documents it as a new phase in the radiation treatment summary. Two new technique codes have been added to capture when online adaptive therapy is occurring: CT guided and MR guided adaptive therapy.
- Code 00, no radiation treatment, when diagnosed at autopsy.
- Code 05 for Intensity Modulated Therapy (IMT) or Intensity Modulated Radiation Therapy (IMRT).
- Code 04 for Conformal or 3-0 Conformal Therapy whenever either is explicitly mentioned.
- When code 98 is recorded, document the planning technique in the appropriate text data item.
- Blanks allowed if no Phase III radiation treatment administered.

Code	Label	Definition
00	No radiation treatment	Radiation therapy was not administered to the patient. Diagnosed at autopsy.
01	External beam, NOS	The treatment is known to be by external beam, but there is insufficient information to determine the specific planning technique.
02	Low energy x-ray/photon therapy	External beam therapy administered using equipment with a maximum energy of less than one (1) million volts (MV). Energies are typically expressed in units of kilovolts (kV). These types of treatments are sometimes referred to as electronic brachytherapy or orthovoltage or superficial therapy. Clinical notes may refer to the brand names of low energy x-ray delivery devices, e.g. Axxent®, INTRABEAM®, or Esteya®.
03	2-D therapy	An external beam planning technique using 2-D imaging, such as plain film x-rays or fluoroscopic images, to define the location and size of the treatment beams. Should be dearly described as 2-D therapy. This planning modality is typically used only for palliative treatments.
04	Conformal or 3-D conformal therapy	An external beam planning technique using multiple, fixed beams shaped to conform to a defined target volume. Should be dearly described as conformal or 3-D therapy in patient record.
05	Intensity modulated therapy	An external beam planning technique where the shape or energy of beams is optimized using software algorithms. Any external beam modality can be modulated but these generally refer to photon or proton beams. Intensity modulated therapy can be described as intensity modulated radiation therapy (IMRT), intensity modulated x-ray or proton therapy (IMXT /IMPT), volumetric arc therapy (VMAT) and other ways. If a treatment is described as IMRT with online re-optimization/re-planning, then it should be categorized as online re-optimization or re-planning.
06	Stereotactic radiotherapy or radiosurgery, NOS	Treatment planning using stereotactic radiotherapy/radiosurgery techniques, but the treatment is not described as Cyberknife® or Gamma Knife®. These approaches are sometimes described as SBRT (stereotactic body radiation), SABR (stereotactic ablative radiation), SRS (stereotactic radiosurgery), or SRT (stereotactic radiotherapy). If the treatment is described as robotic radiotherapy (e.g. Cyberknife®) or Gamma Knife® , use stereotactic radiotherapy subcodes below. If a treatment is described as stereotactic radiotherapy or radiosurgery with online re-optimization/re-planning, then it should be categorized as online re-optimization or re-planning.
07	Stereotactic radiotherapy or radiosurgery, robotic	Treatment planning using stereotactic radiotherapy/radiosurgery techniques which is specifically described as robotic (e.g. Cyberknife®).
08	Stereotactic radiotherapy or radiosurgery, Gamma Knife	Treatment planning using stereotactic radiotherapy/radiosurgery techniques which uses a Cobalt-60 gamma ray source and is specifically described as Gamma Knife®. This is most commonly used for treatments in the brain.
09	CT-guided online adaptive therapy	An external beam technique in which the treatment plan is adapted over the course of radiation to reflect changes in the patient's tumor or normal anatomy radiation using a CT scan obtained at the treatment machine (online). These approaches are sometimes described as CT-guided online re-optimization or online re-planning. If a treatment technique is described as both CT-guided online adaptive therapy as well as another external beam technique (IMRT, SBRT, etc.), then it should be categorized as CT-guided online adaptive therapy. If a treatment is described as "adaptive" but does not include the descriptor "online", this code should not be used.

Code	Label	Definition
10	MR-guided online adaptive therapy	An external beam technique in which the treatment plan is adapted over the course of radiation to reflect changes in the patient's tumor or normal anatomy radiation using an MRI scan obtained at the treatment machine (online). These approaches are sometimes described as MR-guided online re-optimization or online re-planning. If a treatment technique is described as both MR-guided online adaptive therapy as well as another external beam technique (IMRT, SBRT, etc.), then it should be categorized as MR-guided online adaptive therapy. If a treatment is described as "adaptive" but does not include the descriptor "online", this code should not be used.
88	Not applicable	Treatment not by external beam.
98	Other, NOS	Other radiation, NOS; Radiation therapy administered, but the treatment modality is not specified or is unknown.
99	Unknown	It is unknown whether radiation therapy was administered.

Phase III Dose per Fraction

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1521	5	New 01/18	Required by CoC

Description

Records the dose per fraction (treatment session) delivered to the patient in the third phase of radiation during the first course of treatment. The unit of measure is centi-Gray (cGy).

Rationale

Radiation therapy is delivered in one or more phases with identified dose per fraction. It is necessary to capture information describing the dose per fraction to evaluate patterns of radiation oncology care. Outcomes are strongly related to the dose delivered.

Coding Instructions

- The International Council for Radiation Protection (ICRP) recommends recording doses at the axis point where applicable (opposed fields, four field box, wedged pair, and so on). For maximum consistency in this data item, the ICRP recommendations should be followed whenever possible. Where there is no clear axis point, record the total dose as indicated in the summary chart. Determining the exact dose may require assistance from the radiation oncologist for consistent coding.
- Radiation treatment Phase III dose will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the Phase III dose of radiation therapy may require assistance from the radiation oncologist for consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase II, Phase III, etc., accordingly.
- Record the actual dose delivered (NOT the initially prescribed dose) as documented in the treatment summary.
- For proton treatment, dosage may occasionally be specified as in cGe units (Cobalt Gray Equivalent) rather than cGy. 1 cGe = 100 cGy (for the Phase I Total Dose, you would need to multiply cGe by 100).
    - Note that dose is still occasionally specified in "rads". One rad is equivalent to one centi-Gray (cGy).
- 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.
- Code 99998 when radioisotopes were administered to the patient (codes 13-16 for *Phase III Treatment Modality*).
- Blanks allowed if no Phase III radiation treatment administered.

Code	Label
00000	No radiation treatment
00001-99997	Record the actual Phase III dose delivered in cGy
99998	Not applicable, radioisotopes administered to the patient
99999	Phase III (Boost) radiation therapy was administered but dose is unknown; It is unknown whether Phase III radiation therapy was administered. Death Certificate only.

Examples:

Code	Reason
00200	A patient with a metastatic left supraclavicular node and an isolated liver metastasis from a gastric carcinoma received 6,000 cGy to the stomach. 2000 cGy external beam administered to the supraclavicular node in 10 fractions followed by 2000 cGy administered to the liver metastasis in ten fractions. Record 00200 for phase Ill dose per fraction.
00200	A patient with a Stage II breast carcinoma is treated with the breast intact. Tangent fields are utilized to bring the dose of the breast to 5,500 cGy in 25 fractions. The axillary lymph nodes were then treated with an additional 1000 cGy in 10 fractions. Phase Ill in the primary tumor bed delivered to a small volume in the breast of 1000 cGy in 5 fractions. Record 00200 for phase Ill dose per fraction.

Phase III Number of Fractions

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1523	3	New 01/18	Required by CoC

Description

Records the total number of fractions (treatment sessions) delivered to the patient in the third phase of radiation during the first course of treatment.

Rationale

Radiation therapy is delivered in one or more phases with each phase spread out over a number of fractions (treatment sessions). It is necessary to capture information describing the number of fraction(s) to evaluate patterns of radiation oncology care.

Coding Instructions

- The number of fractions or treatments will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the exact number of treatments or fractions delivered to the patient may require assistance from the radiation oncologist for consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase II, Phase III, etc., accordingly.
- Although a fraction or treatment session may include several treatment portals delivered within a relatively confined period of time-usually a few minutes-it is still considered one session.
- Count each separate administration of brachytherapy or implants as a single fraction or treatment.
- Record the actual number of fractions delivered (NOT initially prescribed), as documented in the treatment summary.
- Code 999 for Death Certificate Only (DCO) cases.
- 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.
- Blanks allowed if no Phase III radiation treatment administered.

Code	Label
000	No radiation treatment
001-998	Number of fractions administered to the patient during the third phase of radiation therapy
999	Phase III Radiation therapy was administered, but the number of fractions is unknown; It is unknown whether radiation therapy was administered

Examples:

Code	Reason
005	A patient with breast carcinoma had treatment sessions in which treatment was delivered to the chest wall and separately to the ipsilateral supraclavicular region for a total of three fraction portals. Phase Ill was an additional 1000 cGy to axillary nodes for 5 fractions. Record 005 for Phase Ill Number of Fractions.
Blank	A patient with Stage 111B bronchogenic carcinoma received 25 treatments to the left hilum and mediastinum, given in 25 daily fractions over five weeks. Leave Phase Ill Number of Fractions blank. Only one phase of radiation therapy administered.
010	A patient with metastatic head and neck cancer was treated using "hyperfractionation." Three fields were delivered in each session; two sessions were given each day, six hours apart, with each session delivering a total dose of 150 cGy. Treatment was given for a total of 25 days. Additional 1000 cGy in 10 fractions given to thoracic spine followed by 1000 cGy in 10 fractions to liver. Record 010 for Phase Ill Number of Fractions.

Phase III Total Dose

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1527	6	New 01/18	Required by CoC

Description

Identifies the total radiation dose administered during the third phase of radiation treatment delivered to the patient during the first course of treatment. The unit of measure is centi-Gray (cGy).

Rationale

To evaluate the patterns of radiation care, it is necessary to capture information describing the prescribed dose of Phase III radiation to the patient during the first course of treatment. Outcomes are strongly related to the total dose delivered.

Coding Instructions

- The International Council for Radiation Protection (ICRP) recommends recording doses at the axis point where applicable (opposed fields, four field box, wedged pair, and so on). For maximum consistency in this data item, the ICRP recommendations should be followed whenever possible. Where there is no clear axis point, record the total dose as indicated in the summary chart. Determining the exact dose may be highly subjective and require assistance from the radiation oncologist for consistent coding.
- Phase III radiation treatment dose will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the Phase III dose of radiation therapy may require assistance from the radiation oncologist for consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase II, Phase III, etc., accordingly.
- Record the actual total dose delivered (NOT initially prescribed), as documented in the treatment summary. The value recorded for this data item should NOT be auto-calculated within the registry abstraction software.
- For proton treatment, dosage may occasionally be specified as in cGe units (Cobalt Gray Equivalent) rather than cGy. 1 cGe = 100 cGy (for the Phase III Total Dose, you would need to multiply cGe by 100).
    - Note that dose is still occasionally specified in "rads". One rad is equivalent to one centi-Gray (cGy).
- Code 000000, radiation therapy not administered, when diagnosed at autopsy.
- Code 999998 when radioisotopes are administered to the patient (codes 13-16 recorded in the *Phase III Treatment Modality*).
- Code 999999 for Death Certificate Only (DCO) cases.
- 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.
- Blanks allowed if no Phase III radiation treatment administered.

Code	Label
00000	No radiation treatment. Diagnosed at autopsy
000001-999997	Record the actual total dose delivered in cGy
999998	Not applicable, radioisotopes administered to the patient
999999	Radiation therapy was administered, but the total dose is unknown; it is unknown whether radiation therapy was administered, or diagnosed by death certificate only

Examples:

Code	Reason
005000	A patient with Stage Ill prostate carcinoma received pelvic irradiation of 5,000 cGy during Phase III Radiation Treatment. Record the Phase III Total Dose of 5,000 cGy as 005000.
006000	A patient with a left supraclavicular metastasis from a gastric carcinoma received 6,000 cGy to the left supraclavicular region during Phase III Radiation Treatment. Record the Phase III Total Dose of 6,000 cGy as 006000.
005500	A patient with a Stage II breast carcinoma is treated with the breast intact. During Phase III treatment tangent fields are utilized to bring the dose of the breast to 5,500 cGy. The supraclavicular (draining) lymph nodes are treated 4,500 cGy, calculated to a depth of 3 cm. Record the Phase III Total Dose of 5,500cGy as 005500.

Number of Phases of Radiation Treatment to this Volume

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1532	2	New 01/18	Required by CoC

Description

Identifies the total number of phases administered to the patient during the first course of treatment. A "phase" consists of one or more consecutive treatments delivered to the same anatomic volume with no clinically meaningful change in fraction size, modality or treatment technique. Although the majority of courses of radiation therapy are completed in one or two phases (historically, the "regional" and "boost" treatments) there are occasions in which three or more phases are used, most typically with head and neck malignancies.

Rationale

The number of phases of radiation treatment is used to evaluate patterns of radiation therapy and the treatment schedule.

Coding Instructions

- The number of phases of radiation treatment will typically be found in the radiation oncologist' s summary letter for the first course of treatment. Determination of the exact number of phases delivered to the patient may require assistance from the radiation oncologist for consistent coding.

Code	Label
00	No radiation treatment
01	1 phase
02	2 phases
03	3 phases
04	4 or more phases
99	Unknown number of phases; Unknown if radiation therapy administered.

Examples:

Code	Reason
00	Radiation therapy was not administered.
02	Patient with breast carcinoma treated in two phases, the whole breast with opposed x-ray fields (Phase I) followed by an electron beam boost to the surgical bed (Phase II).

Radiation Treatment Discontinued Early

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1531	2	New 01/18	Required by CoC

Description

This field is used to identify patients/tumors whose radiation treatment course was discontinued earlier than initially planned. That is, the patients/tumors received fewer treatment fractions (sessions) than originally intended by the treating physician.

Rationale

Currently, the total dose of radiation reflects what was actually delivered rather than what was intended. When a patient doesn't complete a radiation course as initially intended this is typically commented on within the radiation end of treatment summary. By flagging these patients within the cancer registry database, these patients can be excluded from analyses attempting to describe adherence to radiation treatment guidelines or patterns of care analyses.

Coding Instructions

- Radiation treatment recorded as discontinued early will typically be found in the radiation oncologist' s summary letter for the first course of treatment.
- Use code 01 when there is no indication in the record that radiation therapy was discontinued or completed early.
- Use code 02-07 when there is an indication in the record that the radiation therapy discontinued or was completed early.
- Use code 99 when radiation therapy was administered, but it is not clear if the treatment course was discontinued early, or if it is unknown whether radiation therapy was administered, or it is a death certificate only case.

Code	Label
00	No radiation treatment
01	Radiation treatment was completed as prescribed
02	Radiation treatment discontinued early – toxicity
03	Radiation treatment discontinued early – contraindicated due to other patient risk factors (comorbid conditions, advanced age, progression of tumor prior to planned radiation, etc.)
04	Radiation treatment discontinued early – patient decision
05	Radiation discontinued early – family decision
06	Radiation discontinued early – patient expired
07	Radiation discontinued early – reason not documented
99	Unknown if radiation treatment discontinued; Unknown whether radiation therapy administered. Death certificate only.

Total Dose

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1533	6	New 01/18	Required by CoC

Description

Identifies the total cumulative radiation dose administered to the patient across all phases during the first course of treatment. The unit of measure is centi-Gray (cGy).

Rationale

To evaluate the patterns of radiation care, it is necessary to capture information describing the prescribed total dose of radiation during the first course of treatment. Outcomes are strongly related to the dose delivered.

Coding Instructions

- The International Council for Radiation Protection (ICRP) recommends recording doses at the axis point where applicable (opposed fields, four field box, wedged pair, and so on). For maximum consistency in this data item, the ICRP recommendations should be followed whenever possible. Where there is no clear axis point, record the total dose as indicated in the summary chart. Determining the exact dose may require assistance from the radiation oncologist for consistent coding.
- Total radiation treatment dose will typically be found in the radiation oncologist's summary letter for the first course of treatment. If the total is not documented, then add the dose from each phase (I, II, 111, or IV or more) and document the total cumulative dose. However, do not sum doses across phases if the phases use different treatment fraction sizes or modalities (i.e. external beam in Phase I and brachytherapy in Phase II). Determination of the total dose of radiation therapy may require assistance from the radiation oncologist for consistent coding.
- For proton treatment, dosage may occasionally be specified as in cGe units (Cobalt Gray Equivalent) rather than cGy. 1 cGe = 100 cGy (for the Phase I Total Dose, you would need to multiply cGe by 100).
    - Note that dose is still occasionally specified in "rads". One rad is equivalent to one centi-Gray (cGy).
- 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.
- Code 999998 when radioisotopes are administered to the patient (codes 13-16 recorded in the *Phase I, Phase II, or Phase III Treatment Modality* data items).
- Doses should ONLY be summed across phases to create a Total Dose when all of the phases were delivered sequentially to the same body site using the same modality and dose-fractionation. If phases were delivered simultaneously (multiple body sites [volumes], e.g. simultaneous treatment to multiple metastatic sites, or dose-painting), with brachytherapy and any other different modality (e.g. external beam with a brachytherapy boost), or using different fractionation schemes, then code 999998, Not applicable.
- Code 000000, radiation therapy not administered, when diagnosed at autopsy.

Code	Label
000000	No radiation treatment. Diagnosed at autopsy.
000001-999997	Record the actual total dose delivered in cGy
999998	Not applicable, radioisotopes administered to the patient
999999	Radiation therapy was administered, but the total dose is unknown; it is unknown whether radiation therapy was administered

Location of Radiation Treatment

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1550	1	01/04, 01/12, 01/18	Required by CoC

Description

Identifies the location of the facility where radiation therapy was administered during the first course of treatment.

In RMCDS, click on the button "Radiation Detail" to enter Modality, cGy, Treatment Volume, and Location of Treatment.

Rationale

This data item provides information useful to understanding the referral patterns for radiation therapy services and for assessing the quality and outcome or radiation therapy by delivery site.

Coding Instructions

- Location of radiation treatment will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the location of radiation treatment may require assistance from the radiation oncologist for consistent coding.
- If the radiation treatment was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the radiation administered in the item *Palliative Care*.
- In this context, "regional" is used to distinguish from "boost" or "cone down"; it does not refer to "regional" as used to identify stage or disease spread. In general, regional treatment will correspond to the phase in which the treatment fields had their largest dimension. In most, but not all, cases this will be Phase I.
- For cases diagnosed January 1, 2018 and later, the first phase (regional treatment) may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase II, Phase III, etc., accordingly.

Code	Label	Definition
0	No radiation treatment	No radiation therapy was administered to the patient. Diagnosed at autopsy.
1	All radiation treatment at this facility	All radiation therapy was administered at the reporting facility.
2	Regional treatment at this facility, boost elsewhere	Regional treatment was administered at the reporting facility; a boost dose was administered elsewhere.
3	Boost radiation at this facility, regional elsewhere	Regional treatment was administered elsewhere; a boost dose was administered at the reporting facility.
4	All radiation treatment elsewhere	All radiation therapy was administered elsewhere.
8	Other	Radiation therapy was administered, but the pattern does not fit above the categories.
9	Unknown	Radiation therapy was administered, but the location of the treatment facility is unknown or not stated in patient record; or it is unknown whether radiation therapy was administered, or diagnosis was by Death certificate only.

Examples:

Code	Reason
2	A patient received radiation therapy to the entire head and neck region at the reporting facility and is then referred to another facility for high-dose-rate (HDR) intracavitary boost.
3	A patient was diagnosed with breast cancer at another facility and received surgery and regional radiation therapy at that facility before being referred to the reporting facility for boost dose therapy.
8	Regional treatment was initiated at another facility and midway through treatment the patient was transferred to the reporting facility to complete the treatment regime.
9	Patient is known to have received radiation therapy, but records do not define the facility or facility(s) where the treatment was administered.

Chemotherapy

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Summ – Chemotherapy	1390	2	01/09, 01/10, 01/13, 01/15	Required

Description

Records the type of chemotherapy administered as first course treatment at this and all other facilities. If chemotherapy was not administered, then this item records the reason it was not administered to the patient. Chemotherapy consists of a group of anticancer drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis.

In RMCDS, click on the box "First Course Treatment" to enter Chemotherapy.

Rationale

Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of the administration of chemotherapeutic agents as part of the first course of therapy. In addition, when evaluating the quality of care, it is useful to know the reason if chemotherapy was not administered.

Coding Instructions

- Code 00 if chemotherapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.
- Code 00 if the treatment plan offered multiple alternative treatment options, and the patient selected treatment that did not include chemotherapy or if the option of "no treatment" was accepted by the patient.
- If it is known that chemotherapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
- Code 87 if the patient refused recommended chemotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 88 if it is known that a physician recommended the patient receive chemotherapy but no further documentation is available yet to confirm its administration.
- Code 88 to indicate referral was made to medical oncologist and the registry must follow to determine whether it was given. If follow-up with the specified specialist or facility indicates the patient was never there, code 00.
- Cases coded 88 must be followed to determine what kind of chemotherapy was administered or why it was not.
- Code 99 if it is not known whether chemotherapy is usually administered for this type and stage of cancer and there is no mention in the patient record whether it was recommended or administered.
- Code chemoembolization as 01, 02, or 03 depending on the number of chemotherapeutic agents involved.
- If the managing physician changes one of the agents in a combination regimen, and the replacement agent belongs to a different group (chemotherapeutic agents are grouped as alkylating agents, antimetabolites, natural products, or other miscellaneous) than the original agent, the new regimen represents the start of subsequent therapy, and o*nly the original agent or regimen is recorded as first course therapy*.
- Refer to the *SEER*Rx Interactive Drug Database* (http://seer.cancer.gov/) for a list of chemotherapeutic agents.
- If chemotherapy was provided as a radiosensitizer or radioprotectant DO NOT code as chemotherapy treatment. When chemotherapy is given for radiosensitization or radioprotection, it is given in low doses that do not affect the cancer.
- If chemotherapy was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the chemotherapy in the item *Palliative Care*.

Important information affecting classification of some systemic therapies. The six drugs listed in the table below were previously classified as Chemotherapy and are now classified as BRM/Immunotherapy. This change is effective for cases diagnosed January 1, 2013 and forward. For cases diagnosed prior to January 1, 2013, registrars have been instructed to continue coding these drugs as Chemotherapy. Coding instructions related to this change have been added to the remarks field for the applicable drugs in *SEER*Rx Interactive Drug Database*.

Drug Name(s)	Category Prior to 2013	Category 2013+
Alemtuzumab/Campath	Chemotherapy	BRM/Immunotherapy
Bevacizumab/Avastin	Chemotherapy	BRM/Immunotherapy
Rituximab	Chemotherapy	BRM/Immunotherapy
Trastuzumab/Herceptin	Chemotherapy	BRM/Immunotherapy
Pertuzumab/Perjeta	Chemotherapy	BRM/Immunotherapy
Cetuxumab/Erbitux	Chemotherapy	BRM/Immunotherapy

Code	Definition
00	None, chemotherapy was not part of the planned first course of therapy. Diagnosed at autopsy.
01	Chemotherapy administered as first course therapy, but the type and number of agents is not documented in patient record.
02	Single-agent chemotherapy administered as first course therapy.
03	Multiagent chemotherapy administered as first course therapy.
82	Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age, progression of tumor prior to administration, etc.).
85	Chemotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Chemotherapy was not administered. It was recommended by the patient's physician but was not administered as part of the first course of therapy. No reason was stated in patient record.
87	Chemotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Chemotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a chemotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Examples:

Code	Reason
01	A patient with primary liver cancer is known to have received chemotherapy; however, the name(s) of agent(s) administered is not stated in patient record.
02	A patient with Stage III colon cancer is treated with a combination of fluorouracil and levamisole. Code the administration of fluorouracil as a single agent chemotherapy, and levamisole as an immunotherapeutic agent.
02	A patient with non-Hodgkin's lymphoma is treated with fludarabine.
03	A patient with early stage breast cancer receives chemotherapy. The patient chart indicates that a regimen containing doxorubicin is to be administered.
86	After surgical resection of an ovarian mass the following physician recommends chemotherapy. The patient record states that chemotherapy was not subsequently administered to the patient, but the reason why chemotherapy was not administered is not given.

Date of Chemotherapy

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Date – Chemotherapy	1220	8	01/10, 01/11	Required

Description

Records the date of initiation of chemotherapy that is part of the first course of treatment.

In RMCDS, click on the box "First Course Treatment" to enter Date of Chemotherapy.

Rationale

Collecting dates for each treatment modality allows the sequencing of multiple treatments and aids in the evaluation of time intervals from diagnosis to treatment and from treatment to recurrence.

Coding Instructions

- Record the first or earliest date on which chemotherapy was administered by any facility. This date corresponds to administration of the agents coded in *Chemotherapy*.
- This item was required in the past but discontinued in FORDS as a required item in 2003. If the date was not collected between 2003 and 2009, this field may be left blank. However, if it was collected for cases diagnosed in those years, it should be retained in this field.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date of Chemotherapy* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of Chemotherapy* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *Date of Chemotherapy Flag* is used to explain why *Date of Chemotherapy* is not a known date. See *Date of Chemotherapy Flag* for an illustration of the relationships among these items.

Date of Chemotherapy Flag

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Date – Chemo Flag	1221	2	New 01/10	Required

Description

This flag explains why there is no appropriate value in the corresponding date field, *Date of Chemotherapy*.

In RMCDS, click on the box "First Course Treatment" to enter Date of Chemotherapy Flag.

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

- Leave this item blank if *Date of Chemotherapy* has a full or partial date recorded.
- Code 12 if the *Date of Chemotherapy* cannot be determined, but the patient did receive first course chemotherapy.
- Code 10 if it is unknown whether any chemotherapy was given.
- Code 11 if no chemotherapy is planned or given.
- Code 15 if chemotherapy is planned, but not yet started. Follow this patient for chemotherapy and update this item, *Date of Chemotherapy*, and all other relevant chemotherapy items.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.
- Leave this item blank for diagnoses between 2003 and 2009 (inclusive) if this facility did not collect *Date of Chemotherapy* at that time.

Code	Definition
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any chemotherapy was given).
11	No proper value is applicable in this context (for example, no chemotherapy given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (for example, chemotherapy was given but date is unknown).
15	If information is not available at this time, but it is expected that it will be available later (for example, chemotherapy is planned as part of first course treatment, but had not yet started at the time of the last follow-up).
(Blank)	A valid date is provided in item *Date of Chemotherapy*. Case was diagnosed between 2003 and 2009 and the facility did not record *Date of Chemotherapy* at that time.

Hormone Therapy

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Summ – Hormone Therapy	1400	2	01/09, 01/10, 01/12, 01/13	Required

Description

Records the type of hormone therapy administered as first course treatment at this and all other facilities. If hormone therapy was not administered, then this item records the reason it was not administered to the patient. Hormone therapy consists of a group of drugs that may affect the long-term control of a cancer's growth. It is not usually used as a curative measure.

In RMCDS, click on the box "First Course Treatment" to enter Hormone Therapy.

Rationale

Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of the administration of hormonal agents as part of the first course of therapy. In addition, when evaluating the quality of care, it is useful to know the reason if hormone therapy was not administered.

Coding Instructions

- Record prednisone as hormonal therapy when administered in combination with chemotherapy, such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone) or COPP (cyclophosphamide, vincristine, procarbazine, prednisone).
- Do not code prednisone as hormone therapy when it is administered for reasons other than chemotherapeutic treatment.
- Tumor involvement or treatment may destroy hormone-producing tissue. Hormone replacement therapy will be given if the hormone is necessary to maintain normal metabolism and body function. Do not code hormone replacement therapy as part of first course therapy.
- Code 00 if hormone therapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.
- Code 00 if the treatment plan offered multiple alternative treatment options, and the patient selected treatment that did not include hormone therapy or if the option of "no treatment" was accepted by the patient.
- Code 01 for thyroid replacement therapy which inhibits TSH (thyroid-stimulating hormone). TSH is a product of the pituitary gland that can stimulate tumor growth.
- If it is known that hormone therapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
- Code 87 if the patient refused recommended hormone therapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 88 if it is known that a physician recommended hormone therapy, but no further documentation is available yet to confirm its administration.
- Code 88 to indicate the patient was referred to a medical oncologist and the registry should follow the case for hormone therapy. If follow-up with the specified specialist or facility indicates the patient was never there, code 00.
- Cases coded 88 should be followed to determine whether they received hormone therapy or why not.
- Code 99 if it is not known whether hormone therapy is usually administered for this type and stage of cancer and there is no mention in the patient record whether it was recommended or administered.
- Refer to the *SEER*Rx Interactive Drug Database* (http://seer.cancer.gov/) for a list of hormonal agents.
- If hormone therapy was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the hormone therapy administered in the item *Palliative Care*.

Code	Definition
00	None, hormone therapy was not part of the planned first course of therapy. Diagnosed at autopsy.
01	Hormone therapy administered as first course therapy.
82	Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age, progression of tumor prior to administration, etc.).
85	Hormone therapy was not administered because the patient died prior to planned or recommended therapy.
86	Hormone therapy was not administered. It was recommended by the patient's physician but was not administered as part of the first course of therapy. No reason was stated in patient record.
87	Hormone therapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Hormone therapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a hormonal agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Examples:

Code	Reason
00	A patient has advanced lung cancer with multiple metastases to the brain. The physician orders Decadron to reduce the edema in the brain and relieve the neurological symptoms. Decadron is not coded as hormonal therapy.
00	A patient with breast cancer may be treated with aminoglutethimide (Cytadren, Elipten), which suppresses the production of glucocorticoids and mineralocorticoids. This patient must take glucocorticoid (hydrocortisone) and may also need a mineralocorticoid (florinef) as a replacement therapy.
00	A patient with advanced disease is given prednisone to stimulate the appetite and improve nutritional status. Prednisone is not coded as hormone therapy.
01	A patient with metastatic prostate cancer is administered flutamide (an antiestrogen).
87	A patient with metastatic prostate cancer declines the administration of Megace (a progestational agent) and the refusal is noted in the patient record.

Date of Hormone Therapy

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Date – Hormone Therapy	1230	8	01/10, 01/11	Required

Description

Records the date of initiation of hormone therapy that is part of the first course of treatment.

In RMCDS, click on the box "First Course Treatment" to enter Date of Hormone Therapy.

Rationale

Collecting dates for each treatment modality allows the sequencing of multiple treatments and aids in the evaluation of time intervals from diagnosis to treatment and from treatment to recurrence.

Coding Instructions

- Record the first or earliest date on which hormone therapy was administered by any facility. This date corresponds to administration of the agents coded in *Hormone Therapy*.
- This item was required in the past but discontinued in FORDS as a required item in 2003. If the date was not collected between 2003 and 2009, this field may be left blank. However, if it was collected for cases diagnosed in those years, it should be retained in this field.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date of Hormone Therapy* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of Hormone Therapy* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *Date of Hormone Flag* is used to explain why *Date of Hormone Therapy* is not a known date. See *Date of Hormone Flag* for an illustration of the relationships among these items.

Date of Hormone Flag

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Date – Hormone Flag	1231	2	New 01/10	Required

Description

This flag explains why there is no appropriate value in the corresponding date field, *Date of Hormone Therapy*.

In RMCDS, click on the box "First Course Treatment" to enter Date of Hormone Flag.

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

- Leave this item blank if *Date of Hormone Therapy* has a full or partial date recorded.
- Code 12 if the *Date of Hormone Therapy* cannot be determined, but the patient did receive first course hormone therapy.
- Code 10 if it is unknown whether any hormone therapy was given.
- Code 11 if no hormone therapy is planned or given.
- Code 15 if hormone therapy is planned, but not yet started. Follow this patient for hormone therapy and update this item, *Date of Hormone Therapy*, and all other relevant hormone therapy items.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.
- Leave this item blank for diagnoses between 2003 and 2009 (inclusive) if this facility did not collect *Date of Hormone Therapy* at that time.

Code	Definition
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any hormone therapy was given).
11	No proper value is applicable in this context (for example, no hormone therapy given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (for example, hormone therapy was given but date is unknown).
15	If information is not available at this time, but it is expected that it will be available later (for example, hormone therapy is planned as part of first course treatment but had not yet started at the time of the last follow-up).
(Blank)	A valid date is provided in item *Date of Hormone Therapy*. Case was diagnosed between 2003 and 2009 and the facility did not record *Date of Hormone Therapy* at that time.

BRM/Immunotherapy

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Summ – BRM/Immunotherapy	1410	2	01/09, 01/10, 01/13, 01/15	Required

Description

Records the type of immunotherapy administered as first course treatment at this and all other facilities. If immunotherapy was not administered, then this item records the reason it was not administered to the patient. Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to tumor cells.

In RMCDS, click on the box "First Course Treatment" to enter BRM/Immunotherapy.

Rationale

Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of the administration of immunotherapeutic agents as part of the first course of therapy. In addition, when evaluating the quality of care, it is useful to know the reason if immunotherapy was not administered.

Coding Instructions

- Code 00 if immunotherapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.
- Code 00 if the treatment plan offered multiple alternative treatment options, and the patient selected treatment that did not include immunotherapy or if the option of "no treatment" was accepted by the patient.
- If it is known that immunotherapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
- Code 87 if the patient refused recommended immunotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 88 if it is known that a physician recommended immunotherapy but no further documentation is available yet to confirm its administration.
- Code 88 to indicate a referral was made to a medical oncologist about immunotherapy and the registry should follow the case to determine whether it was given or why not. If follow-up to the specialist or facility determines the patient was never there, code 00.
- Cases coded 88 should be followed and the code updated as appropriate.
- Code 99 if it is not known whether immunotherapy is usually administered for this type and stage of cancer and there is no mention in the patient record whether it was recommended or administered.
- Refer to the *SEER*Rx Interactive Drug Database* (http://seer.cancer.gov/) for a list of immunotherapeutic agents.
- If immunotherapy was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the immunotherapy administered in the item *Palliative Care*.

Important information affecting classification of some systemic therapies. The six drugs listed in the table below were previously classified as Chemotherapy and are now classified as BRM/Immunotherapy. This change is effective for cases diagnosed January 1, 2013 and forward. For cases diagnosed prior to January 1, 2013, registrars have been instructed to continue coding these drugs as Chemotherapy. Coding instructions related to this change have been added to the remarks field for the applicable drugs in *SEER*Rx Interactive Drug Database*.

Drug Name(s)	Category Prior to 2013	Category 2013+
Alemtuzumab/Campath	Chemotherapy	BRM/Immunotherapy
Bevacizumab/Avastin	Chemotherapy	BRM/Immunotherapy
Rituximab	Chemotherapy	BRM/Immunotherapy
Trastuzumab/Herceptin	Chemotherapy	BRM/Immunotherapy
Pertuzumab/Perjeta	Chemotherapy	BRM/Immunotherapy
Cetuxumab/Erbitux	Chemotherapy	BRM/Immunotherapy

Code	Definition
00	None, immunotherapy was not part of the planned first course of therapy. Diagnosed at autopsy.
01	Immunotherapy administered as first course therapy.
82	Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age, progression of tumor prior to administration, etc.).
85	Immunotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Immunotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record.
87	Immunotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Immunotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether an immunotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Examples:

Code	Reason
01	A patient with malignant melanoma is treated with interferon.
85	Before recommended immunotherapy could be administered, the patient died from cancer.

Date of BRM/Immunotherapy

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Date – BRM/Immunotherapy	1240	8	01/10, 01/11	Required

Description

Records the date of initiation of immunotherapy or a biologic response modifier (BRM) that is part of the first course of treatment.

In RMCDS, click on the box "First Course Treatment" to enter Date of BRM/Immunotherapy.

Rationale

Collecting dates for each treatment modality allows the sequencing of multiple treatments and aids in the evaluation of time intervals from diagnosis to treatment and from treatment to recurrence.

Coding Instructions

- Record the first or earliest date on which immunotherapy or a biologic response modifier was administered by any facility. This date corresponds to the administration of the agents coded in *BRM/Immunotherapy*.
- This item was required in the past but discontinued in FORDS as a required item in 2003. If the date was not collected between 2003 and 2009, this field may be left blank. However, if it was collected for cases diagnosed in those years, it should be retained in this field.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date of BRM/Immunotherapy* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of BRM/Immunotherapy* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *Date of BRM Flag* is used to explain why *Date of BRM/Immunotherapy* is not a known date. See *Date of BRM Flag* for an illustration of the relationships among these items.

Date of BRM Flag

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Date – BRM Flag	1241	2	New 01/10	Required

Description

This flag explains why there is no appropriate value in the corresponding date field, *Date of BRM/Immunotherapy*.

In RMCDS, click on the box "First Course Treatment" to enter Date of BRM Flag.

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

- Leave this item blank if *Date of BRM/Immunotherapy* has a full or partial date recorded.
- Code 12 if the *Date of BRM/Immunotherapy* cannot be determined, but the patient did receive first course immunotherapy or a biologic response modifier therapy.
- Code 10 if it is unknown whether any immunotherapy or a biologic response modifier was given.
- Code 11 if no immunotherapy or a biologic response modifier is planned or given.
- Code 15 if immunotherapy or a biologic response modifier is planned, but not yet started. Follow this patient for immunotherapy and update this item, *Date of BRM/Immunotherapy*, and all other relevant immunotherapy items.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.
- Leave this item blank for diagnoses between 2003 and 2009 (inclusive) if this facility did not collect *Date of BRM/Immunotherapy* at that time.

Code	Definition
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any immunotherapy was given).
11	No proper value is applicable in this context (for example, no immunotherapy given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (for example, immunotherapy was given but date is unknown).
15	If information is not available at this time, but it is expected that it will be available later (for example, immunotherapy is planned as part of first course treatment, but had not yet started at the time of the last follow-up).
(Blank)	A valid date is provided in item *Date of BRM/Immunotherapy*. Case was diagnosed between 2003 and 2009 and the facility did not record *Date of BRM/Immunotherapy* at that time.

Other Treatment

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Summ – Other	1420	1	01/09, 01/10, 01/11, 01/12	Required

Description

Identifies other treatment that cannot be defined as surgery, radiation, or systemic therapy according to the defined data items in this manual.

In RMCDS, click on the box "First Course Treatment" to enter Other Treatment.

Rationale

Information on other treatment is used to describe and evaluate the quality of care and treatment practices.

Coding Instructions

- The principal treatment for certain reportable hematopoietic diseases could be supportive care that does not meet the usual definition of treatment that "modifies, controls, removes, or destroys" proliferating cancer tissue. Supportive care may include phlebotomy, transfusion, or aspirin. In order to report the hematopoietic cases in which the patient received supportive care, SEER and the Commission on Cancer have agreed to record treatments such as phlebotomy, transfusion, or aspirin as "Other Treatment" (code 1) for certain hematopoietic diseases ONLY. Consult the most recent version of the **Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual** for Coding Instructions care of specific hematopoietic neoplasms for this item.
- Assign code 0 when:
    - There is no information in the patient's medical record about other therapy AND it is known that other therapy is not usually performed for this type and/or stage of cancer OR there is no reason to suspect that the patient would have had other therapy.
    - If the treatment plan offered multiple treatment options and the patient selected treatment that did not include other therapy.
    - Patient elects to pursue no treatment following the discussion of other therapy. Discussion does not equal a recommendation.
    - Patient diagnosed at autopsy.
- Code 1 for hematopoietic treatments such as phlebotomy, transfusions, or aspirin.
- Code 1 for embolization using alcohol as an embolizing agent.
- Code 1 for embolization to a site other than the liver where the embolizing agent is unknown.
- Code 1 for PUVA (psoralen and long-wave ultraviolet radiation).
- Do not code presurgical embolization that is given for a purpose to shrink the tumor.
- Assign code 2 for any experimental or newly developed treatment, such as a clinical trial, that differs greatly from proven types of cancer therapy.
- Assign code 3 when the patient is enrolled in a double-blind clinical trial. When the trial is complete and the code is broken, review and recode the therapy.
- Assign code 6 for **unconventional** methods whether they are the only therapy or are given **in combination** with conventional therapy.
- Assign code 6 for alternative therapy ONLY if the patient receives no other type of treatment.
- A complete description of the treatment plan should be recorded in the text field for "*Other Treatment*" on the abstract.
- If other treatment was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the other treatment administered in the item *Palliative Care*.
- Code 8 if it is known that a physician recommended treatment coded as *Other Treatment*, and no further documentation is available yet to confirm its administration.

- Code 8 to indicate referral to a specialist for *Other Treatment* and the registry should follow. If follow-up with the specialist or facility determines the patient as never there, code 0.

Code	Label	Definition
0	None	All cancer treatment was coded in other treatment fields (surgery, radiation, systemic therapy). Patient received no cancer treatment. Diagnosed at autopsy.
1	Other	Cancer treatment that cannot be appropriately assigned to specified treatment data items (surgery, radiation, systemic).
2	Other-Experimental	This code is not defined. It may be used to record participation in institution-based clinical trials.
3	Other-Double Blind	A patient is involved in a double-blind clinical trial. Code the treatment actually administered when the double-blind trial code is broken.
6	Other-Unproven	Cancer treatments administered by non-medical personnel.
7	Refusal	Other treatment was not administered. It was recommended by the patient's physician, but this treatment (which would have been coded 1, 2, or 3) was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in the patient record.
8	Recommended; unknown if administered	Other treatment was recommended, but it is unknown whether it was administered.
9	Unknown	It is unknown whether other treatment was recommended or administered, and there is no information in the medical record to confirm the recommendation or administration of other treatment. Death certificate only.

Notes:

- Phlebotomy may be called blood removal, blood letting, or venisection.
- Transfusions may include whole blood, RBCs, platelets, plateletpheresis, fresh frozen plasma (FFP), plasmapheresis, and cryoprecipitate.
- Aspirin (also known as ASA, acetylsalicylic acid, or by a brand name) is used as a treatment for essential thrombocythemia. Record ONLY aspirin therapy to thin the blood for symptomatic control of thrombocythemia. To determine whether aspirin is administered for pain, cardiovascular protection, or thinning of platelets in the blood, use the following general guideline:
  - Pain control is approximately 325-1000 mg every 3-4 hours.
  - Cardiovascular protection starts at about 160 mg/day.
  - Aspirin treatment for essential thrombocythemia is low dose, approximately 70-100 mg/day.

Date of Other Treatment

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Date – Other	1250	8	01/10, 01/11	Required

Description

Records the date on which other treatment began at any facility.

In RMCDS, click on the box "First Course Treatment" to enter Date of Other Treatment.

Rationale

Collecting dates for each treatment modality allows for the sequencing of multiple treatments and aids in the evaluation of time intervals from diagnosis to treatment and from treatment to recurrence.

Coding Instructions

- Record the date on which the care coded as *Date of Other Treatment* was initiated.
- If other treatment is the first or only treatment administered to the patient, then the date of other treatment started should be the same as the *Date of First Course of Treatment*.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date of Other Treatment* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of Other Treatment* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *Date of Other Treatment Flag* is used to explain why *Date of Other Treatment* is not a known date. See *Date of Other Treatment Flag* for an illustration of the relationships among these items.

Examples:

Code	Reason
03162010	A patient with metastatic disease was started on an experimental therapy on March 16, 2010.
08012009	Alcohol was used as an embolizing agent for a patient on August 1, 2009
09172008	A polycythemia vera patient was given several phlebotomies, the first being on September 17, 2008.

Date of Other Treatment Flag

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Date – Other Flag	1241	2	New 01/10, 01/15	Required

Description

This flag explains why there is no appropriate value in the corresponding date field, *Date of Other Treatment*.

In RMCDS, click on the box "First Course Treatment" to enter Date of Other Treatment Flag.

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

- Leave this item blank if *Date of Other Treatment* has a full or partial date recorded.
- Code 12 if the *Date of Other Treatment* cannot be determined, but the patient did receive first course other treatment.
- Code 10 if it is unknown whether any other treatment was given (*Other Treatment* = 9).
- Code 11 if no other treatment is planned or given (*Other Treatment* = 0, 7, or 8).
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Definition
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any other treatment was given).
11	No proper value is applicable in this context (for example, no other treatment given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (for example, other treatment was given but date is unknown).
15	Other therapy is planned as part of the first course of treatment but had not been started at the time of the most recent follow-up.
(Blank)	A valid date is provided in item *Date of Other Treatment*.

Transplant/Endocrine

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Summ – Transplant/Endocrine	3250	2	06/05, 01/10, 01/12, 01/13	Required

Description

Identifies systemic therapeutic *procedures* administered as part of the first course of treatment at this and all other facilities. If none of these *procedures* were administered, then this item records the reason they were not performed. These include bone marrow transplants, stem cell harvests, surgical and/or radiation endocrine therapy.

In RMCDS, click on the box "First Course Treatment" to enter Transplant/Endocrine.

Rationale

This data item allows the evaluation of patterns of treatment which involve the alteration of the immune system or change the patient's response to tumor cells but does not involve the administration of antineoplastic agents. In addition, when evaluating the quality of care, it is useful to know the reason if these *procedures* were not performed.

Coding Instructions

- Bone marrow transplants should be coded as either autologous (bone marrow originally taken from the patient) or allogeneic (bone marrow donated by a person other than the patient). For cases in which the bone marrow transplant was syngeneic (transplanted marrow from an identical twin), the item is coded as allogenic.
- Stem cell harvests involve the collection of immature blood cells from the patient and the reintroduction by transfusion of the harvested cells following chemotherapy or radiation therapy.
- Endocrine irradiation and/or endocrine surgery are procedures which suppress the naturally occurring hormonal activity of the patient and thus alter or affect the long-term control of the cancer's growth. These procedures must be bilateral to qualify as endocrine surgery or endocrine radiation. If only one gland is intact at the start of treatment, surgery and/or radiation to that remaining gland qualifies as endocrine surgery or endocrine radiation.
- Code 00 if a transplant or endocrine procedure was not administered to the patient, and it is known that these procedures are not usually administered for this type and stage of cancer.
- Code 00 if the treatment plan offered multiple alternative treatment options, and the patient selected treatment that did not include a transplant or endocrine procedure or if the option of "no treatment" was accepted by the patient.
- If it is known that a transplant or endocrine procedure is not usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
- Code 87 if the patient refused a recommended transplant or endocrine procedure, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 88 if it is known that a physician recommended a hematologic transplant or endocrine procedure, but no further documentation is available yet to confirm its administration.
- Code 88 to indicate referral to a specialist for hematologic transplant or endocrine procedures and the registry should follow the case. If follow-up to the specified specialist or facility determines the patient was never there, code 00.
- Code 88 if a bone marrow or stem cell harvest was undertaken but was not followed by a rescue or re-infusion as part of first course treatment.
- Cases coded 88 should be followed to determine whether they were given a hematologic transplant or endocrine procedure or why not.
- Code 99 if it is not known whether a transplant or endocrine procedure is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered.
- If the hematologic transplant or endocrine procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the hematologic transplant or endocrine procedure provided in the item *Palliative Care*.

Code	Definition
00	No transplant procedure or endocrine therapy was administered as part of the first course of therapy. Diagnosed at autopsy.
10	A bone marrow transplant procedure was administered, but the type was not specified.
11	Bone marrow transplant – autologous.
12	Bone marrow transplant – allogeneic.
20	Stem cell harvest and infusion. Umbilical cord stem cell transplant.
30	Endocrine surgery and/or endocrine radiation therapy.
40	Combination of endocrine surgery and/or radiation with a transplant procedure. (Combination of codes 30 and 10, 11, 12, or 20).
82	Hematologic transplant and/or endocrine surgery/radiation was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age, progression of disease prior to administration, etc.).
85	Hematologic transplant and/or endocrine surgery/radiation was not administered because the patient died prior to planned or recommended therapy.
86	Hematologic transplant and/or endocrine surgery/radiation was not administered. It was recommended by the patient's physician but was not administered as part of the first course of therapy. No reason was stated in patient record.
87	Hematologic transplant and/or endocrine surgery/radiation was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Hematologic transplant and/or endocrine surgery/radiation was recommended, but it is unknown if it was administered.
99	It is unknown whether hematologic transplant and/or endocrine surgery/radiation was recommended or administered because it is not stated in patient record. Death certificate only.

Date of Transplant/Endocrine

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	n/a	8	01/11	Required

Description

Records the date on which transplant or endocrine treatment began at any facility.

In RMCDS, click on the box "First Course Treatment" to enter Date of Transplant/Endocrine.

Rationale

Collecting dates for each treatment modality allows for the sequencing of multiple treatments and aids in the evaluation of time intervals from diagnosis to treatment and from treatment to recurrence.

Coding Instructions

- Record the date on which the care coded as *Date of Transplant/Endocrine* was initiated.
- If the date of transplant/endocrine treatment is the first or only treatment administered to the patient, then the date of other treatment started should be the same as the *Date of First Course of Treatment*.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date of Transplant/Endocrine* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of Transplant/Endocrine* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date. The *Date of Transplant/Endocrine Flag* is used to explain why *Date of Transplant/Endocrine* is not a known date or where a date is not applicable. See *Date of Transplant/Endocrine Flag* for an illustration of the relationships among these items.

Date of Transplant/Endocrine Flag

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	n/a	2		Optional

Description

This flag explains why there is no appropriate value in the corresponding date field, *Date of Transplant/Endocrine*.

In RMCDS, click on the box "First Course Treatment" to enter Date of Transplant/Endocrine Flag.

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

- Leave this item blank if *Date of Transplant/Endocrine* has a full or partial date recorded.
- Code 12 if the *Date of Transplant/Endocrine* cannot be determined, but the patient did receive first course other treatment.
- Code 10 if it is unknown whether any other treatment was given.
- Code 11 if no other treatment is planned or given.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Definition
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any transplant/endocrine was given).
11	No proper value is applicable in this context (for example, no transplant/endocrine given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (for example, transplant/endocrine was given but date is unknown).
(Blank)	A valid date is provided in item *Date of Transplant/Endocrine*.

Date of Systemic Treatment

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Date – Systemic	3230	8	01/10, 01/11, 01/15	Required by CoC

Description

Records the date of initiation for systemic therapy that is part of the first course of treatment. Systemic therapy includes the administration of chemotherapy agents, hormonal agents, biological response modifiers, bone marrow transplants, stem cell harvests, and surgical and/or radiation endocrine surgery.

In RMCDS, click on the box "First Course Treatment" to enter Date of Systemic Treatment.

Rationale

Collecting dates for each treatment modality allows the sequencing of multiple treatments and aids in the evaluation of time intervals – from diagnosis to treatment and from treatment to recurrence.

Coding Instructions

- Record the first or earliest date on which systemic therapy was administered. Systemic therapy includes Chemotherapy, Hormone Therapy, Immunotherapy, and Hematologic Transplant and Endocrine Procedures.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date of Systemic Treatment* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of Systemic Treatment* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *Date of Systemic Treatment Flag* is used to explain why *Date of Systemic Treatment* is not a known date. See *Date of Systemic Treatment Flag* for an illustration of the relationships among these items.

Examples:

Code	Reason
12152003	A patient with breast cancer begins her regimen of chemotherapy on December 15, 2003 and is subsequently given Tamoxifen on January 20, 2004.
06022003	A patient with Stage IV prostate cancer has an orchiectomy on June 2, 2003. The patient is then started on a regime of hormonal agents on June 9, 2003.

Date of Systemic Treatment Flag

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Date – Systemic Flag	3231	2	New 01/10, 01/12, 01/15	Required by CoC

Description

This flag explains why there is no appropriate value in the corresponding date field, *Date of Systemic Treatment*.

In RMCDS, click on the box "First Course Treatment" to enter Date of Systemic Treatment Flag.

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

- Leave this item blank if *Date of Systemic Treatment* has a full or partial date recorded.
- Code 12 if the *Date of Systemic Treatment* cannot be determined, but the patient did receive first course systemic therapy.
- Code 10 if it is unknown whether any systemic therapy was performed.
- Code 11 if no systemic therapy is planned or given.
- Code 15 if systemic therapy is planned but has not yet started and the start date is not yet available. Follow this patient for systemic therapy and update this item, *Date of Systemic Treatment*, and all other radiation items.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Definition
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any systemic therapy was given).
11	No proper value is applicable in this context (for example, no systemic therapy given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (for example, systemic therapy was given but date is unknown).
15	If information is not available at this time, but it is expected that it will be available later (for example, systemic therapy is planned as part of first course of therapy but had not been started at the time of the most recent follow-up).
(Blank)	A valid date is provided in item *Date of Systemic Treatment*.

Scope of Regional Lymph Node Surgery

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Summ – Scope of Reg LN Surg	1292	1	01/11, 04/12, 01/13, 01/15	Required

Description

Identifies the removal, biopsy, or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event.

In RMCDS, click on the box "First Course Treatment" to enter Scope of Regional Lymph Node Surgery.

Rationale

This data item can be used to compare and evaluate the extent of surgical treatment.

Coding Instructions

- 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. Record the date of this surgical procedure in data item *Date of First Course of Treatment* and/or *Date of Surgery* if applicable.
- Codes 0-7 are hierarchical. If only one procedure can be recorded, code the procedure that is numerically higher.
- If two or more surgical procedures of regional lymph nodes are performed, the codes entered in the registry for each subsequent procedure must include the cumulative effect of all preceding procedures. For example, a sentinel lymph node biopsy followed by a regional lymph node dissection at a later time is coded 7. Do not rely on registry software to determine the cumulative code.
- For intracranial and central nervous system primaries (C70.0-C70.9, C71.0-C71.9, C72.0-C72.9, C75.1-C75.3), code 9.
- For lymphomas (M-9590-9726, 9728-9732, 9734-9740, 9750-9762, 9811-9831, 9940, 9948, and 9971) with a lymph node primary site (C77.0-C77.9), code 9.
- For an unknown or ill-defined primary (C76.0-C76.8, C80.9) or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4, or M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992), code 9.
- Do not code *distant* lymph nodes removed during surgery to the primary site for this data item. Distant nodes are coded in the data field *Surgical Procedure/Other Site*.
- Refer to the current *AJCC Cancer Staging Manual* for site-specific identification of regional lymph nodes.
- If the procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item *Palliative Care*.

Note: One important use of registry data is the tracking of treatment patterns over time. In order to compare contemporary treatment with previously published treatment based on former codes, or to data unmodified from pre- 1998 definitions, the ability to differentiate surgeries in which four or more regional lymph nodes are removed is desirable. However, it is *very important* to note that the distinction between codes 4 and 5 is made to permit comparison of current surgical procedures with procedures coded in the past when the removal of fewer than 4 lymph nodes was not reflected in surgery codes. *It is not intended to reflect clinical significance* when applied to a particular surgical procedure. It is important to *avoid inferring, by data presentation or other methods, that one category is preferable to another within the intent of these items*.

Code	Label	General Instructions Applying to All Sites	Additional Notes Specific to Breast (C50.x)
		Use the operative report as the primary source document to determine whether the operative procedure was a sentinel lymph node biopsy (SNLBx), or a more extensive dissection of regional lymph nodes, or a combination of both SLNBx and regional lymph node dissection. The operative report will designate the surgeon's planned procedure as well as a description of the procedure that was actually performed. The pathology report may be used to complement the information appearing in the operative report, but the operative report takes precedence when attempting to distinguish between SLNBx and regional lymph node dissection or a combination of these two procedures. Do not use the number of lymph nodes removed and pathologically examined as the sole means of distinguishing between a SLNBx and a regional lymph node dissection.	Use the operative report as the primary source document to determine whether the operative procedure was a sentinel lymph node biopsy (SLNBx), and axillary node dissection (ALND), or a combination of both SLNBx and ALND. The operative report will designate the surgeon's planned procedure as well as a description of the procedure that was actually performed. The pathology report may be used to complement the information appearing in the operative report, but the operative report takes precedence when attempting to distinguish between SLNBx and ALND, or a combination of these two procedures. Do not use the number of lymph nodes removed and pathologically examined as the sole means of distinguishing between a SLNBx and a ALND.
0	No regional LN surgery	No regional lymph node surgery.	
1	Biopsy or aspiration of regional lymph node(s)	Review the operative report to confirm whether an excisional biopsy or aspiration of regional lymph nodes was actually performed. If additional procedures were performed on the lymph nodes, use the appropriate code 2-7.	Excisional biopsy or aspiration of regional lymph nodes for breast cancer is uncommon. Review the operative report to confirm whether an excisional biopsy or aspiration of regional lymph nodes was actually performed; it is highly possible that the procedure is a SLNBx (code 2) instead. If additional procedures were performed on the lymph nodes, such as axillary lymph node dissection, use the appropriate code 2-7.
2	Sentinel lymph node biopsy	• The operative report states that a SLNBx was performed. • Code 2 SLNBx when the operative report describes a procedure using injection of a dye, radio label, or combination to identify a lymph node (possibly more than one) for removal/examination. • When a SLNBx is performed, additional non-sentinel nodes can be taken during the same procedure. These additional non-sentinel nodes may be discovered by the pathologist or selectively removed (or harvested) as part of the SLNBx procedure by the surgeon. Code this as a SLNBx (code 2). If review of the operative report confirms that a regional lymph node dissection followed the SLNBx, code these cases as 6.	• If a relatively large number of lymph nodes, more than 5, are pathologically examined, review the operative report to confirm the procedure was limited to a SLNBx and did not include an axillary lymph node dissection (ALND). • Infrequently, a SLNBx is attempted and the patient fails to map (i.e., no sentinel lymph nodes are identified by the dye and/or radio label injection) and no sentinel nodes are removed. Review the operative report to confirm that an axillary incision was made and a node exploration was conducted. Patients undergoing SLNBx who fail to map will often undergo ALND. Code these cases as 2 if no ALND was performed or 6 when ALND was performed during the same operative event. Enter the appropriate number of nodes examined and positive in the data items *Regional Lymph Nodes Examined* and *Regional Lymph Nodes Positive*.

Code	Label	General Instructions Applying to All Sites	Additional Notes Specific to Breast (C50.x)
3	Number of regional nodes removed unknown or not stated; regional lymph nodes removed, NOS	• The operative report states that a regional lymph node dissection was performed (a SLNBx was not done during this procedure or in a prior procedure). • Code 3 (number of regional lymph nodes removed unknown, not stated; regional lymph nodes removed, NOS). Check the operative report to ensure this procedure is not a SLNBx only (code 2), or a SLNBx with a regional lymph node dissection (code 6 or 7).	Generally, ALND removes at least 7-9 nodes. However, it is possible for these procedures to remove or harvest fewer nodes. Review the operative report to confirm that there was not a SLNBx in addition to a more extensive regional lymph node dissection during the same procedure (code 6 or 7).
4	1-3 regional lymph nodes removed	• Code 4 (1-3 regional lymph nodes removed) should be used infrequently. Review the operative report to ensure the procedure was not a SLNBx only.	
5	4 or more regional lymph nodes removed	• Code 5 (4 or more regional lymph nodes removed). If a relatively small number of nodes was examined pathologically, review the operative report to confirm the procedure was not a SLNBx only (code 2). If a relatively large number of nodes was examined pathologically, review the operative report to confirm that there was not a SLNBx in addition to a more extensive regional lymph node dissection during the same, or separate, procedure (code 6 or 7). • Infrequently, a SNLBx is attempted and the patient fails to map (i.e., no sentinel lymph nodes are identified by the dye and/or radio label injection). When mapping fails, surgeons usually perform a more extensive dissection or regional lymph nodes. Code these cases as 2 if no further dissection of regional lymph nodes was undertaken, or 6 when regional lymph nodes were dissected during the same operative event.	

Code	Label	General Instructions Applying to All Sites	Additional Notes Specific to Breast (C50.x)
6	Sentinel node biopsy and code 3, 4, or 5 at same time, or timing not stated	• SNLBx and regional lymph node dissection (code 3, 4, or 5) during the same surgical event, or timing not known. • Generally, SLNBx followed by a regional lymph node completion will yield a relatively large number of nodes. However, it is possible for these procedures to harvest only a few nodes. • If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only. • Infrequently, a SNLBx is attempted and the patient fails to map (i.e., no sentinel lymph nodes are identified by the dye and/or radio label injection). When mapping fails, the surgeon usually performs a more extensive dissection of regional lymph nodes. Code these cases as 6.	• Generally, a SLNBx followed by ALND will yield a minimum of 7-9 nodes. However, it is possible for these procedures to harvest fewer (or more) nodes. • If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx, or whether a SLNBx plus an ALND was performed.
7	Sentinel node biopsy and code 3, 4, or 5 at different times	• SNLBx and regional lymph node dissection (code 3, 4, or 5) in separate surgical events. • Generally, SLNBx followed by regional lymph node completion will yield a relatively large number of nodes. However, it is possible for these procedures to harvest only a few nodes. • If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only.	• Generally, a SLNBx followed by ALND will yield a minimum of 7-9 nodes. However, it is possible for these procedures to harvest fewer (or more) nodes. • If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only, or whether a SLNBx plus an ALND was performed.
9	Unknown or not applicable	The status of regional lymph node evaluation should be known for surgically-treated cases (i.e., cases coded 19-90 in the date item *Surgery of Primary Site)*. Review surgically treated cases coded 9 in *Scope of Regional Lymph Node Surgery* to confirm the code.	

Examples:

Code	Reason
0	No effort was made to locate sentinel lymph nodes, and no nodes were found in pathologic analysis.
2	**(C50.1-Breast)** There was an attempt at sentinel lymph node dissection, but no lymph nodes were found in the pathological specimen.
1	**(C14.0-Pharynx)** Aspiration of regional lymph node to confirm histology of widely metastatic disease.
2	**(C44.5-Skin of Back)** Patient has melanoma of the back. A sentinel lymph node dissection was done with the removal of one lymph node. This node was negative for disease.
3	**(C61.9-Prostate)** Bilateral pelvic lymph node dissection for prostate cancer.
6	**(C50.3-Breast)** Sentinel lymph node biopsy (SLNBx) of right axilla, followed by right axillary lymph node dissection (ALND) during the same surgical event.
7	**(C50.4-Breast)** Sentinel lymph node biopsy (SLNBx) of left axilla, followed in a second procedure 5 days later by a left axillary lymph node dissection (ALND).
9	**(C34.9-Lung)** Patient was admitted for radiation therapy following surgery for lung cancer. There is no documentation on the extent of surgery in patient record.

Surgery of Other Regional/Distant Site

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Summ – Surg Oth Reg/Dist Site	1294	1	01/10, 01/11, 01/12, 01/13	Required

Description

Records the surgical removal of *distant lymph nodes* or other tissue(s) or organ(s) removed beyond the primary site.

In RMCDS, click on the box "First Course Treatment" to enter Surgery of Other Regional/Distant Site.

Rationale

The removal of non-primary tissue documents the extent of surgical treatment and is useful in evaluating the extent of metastatic involvement.

Coding Instructions

- Assign the highest numbered code that describes the surgical resection of other tissue or organs beyond the primary site surgical code.
- If other tissue organs are removed during primary site surgery that are not specifically defined by the site-specific *Surgery of Primary Site* code, assign the highest numbered code that describes the surgical resection of other tissue or organs beyond the primary site surgical code.
- Incidental removal of tissue or organs is not a "*Surgery of Other Regional/Distant Site*".
- If multiple first course surgical procedures coded in this item are performed for a single primary, the code should represent the cumulative effect of those surgeries. Do not rely on registry software to perform this task for you.
- *Surgery of Other Regional/Distant* Site is collected for each surgical event even if surgery of the primary site was not performed.
- Code 1 if any surgery is performed to treat tumors of unknown or ill-defined primary sites (C76.0-C76.8, C80.9) or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4 or M-9727, 9733, 941-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992).
- If the procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item *Palliative Care*.

Code	Label	Definition
0	None	No surgical procedure of non-primary site was performed. Diagnosed at autopsy.
1	Non-primary surgical procedure performed	Non-primary surgical resection to other site(s), unknown if whether the site(s) is regional or distant.
2	Non-primary surgical procedure to other regional sites	Resection of regional site.
3	Non-primary surgical procedure to *distant lymph node(s)*	Resection of *distant lymph node(s)*.
4	Non-primary surgical procedure to distant site	Resection of distant site.
5	Combination of codes	Any combination of surgical procedures 2, 3, or 4.
9	Unknown	It is unknown whether any surgical procedure of a non-primary site was performed. Death certificate only.

Examples:

Code	Reason
0	**(C18.1-Colon)** The incidental removal of the appendix during a surgical procedure to remove a primary malignancy in the right colon.
1	Surgical removal of metastatic lesion from liver; unknown primary.
2	**(C18.3-Colon)** Surgical ablation of solitary liver metastasis, hepatic flexure primary.
4	**(C34.9-Lung)** Removal of solitary brain metastasis.
5	**(C21.0-Anus)** Excision of solitary liver metastasis and one large hilar lymph node.

Palliative Care

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Summ – Palliative Care	3270	1	01/04, 01/10	Required by CoC

Description

Identifies any care provided in an effort to palliate or alleviate symptoms. Palliative care is performed to relieve symptoms and may include surgery, radiation therapy, systemic therapy (chemotherapy, hormone therapy, or other systemic drugs), and/or other pain management therapy.

In RMCDS, click on the box "First Course Treatment" to enter Palliative Care.

Rationale

This data item allows reporting facilities to track care that is considered palliative rather than diagnostic or curative in intent.

Coding Instructions

- Record the type of palliative care provided.
- Surgical procedures, radiation therapy, or systemic therapy provided to prolong the patient's life by controlling symptoms, to alleviate pain, or to make the patient comfortable should be coded palliative care and as first course therapy if that procedure removes or modifies either primary or secondary malignant tissue.
- Palliative care is not used to diagnose or stage the primary tumor.
- Do not record routine pain management following surgery or other treatment; do code first course pain management for persistent pain.

Code	Definition
0	No palliative care provided. Diagnosed at autopsy.
1	Surgery (which may involve a bypass procedure) to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
2	Radiation therapy to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
3	Chemotherapy, hormone therapy, or other systemic drugs to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
4	Patient received or was referred for pain management therapy with no other palliative care.
5	Any combination of codes 1, 2, and/or 3 without code 4.
6	Any combination of codes 1, 2, and/or 3 with code 4.
7	Palliative care was performed or referred, but no information on the type of procedure is available in patient record. Palliative care was provided that does not fit the descriptions for codes 1-6.
9	It is unknown if palliative care was performed or referred; not stated in patient record.

Examples:

Code	Reason
0	No palliative care was given.
1	A patient undergoes palliative surgical removal of brain metastasis. [Surgery recorded in *Other Treatment*].
1	A patient with unresectable pancreatic carcinoma (no surgical procedure of the primary site is performed) receives bypass surgery to alleviate jaundice and pain.
2	A patient is diagnosed with Stage IV prostate cancer. His only symptoms are painful bony metastases in his right hip and lower spine. XRT is given to those areas. (Record all radiotherapy items also).
2	A patient with lung cancer with a primary tumor extending into the spine is treated with XRT to shrink tumor away from spine/nerves to provide pain relief. Record all radiotherapy items also).
3	A patient is given palliative chemotherapy for Stage IIIB lung cancer. [Chemotherapy is recorded in *Chemotherapy*].
4	A 93-year old patient is diagnosed with multiple myeloma and enters a pain management clinic to treat symptoms. No other treatment is planned due to other medical problems.
5	A patient is diagnosed with widely disseminated small cell lung cancer. A palliative resection of a solitary brain metastasis is performed followed by XRT to the lower spine for painful bony metastasis. There is no known referral for pain management. (Record all surgery and radiotherapy items also).
6	A patient diagnosed with colon cancer receives bypass surgery to alleviate symptoms and XRT to the liver for metastasis, and then enters a pain management clinic for treatment of unremitting abdominal pain. (Record all radiotherapy items also).
7	A patient enters the facility with a clinical diagnosis of unresectable carcinoma of pancreas. A stent was inserted into the bile duct to relieve obstruction and improve the bile duct flow.

Surgical Approach 2010

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	668	1	New 01/10, 01/11, 01/15	Required by CoC

Description

This item is used to describe the surgical method used to approach the primary site for patients undergoing surgery of the primary site at this facility.

In RMCDS, click on the box "First Course Treatment" to enter Approach – Surgery of Primary Site.

Rationale

This item is used to monitor patterns and trends in the adoption and utilization of minimally-invasive surgical techniques.

Coding Instructions

- This item may be left blank for cases diagnosed prior to 2010.
- If the patient has multiple surgeries of the primary site, this item describes the approach used for the most invasive, definitive surgery.
- For ablation of skin tumors, assign code 3.
- Assign code 2 or 4 if the surgery began as robotic assisted or endoscopic and was converted to open.
- If both robotic and minimally invasive (for example, endoscopic or laparoscopic) surgery are used, code to robotic (codes 1 or 2).
- This item should not be confused with the obsolete item *Surgical Approach*.

Code	Definition
0	No surgical procedure of primary site at this facility; Diagnosed at autopsy
1	Robotic assisted
2	Robotic converted to open
3	Endoscopic or laparoscopic
4	Endoscopic or laparoscopic converted to open
5	Open or approach unspecified
9	Unknown whether surgery was performed at this facility

Examples:

Code	Reason
0	Patient received radiation at this facility after having surgery elsewhere
3	Surgery was performed endoscopically
5	The surgical report described conventional open surgery, but did not use the term "open"

Treatment Status

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Summ – Treatment Status	1285	1	New 01/10, 01/11	Required

Description

This data item summarizes whether the patient received any treatment or the tumor was under active surveillance.

In RMCDS, click on the box "First Course Treatment" to enter Treatment Status.

Rationale

This data item documents active surveillance (watchful waiting) and eliminates searching each treatment modality to determine whether treatment was given. It is used in conjunction with *Date of First Course of Treatment* to document whether treatment was or was not given, it is unknown if treatment was given, or treatment was given on an unknown date.

Coding Instructions

- This item may be left blank for cases diagnosed prior to 2010.
- Treatment given after a period of active surveillance is considered subsequent treatment and it is not coded in this item.
- Use code 0 when treatment is refused or the physician decides not to treat for any reason such as the presence of comorbidities.

Code	Definition
0	No treatment given
1	Treatment given
2	Active Surveillance (watchful waiting)
9	Unknown if treatment was given

Examples:

Code	Reason
0	An elderly patient with pancreatic cancer requested no treatment.
0	Patient is expected to receive radiation, but it has not occurred yet (*Reason for No Radiation* = 8).
2	Treatment plan for a lymphoma patient is active surveillance.

Readmission to the Same Hospital Within 30 Days of Surgical Discharge

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	3190	1	01/04, 06/05, 01/10, 01/18	Required by CoC

Description

Records a readmission to the same hospital, for the same illness, within 30 days of discharge following hospitalization for surgical resection of the primary site.

In RMCDS, click on the box "First Course Treatment" to enter Readmission within 30 Days.

Rationale

This data item provides information related to the quality of care. A patient may have a readmission related to the primary diagnosis on discharge if the length of stay was too short, and then he/she needed to return due to problems or complications. A patient may also need to be readmitted if discharge planning and/or follow-up instructions were ineffective. It is important to distinguish a planned from an unplanned readmission, since a planned readmission is not an indicator of quality of care problems.

Coding Instructions

- Consult patient record or information from the billing department to determine if a readmission to the same hospital occurred within 30 days of the date recorded in the item *Date of Surgical Discharge*.
- Only record a readmission related to the treatment of this cancer.
- Review the treatment plan to determine whether the readmission was planned.
- If there was an unplanned admission following surgical discharge, check for an ICD-10-CM "Y" code and record it, space allowing, as an additional *Secondary Diagnosis 1-10*.
- 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.

Code	Definition
0	No surgical procedure of the primary site was performed, or the patient was not readmitted to the same hospital within 30 days of discharge.
1	A patient was surgically treated and was readmitted to the same hospital within 30 days of being discharged. This readmission was unplanned.
2	A patient was surgically treated and was then readmitted to the same hospital within 30 days of being discharged. This readmission was planned (chemotherapy port insertion, revision of colostomy, etc.)
3	A patient was surgically treated and, within 30 days of being discharged, the patient had both a planned and an unplanned readmission to the same hospital.
9	It is unknown whether surgery of the primary site was recommended or performed. It is unknown whether the patient was readmitted to the same hospital within 30 days of discharge. Death certificate only.

Examples:

Code	Reason
0	A patient does not return to the hospital following a local excision for a Stage I breast cancer.
0	A patient was surgically treated and, upon discharge from acute hospital care, was admitted/transferred to an extended care ward of the hospital.
1	A patient is readmitted to the hospital three weeks (21 days) following a colon resection due to unexpected perirectal bleeding.
2	Following surgical resection the patient returns to the hospital for the insertion of a chemotherapy port.

Surgical Margins

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Summ – Surgical Margins	1320	1	01/10, 01/11, 01/13	Required by CoC

Description

Records the final status of the surgical margins after resection of the primary tumor.

In RMCDS, click on the box "First Course Treatment" to enter Surgical Margins.

Rationale

This data item serves as a quality measure for pathology reports and is used for staging and may be a prognostic factor in recurrence.

Coding Instructions

- Record the margin status as it appears in the pathology report.
- Codes 0-3 are hierarchical; if two codes describe the margin status, use the numerically higher code.
- Code 7 if the pathology report indicates the margins could not be determined.
- If no surgery of the primary site was performed, code 8.
- Code 9 if the pathology report makes no mention of margins or no tissue was sent to pathology.
- For lymphomas (M-9590-9726, 9728-9732, 9734-9740, 9750-9762, 9811-9831, 9940, 9948, and 9971) with a lymph node primary site (C77.0-C77.9), code 9.
- For an unknown or ill-defined primary (C76.0-C76.8, C80.9) or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4, or M-9727, 9733, 941-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992), code 9.

Code	Label	Definition
0	No residual tumor	All margins are grossly and microscopically negative
1	Residual tumor, NOS	Involvement is indicated, but not otherwise specified
2	Microscopic residual tumor	Cannot be seen by the naked eye
3	Macroscopic residual tumor	Gross tumor of the primary site which is visible to the naked eye
7	Margins not evaluable	Cannot be assessed (indeterminate)
8	No primary site surgery	No surgical procedure of the primary site. Diagnosed at autopsy.
9	Unknown or not applicable	If is unknown whether a surgical procedure to the primary site was performed; death certificate-only; for lymphomas with a lymph node primary site; an unknown or ill-defined primary; or for Hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease

Example:

Code	Reason
3	(C18-Colon) The pathology report from a colon resection describes the proximal margin as grossly involved with tumor (code 3) and the distal margin as microscopically involved (code 2). Code macroscopic involvement (code 3).

Date of First Course of Treatment

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1270	8	01/10, 01/11	Required

Description

Records the date on which treatment (surgery, radiation, systemic, or other treatment) of the patient began at any facility.

Rationale

It is important to be able to measure the delay between diagnosis and the onset of treatment. A secondary use for this date is as a starting point for survival statistics (rather than using the diagnosis date). This date cannot be calculated from the respective first course treatment modality dates if no treatment was given. Therefore, providing the date on which active surveillance is chosen, a physician decides not to treat a patient, or a patient's family or guardian declines treatment is important.

Coding Instructions

- Record the earliest of the following dates: *Date of First Surgical Procedure*, *Date Radiation Started*, *Date Systemic Therapy Started*, or *Date Other Treatment Started*.
- If active surveillance or watchful waiting is selected as the first course of treatment (*Treatment Status* = 2) record the date this decision is made.
- In cases of non-treatment (*Treatment Status* = 0), in which a physician decides not to treat a patient or a patient's family or guardian declines all treatment, the date of first course of treatment is the date this decision was made.
- Leave this item blank if the cancer was diagnosed at autopsy and not suspected prior to that.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date of First Course of Treatment* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of First Course of Treatment* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *Date 1st Course RX Flag* is used to explain why *Date of First Course of Treatment* is not a known date. See *Date 1st Course RX Flag* for an illustration of the relationships among these items.

Examples:

Code	Reason
02142004	A patient has a core biopsy on February 12, 2004 and subsequently undergoes an excisional biopsy on February 14, 2004
04212005	A patient begins receiving preoperative radiation therapy elsewhere on April 21, 2005 and subsequent surgical therapy at this facility on June 2, 2005.

Date 1st Course RX Flag

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1271	2	New 01/10, 01/12, 01/15	Required

Description

This flag explains why there is no appropriate value in the corresponding date field, *Date of First Course of Treatment.*

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

- Leave this item blank if *Date of First Course of Treatment* has a full or partial date recorded.
- Code 12 if the *Date of First Course of Treatment* cannot be determined at all, but the patient did receive first course treatment.
- Code 12 if a decision not to treat was made, but the date is totally unknown.
- Code 12 if a decision to use active surveillance was made, but the date is totally unknown.
- Code 10 if it is unknown whether any treatment was administered.
- Code 11 if the initial diagnosis was at autopsy.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Definition
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any treatment was given).
11	No proper value is applicable in this context (that is, autopsy only).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (for example, treatment was given but the date is unknown).
(Blank)	A valid date is provided in item *Date of First Course of Treatment*.

Reason for No Surgery

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1340	1	01/04, 01/12, 01/13	Required

Description

Records the reason that no surgery was performed on the primary site.

Rationale

This data item provides information related to the quality of care and describes why primary site surgery was not performed.

Coding Instructions

- If *Surgery of Primary Site* is coded 00, then record the reason based on documentation in the patient record.
- Code 1 if the treatment plan offered multiple alternative treatment options and the patient selected treatment that did not include surgery of the primary site, or if the option of "no treatment" was accepted by the patient.
- Code 1 if *Surgery of Primary Site* is coded 98.
- Code 7 if the patient refused recommended surgical treatment, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Cased coded 8 should be followed and updated to a more definitive code as appropriate.
- Code 9 if the treatment plan offered multiple choices, but it is unknown which treatment, if any was provided.

Code	Definition
0	Surgery of the primary site was performed.
1	Surgery of the primary site was not performed because it was not part of the planned first course treatment. Diagnosed at autopsy.
2	Surgery of the primary site was not recommended/performed because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, etc.)
5	Surgery of the primary site was not performed because the patient died prior to planned or recommended surgery.
6	Surgery of the primary site was not performed; it was recommended by the patient's physician but was not performed as part of the first course of therapy. No reason was noted in patient record.
7	Surgery of the primary site was not performed; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in the patient record.
8	Surgery of the primary site was recommended, but it is unknown if it was performed. Further follow-up is recommended.
9	It is unknown whether surgery of the primary site was recommended or performed. Death certificate only.

Examples:

Code	Reason
2	A patient with a primary tumor of the liver is not recommended for surgery due to advanced cirrhosis.
8	A patient is referred to another facility for recommended surgical resection of a gastric carcinoma, but further information from the facility to which the patient was referred is not available.

Reason for No Radiation

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1430	1	09/04, 01/13	Required

Description

Records the reason that no regional radiation therapy was administered to the primary site.

Rationale

When evaluating the quality of care, it is useful to know the reason that various methods of therapy were not used, and whether the failure to provide a given type of therapy was due to the physician's failure to recommend that treatment, or due to the refusal of the patient, a family member, or the patient's guardian.

Coding Instructions

- If *Regional Treatment Modality* is coded 00, then record the reason based on documentation in the patient record.
- Code 1 if the treatment plan offered multiple alternative treatment options and the patient selected treatment that did not include radiation therapy.
- Code 7 if the patient refused recommended radiation therapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Cased coded 8 should be followed and updated to a more definitive code as appropriate.
- Code 9 if the treatment plan offered multiple alternative treatment options, but it is unknown which treatment, if any was provided.

Code	Definition
0	Radiation therapy was performed.
1	Radiation therapy was not performed because it was not part of the planned first course treatment. Diagnosed at autopsy.
2	Radiation therapy was not recommended/administered because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, etc.)
5	Radiation therapy was not administered because the patient died prior to planned or recommended surgery.
6	Radiation therapy was not administered; it was recommended by the patient's physician but was not performed as part of the first course of therapy. No reason was noted in patient record.
7	Radiation therapy was not administered; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in the patient record.
8	Radiation therapy was recommended, but it is unknown if it was administered.
9	It is unknown if radiation therapy was recommended or administered. Death certificate cases only.

Examples:

Code	Reason
1	A patient with Stage I prostate cancer is offered either surgery or brachytherapy to treat his disease. The patient elects to be surgically treated.

Surgery/Radiation Sequence

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Summ – Surg/Rad Sequence	1380	1	01/04, 01/10, 01/11, 01/12	Required

Description

Records the sequencing of radiation and surgical procedures given as part of the first course of treatment.

Rationale

The sequence of radiation and surgical procedures given as part of the first course of treatment cannot always be determined using the date on which each modality was started or performed. This data item can be used to more precisely evaluate the timing of delivery of treatment to the patient.

Coding Instructions

- Surgical procedures include the *Surgery of Primary Site*; *Scope of Regional Lymph Node Surgery*; and *Surgical Procedure/Other Site*. If all of these procedures are coded 0, or it is not known whether the patient received both surgery and radiation, then this item should be coded 0.
- If the patient received both radiation therapy and any one or a combination of the following surgical procedures: *Surgery of Primary Site*; *Scope of Regional Lymph Node Surgery*; or *Surgical Procedure/Other Site*, then code this item 2-9, as appropriate.
- If multiple first course treatment episodes were given such that both codes 4 and 7 seem to apply, use the code that defines the first sequence that applies.

Code	Label	Definition
0	No radiation therapy and/or surgical procedures	No radiation therapy given or unknown if radiation given; and/or no surgery of the primary site; no scope of regional lymph node surgery; no surgery to other regional site(s), distant site(s), or distant lymph node(s); or it is unknown whether any surgery given.
2	Radiation therapy before surgery	Radiation therapy given before surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
3	Radiation therapy after surgery	Radiation therapy given after surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
4	Radiation therapy both before and after surgery	At least two courses of radiation therapy are 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).
5	Intraoperative radiation therapy	Intraoperative therapy given during surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
6	Intraoperative radiation therapy with other therapy administered before or after surgery	Intraoperative radiation therapy given during surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s) with other radiation therapy administered before or after surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
7	Surgery both before and after radiation	Radiation was administered between two separate surgical procedures to the primary site; regional lymph nodes; surgery to other regional site(s), distant site(s), or distant lymph node(s).
9	Sequence unknown	Administration of radiation therapy and surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s) were performed and the sequence of the treatment is not stated in the patient record.

Examples:

Code	Reason
0	Due to other medical conditions surgery was not performed. The patient received palliative radiation therapy to alleviate pain.
2	A large lung lesion received radiation therapy prior to resection.
3	A patient received a wedge resection of a right breast mass with axillary lymph node dissection followed by radiation to right breast.
4	Preoperative radiation therapy was given to a large, bulky vulvar lesion and was followed by a lymph node dissection. This was then followed by radiation therapy to treat positive lymph nodes.
5	A cone biopsy of the cervix was followed by intracavitary implant for IIIB cervical carcinoma.
6	Stage IV vaginal carcinoma was treated with 5,000 cGy to the pelvis followed by a lymph node dissection and 2,500 cGy of intracavitary brachytherapy.
9	An unknown primary of the head and neck was treated with surgery and radiation prior to admission, but the sequence is unknown. The patient enters for chemotherapy.

Systemic/Surgery Sequence

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Summ – Systemic/Surg Seq	1639	1	01/10, 01/11, 01/12	Required

Description

Records the sequencing of systemic therapy and surgical procedures given as part of the first course of treatment.

Rationale

The sequence of systemic therapy and surgical procedures given as part of the first course of treatment cannot always be determined using the date on which each modality was started or performed. This data item can be used to more precisely evaluate the timing of delivery of treatment to the patient.

Coding Instructions

- *Systemic/Surgery Sequence* is to be used for patients diagnosed on or after January 1, 2006.
- Code the administration of systemic therapy in sequence with the first surgery performed, described in the item *Date of Surgery*.
- If none of the following surgical procedures were performed: *Surgery of Primary Site*; *Scope of Regional Lymph Node Surgery*; and *Surgical Procedure/Other Site* then this item should be coded 0.
- If the patient received both systemic therapy and any one or a combination of the following surgical procedures: *Surgery of Primary Site*, *Scope of Regional Lymph Node Surgery*, or *Surgical Procedure/Other Site*, then code this item 2-9, as appropriate.
- If multiple first course treatment episodes were given such that both codes 4 and 7 seem to apply, use the code that defines the first sequence that applies. For example: the sequence, chemo then surgery then hormone therapy then surgery is coded 4 for "chemo then surgery then hormone".

Code	Label	Definition
0	No systemic therapy and/or surgical procedures	No systemic therapy was given; and/or no surgical procedure of primary site; no scope of regional lymph node surgery; no surgery to other regional site(s), distant site(s), or distant lymph node(s); or no reconstructive surgery was performed. It is unknown whether both surgery and systemic treatment were provided.
2	Systemic therapy before surgery	Systemic therapy was given before surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
3	Systemic therapy after surgery	Systemic therapy was given after surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
4	Systemic therapy both before and after surgery	At least two courses of systemic therapy were given before and at least two more after a surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
5	Intraoperative systemic therapy	Intraoperative systemic therapy was given during surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s).
6	Intraoperative systemic therapy with other therapy administered before or after surgery	Intraoperative systemic therapy was given during surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) with other systemic therapy administered before or after surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
7	Surgery both before and after systemic therapy	Systemic therapy was administered between two separate surgical procedures to the primary site; regional lymph nodes; surgery to other regional site(s), distant site(s), or distant lymph node(s).
9	Sequence unknown	Both surgery and systemic therapy were provided, but the sequence is unknown.

Examples:

Code	Reason
0	Due to other medical conditions surgery was not performed. The patient received palliative radiation therapy to alleviate pain.
2	Patient with prostate cancer received hormone therapy prior to a radical prostatectomy.
3	Patient underwent a colon resection followed by a 5-FU based chemotherapy regimen.
4	Patient with breast cancer receives pre-operative chemotherapy followed by post-operative Tamoxifen.
5	Patient with an intracranial primary undergoes surgery at which time a glial wafer is implanted into the resected cavity.
6	Patient with metastatic colon cancer receives intraoperative chemotherapy to the liver.
9	An unknown primary of the head and neck was treated with surgery and chemotherapy prior to admission, but the sequence is unknown. The patient enters for radiation therapy.

Subsequent Treatment

In RMCDS, click on the box “Subsequent Treatment” to enter the screen for recording subsequent treatment.

Record data in the Subsequent Treatment as documented for recording data for First Course of Treatment.

Outcomes

Date of Last Contact or Death

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Date Last Seen	1750	8	01/10, 01/11, 01/15	Required

Description

Records the date of last contact with the patient or the date of death.

Rationale

This information is used for patient follow-up and outcome studies.

Coding Instructions

- Record the last date on which the patient was known to be alive or the date of death.
    - Note that failure to find a patient on a list of deceased individuals does not constitute evidence that the patient is alive. *Vital Status* is not changed, but neither is the *Date of Last Contact or Death* changed. Unless more information is located, follow up of this patient has failed.
- If a patient has multiple primaries, all records should have the same date of last contact.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date of Last Contact or Death* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of Last Contact or Death* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *Date of Last Contact Flag* is used to explain why *Date of Last Contact or Death* is not a known date. See *Date of Last Contact Flag* for an illustration of the relationships among these items.

Date of Last Contact Flag

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1751	2	New 01/10	Required

Description

This flag explains why there is no appropriate value in the corresponding date field, *Date of Last Contact or Death*.

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

- Leave this item blank if *Date of Last Contact or Death* has a full or partial date recorded.
- Code 12 if the *Date of Last Contact or Death* cannot be determined.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Definition
12	A proper value is applicable but not known. This event occurred, but the date is unknown (for example, the date of last contact is unknown).
(Blank)	A valid date is provided in item *Date of Last Contact or Death*.

Date of Last Cancer (tumor) Status

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1772	8	New 01/18	Required by CoC

Description

This data item documents the date of last cancer (tumor status) of the patient's malignant or non-malignant tumor. Record in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable.

Rationale

This information is used for patient follow-up and outcomes studies.

Coding Instructions

- Record the last date on which the patient's cancer status (*Cancer Status*) was known to be updated.
- *Cancer Status* is based on information from the patient's physician or other official source such as a death certificate.
- The patient's *Cancer Status* should be changed only if new information is received from the patient's physician or other official source. If information is obtained from the patient, a family member, or other non-physician, then *Cancer Status* is not updated.
- *Cancer Status* changes if the patient has a recurrence or relapse.
- This data item differs from the *Date of Last Contact or Death* as it is a tumor-level data item. If a patient has multiple primaries, each primary could have a different *Date of Last Cancer (tumor) Status*.
- The *Date of Last Cancer (tumor) Status Flag* is used to explain why *Date of Last Cancer (tumor) Status* is not a known date. See *Date of Last Cancer (tumor) Status Flag* for an illustration of the relationships among these items.

Date of Last Cancer (tumor) Status Flag

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1773	2	New 01/18	Required by CoC

Description

This flag explains why there is no appropriate value in the corresponding date field, *Date of Last Cancer (tumor) Status*.

Rationale

This information is used for patient follow-up and outcomes studies. As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

- Leave this item blank if *Date of Last Cancer (tumor) Status* has a full or partial date recorded.
- Code 12 if the *Date of Last Cancer (tumor) Status* cannot be determined
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Label
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, the Date of Last Cancer (tumor) Status is unknown)
(blank)	A valid date value is provided in item *Date of Last Cancer (tumor) Status*

Vital Status

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Patient Status	1760	1	01/15	Required

Description

Records the vital status of the patient as the date entered in *Date of Last Contact or Death*.

Rationale

This information is used for patient follow-up and outcome studies.

Coding Instructions

- This item is collected during the follow-up process with *Date of Last Contact or Death*.
- Note that failure to find a patient on a list of deceased individuals does not constitute evidence that the patient is alive. *Vital Status* is not changed, but neither is the *Date of Last Contact or Death* changed. Unless more information is located, follow up of this patient has failed.
- If a patient has multiple primaries, all records should have the same vital status.

Code	Label
0	Dead
1	Alive

Examples:

Code	Reason
0	Death clearance information obtained from a state central registry confirms the death of the patient within the past year.
1	In response to a follow-up letter to patient's following physician, it is learned the patient is alive.

Cancer Status

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Tumor Status	1770	1	01/04, 01/18	Required

Description

Records the presence or absence of clinical evidence of the patient's malignant or non-malignant tumor as the *Date of Last Cancer (tumor) Status*.

Rationale

This information is used for patient follow-up and outcomes studies.

Coding Instructions

- *Cancer Status* is based on information from the patient's physician or other official source such as a death certificate.
- The patient's *Cancer Status* should be changed **only** if new information is received from the patient's physician or other official source. If information is obtained from the patient, a family member, or other non-physician, then cancer status is not updated.
- *Cancer Status* changes if the patient has a recurrence or relapse.
- If a patient has multiple primaries, each primary could have a different cancer status.

Code	Label
1	No evidence of this tumor
2	Evidence of this tumor
9	Unknown, indeterminate whether this tumor is present; not stated in patient record

Examples:

Code	Reason
1	Patient with hematopoietic disease who is in remission.
1	A patient is seen by the physician on February 2, 2004 with no evidence of this tumor. The patient did not return to the physician. The patient was then called by the registry on August 29, 2005. The *Date of Last Contact or Death* is updated, but the cancer status is not.
2	A patient with prostate cancer is diagnosed with bone metastasis in April 2003. The registrar finds an obituary documenting the patient's death in a nursing home in June 2003.

Letter Frequency

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	n/a	1		Required

Description

Code indicates how many times per year a follow-up inquiry will be generated for each patient.

Rationale

Follow-up for each patient should be conducted once per year. Some registries may opt to follow patients more frequently than once a year.

Coding Instructions

- RMCDS software program automatically defaults this field to a 3 (annual follow-up).
- No follow-up is generated when a code 0 appears in the *Vital Status* field (patient has died). A patient who has died does not need the letter frequency changed to a 9.
- Letter frequency should be coded to a 9 for cervix in-situ, basal and squamous cell skin cancers, and non-reportable benign tumors.

Code	Definition
1	Quarterly letters
2	Semi-annual letters
3	Annual letters
7	Patient residing out of the country; not required to follow these cases. Letter is not generated and case is eliminated from follow-up rate.
8	Special – generates annual letter but leaves physician's address blank.
9	Stops follow-up letters (same as 7 above, but these are counted in follow-up rate except as defined in rules, i.e., cervix in-situ, squamous and basal cell carcinoma of skin, and benign tumors.

Describe Place of Death

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Text – Describe Place of Death	n/a	25		Recommended

Description

Text to manually describe the facility, place, state, or country where the patient died and where the certificate of death is filed.

Rationale

This field also helps carry out death clearance. When a hospital reports a place of death, the information can help in death certificate matching. It can also signal an out-of-state death for which the death certificate is to be requested.

Coding Instructions

- Describe in detail the place where the patient died (e.g., Montana Nursing Home, City, MT)

Place of Death - State

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1942	3	01/15	Required

Description

State or Province where the patient died and where certificate of death is filed. This data item became part of the NAACCR transmission record effective with Volume II, Version 13 in order to include country and state for each geographic item and to use interoperable codes. It supplements the item *Place of Death--Country*. It replaces the use of *Place of Death*.

Rationale

This field also helps carry out death clearance. When a hospital reports a place of death, the information can help in death certificate matching. It can also signal an out-of-state death for which the death certificate is to be requested.

Coding Instructions

- See Appendix B for numeric and alphabetic lists of places and codes.

Place of Death - Country

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1944	3	01/15	Required

Description

Code for the country in which the patient died and where certificate of death is filed. If the patient has multiple tumors, all records should contain the same code. This data item became part of the NAACCR transmission record effective with Volume II, Version 13 in order to include country and state for each geographic item and to use interoperable codes. It supplements the item *Place of Death--State*. It replaces the use of *Place of Death*.

Rationale

Place of death is helpful for carrying out death clearance. When a hospital reports a place of death that is outside of the registry's country, the information can signal a death for which the death certificate will not be available from another state or through the NDI linkage.

Coding Instructions

- See Appendix B for numeric and alphabetic lists of places and codes.

Cause of Death

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Underlying Cause of Death	1910	4	01/15	Required

Description

Official cause of death as coded from the death certificate in valid ICD-10 codes. Central Registries obtain the official underlying cause of death from the Office of Vital Statistics.

Rationale

Cause of death is used for calculation of adjusted survival rates by the life table method. The adjustment corrects for deaths other than from the diagnosed cancer.

Coding Instructions

- Code 7777 when death occurred and underlying cause of death from the death certificate is unavailable.

Code	Definition
0000	Patient alive at last contact
7777	State death certificate not available

Autopsy

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1930	1		Optional

Description

Code indicating whether or not an autopsy was performed.

Rationale

This field indicates if a patient had autopsy at death. Autopsy at death may affect the diagnostic confirmation of the tumor.

Coding Instructions

- Code 0 if patient is alive.

Code	Definition
0	Not applicable; patient alive
1	Autopsy performed
2	No autopsy performed
9	Patient expired, unknown if autopsy performed

Physician - Primary Surgeon

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Surgeon	2480	5		Required

Description

Records the identification number of the physician who performed the most definitive surgical procedure.

Rationale

Administrative, physician, and service referral reports are based on this data item.

Coding Instructions

- The registry assigns a unique number to the primary surgeon. Many registries use the physician's state medical license number.
- Contact the MCTR to assign or obtain new numbers.
- Once the registry has designated a primary surgeon for the patient, the information should not be changed or updated even if the patient receives care from another surgeon.
- Do not update this data item.

Code	Definition
(fill spaces)	The identification number may include numbers and letters. *Note:* If the patient did not have surgery, use the code for the surgeon who performed any surgery or did a surgical consultation.
00000	If the patient had no surgery and no surgical consultation.
88888	If the physician who performed a surgical procedure was not a surgeon, i.e., radiation oncologist, diagnostic radiologist, or general practitioner.
99999	The primary surgeon is unknown or an identification number is not assigned.

Physician - Follow-Up

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Following Physician	2470	5		Required

Description

Records the identification number of the person currently responsible for the patient's medical care.

Rationale

The following physician is the first contact for obtaining information on a patient's status and subsequent treatment. This information may be used for outcome studies.

Coding Instructions

- The registry assigns a unique number for the following physician. Many registries use the physician's state medical license number.
- Contact the MCTR to assign or obtain new numbers.
- Change this data item when patient follow-up becomes the responsibility of another physician.

Code	Definition
(fill spaces)	The identification number may include numbers and letters.
99999	The following physician is unknown or an identification number is not assigned.

Physician - Managing

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Managing Physician	2460	5		Required

Description

Records the identification number of another physician involved in the care of the patient.

Rationale

Administrative, physician, and service referral reports are based on this data item. It can also be used for follow-up purposes.

Coding Instructions

- The registry assigns a unique number to this data item. Many registries use the physician's state medical license number.
- Contact the MCTR to assign or obtain new numbers.

Code	Definition
(fill spaces)	The identification number may include numbers and letters.
99999	The following physician is unknown or an identification number is not assigned.

Physician - 3

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2490	5	01/04, 01/10	Required

Description

Records the identification number of another physician involved in the care of the patient. The Commission on Cancer recommends that this data item identify the physician who performed the most definitive radiation therapy.

Rationale

Administrative, physician, and service referral reports are based on this data item. It can also be used for follow-up purposes.

Coding Instructions

- The registry assigns a unique number to this data item. Many registries use the physician's state medical license number.
- If the registry has a designated primary radiation oncologist for this patient, the information in this data item should not be changed or updated even if the patient receives care from another radiation oncologist.
- Contact the MCTR to assign or obtain new numbers.

Code	Definition
(fill spaces)	The identification number may include numbers and letters.
00000	None; no additional physician.
99999	Physician is unknown or an identification number is not assigned.

Physician - 4

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2500	5	01/04, 01/10	Required

Description

Records the identification number of another physician involved in the care of the patient. The Commission on Cancer recommends that this data item identify the physician who gives the most definitive systemic therapy.

Rationale

Administrative, physician, and service referral reports are based on this data item. It can also be used for follow-up purposes.

Coding Instructions

- The registry assigns a unique number to this data item. Many registries use the physician's state medical license number.
- If the registry has designated a primary medical oncologist for the patient, the information in this data item should not be changed or updated even if the patient receives care from another medical oncologist.
- Contact the MCTR to assign or obtain new numbers.

Code	Definition
(fill spaces)	The identification number may include numbers and letters.
00000	None; no additional physician.
99999	Physician is unknown or an identification number is not assigned.

NPI-Primary Surgeon

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2485	10	01/09, 01/15	Recommended

Description

Identifies the physician who performed the most definitive surgical procedure.

Rationale

Administrative, physician, and service referral reports are based on this data item.

NPI-Primary Surgeon is the NPI equivalent of *Primary Surgeon*. Both are required during a period of transition.

Coding Instructions

- Record the 10-digit NPI for the physician who performed the most definitive surgical procedure.
- Check with the billing or health information departments to determine the physician's NPI or search at https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.
- NPI should be recorded as available for cases diagnosed during 2007 and is required to be recorded for all cases diagnosed January 1, 2008, and later.
- NPI may be blank for cases diagnosed on or before December 31, 2006
- Do not update this item. Once the registry has designated a primary surgeon for the patient, the information should not be changed or updated even if the patient receives care from another surgeon.

Code	Definition
(fill spaces)	10-digit NPI number for the primary surgeon.
(leave blank)	The patient did not have surgery; NPI for the primary surgeon is unknown or not available; or the physician who performed the surgical procedure was not a surgeon (i.e., general practitioner)

NPI-Following Physician

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2475	10	01/09, 01/15	Recommended

Description

Records the NPI for the physician currently responsible for the patient's medical care.

Rationale

The following physician is the first contact for obtaining information on a patient's status and subsequent treatment. This information may be used for outcomes studies.

NPI-Following Physician is the NPI equivalent of *Following Physician*. Both are required during a period of transition.

Coding Instructions

- Record the 10-digit NPI for the physician currently responsible for the patient's medical care.
- Check with the billing or health information departments to determine the physician's NPI or search at https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.
- Change this data item when patient follow-up becomes the responsibility of another physician.
- NPI should be recorded as available for cases diagnosed during 2007 and is required to be recorded for all cases diagnosed January 1, 2008, and later.
- NPI may be blank for cases diagnosed on or before December 31, 2006.

Code	Definition
(fill spaces)	10-digit NPI number for the following physician.
(leave blank)	NPI for the following physician is unknown or not available.

NPI-Managing Physician

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2465	10	01/09, 01/15	Recommended

Description

Identifies the physician who is responsible for the overall management of the patient during diagnosis and/or treatment of this cancer.

Rationale

The managing physician is responsible for the patient's work-up, plans the treatment, and directs the delivery of patient care. In most case, the managing physician is responsible for AJCC staging.

NPI-Managing Physician is the NPI equivalent of *Managing Physician*. Both are required during a period of transition.

Coding Instructions

- Record the 10-digit NPI for the physician responsible for managing the patient's care.
- Check with the billing or health information departments to determine the physician's NPI or search at https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.
- NPI should be recorded as available for cases diagnosed during 2007 and is required to be recorded for all cases diagnosed January 1, 2008, and later.
- NPI may be blank for cases diagnosed on or before December 31, 2006.
- Do not update this item. Once the registry has designated a managing physician for the patient, this item should not be changed even if a different managing physician is assigned.

Code	Definition
(fill spaces)	10-digit NPI number for the managing physician.
(leave blank)	NPI for the managing physician is unknown or not available.

NPI-Physician 3

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Radiation Oncologist	2495	10	01/09, 01/10, 01/15	Recommended

Description

Records the NPI for a physician involved in the care of the patient. The Commission on Cancer recommends that this item identify the physician who performed the most definitive radiation therapy.

Rationale

Administrative, physician, and service referral reports are based on this data item. It also can be used for follow-up purposes.

NPI-Physician 3 is the NPI equivalent of *Physician-3*. Both are required during a period of transition.

Coding Instructions

- Record the 10-digit NPI for the physician.
- Check with the billing or health information departments to determine the physician's NPI or search at https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.
- Do not update this item. If the registry has designated a primary radiation oncologist for the patient, the information in this data item should not be changed or updated even if the patient receives care from another radiation oncologist.
- NPI should be recorded as available for cases diagnosed during 2007 and is required to be recorded for all cases diagnosed January 1, 2008, and later.
- NPI may be blank for cases diagnosed on or before December 31, 2006.

Code	Definition
(fill spaces)	10-digit NPI number for the physician.
(leave blank)	NPI for the primary radiation oncologist is unknown or not available.

NPI-Physician 4

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2505	10	01/09, 01/10, 01/15	Recommended

Description

Records the NPI for a physician involved in the care of the patient. The Commission on Cancer recommends that this data item identify the physician who gives the most definitive systemic therapy.

Rationale

Administrative, physician, and service referral reports are based on this data item. It also can be used for follow-up purposes.

NPI-Physician 4 is the NPI equivalent of *Physician-4*. Both are required during a period of transition.

Coding Instructions

- Record the 10-digit NPI for the physician.
- Check with the billing or health information departments to determine the physician's NPI or search at https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.
- Do not update this item. If the registry has designated a primary medical oncologist for the patient, the information in this data item should not be changed or updated even if the patient receives care from another medical oncologist.
- NPI should be recorded as available for cases diagnosed during 2007 and is required to be recorded for all cases diagnosed January 1, 2008, and later.
- NPI may be blank for cases diagnosed on or before December 31, 2006.

Code	Definition
(fill spaces)	10-digit NPI number for the physician.
(leave blank)	NPI for the primary medical oncologist is unknown or not available.

Follow-up Source

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1790	1	01/15	Required

Description

Records the source from which the latest follow-up information was obtained.

Rationale

This data item is used by registries to identify the most recent follow-up source.

Coding Instructions

Code	Label	Definition
0	Reported hospitalization	Hospitalization at another institution/hospital or first admission to the reporting facility.
1	Readmission	Hospitalization or outpatient visit at the reporting facility.
2	Physician	Information from a physician.
3	Patient	Direct contact with the patient.
4	Depart of Motor Vehicles	The Department of Motor Vehicles confirmed the patient has a current license.
5	Medicare/Medicaid file	The Medicare or Medicaid office confirmed the patient is alive.
7	Death Certificate	Information from the death certificate only.
8	Other	Friends, relatives, employers, other registries, or any sources not covered by other codes.
9	Unknown; not stated in patient record	The follow-up source is unknown or not stated in patient record.

Next Follow-up Source

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1800	1	01/10	Required by CoC

Description

Identifies the method planned for the next follow-up.

Rationale

This data item is used by registries to identify the method planned for the next follow-up.

Coding Instructions

- Registries are not required to follow foreign residents.
- As of January 1, 2006, the CoC does not require Class of Case 00 cases to be followed. The MCTR continues to request follow-up.

Code	Definition
0	Chart requisition
1	Physician letter
2	Contact letter
3	Phone call
4	Other hospital contact
5	Other, NOS
8	Foreign residents (not followed)
9	Not followed. Other cases for which follow-up is not required.

Recurrence Date - 1st

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1860	88	06/05, 01/10, 01/11, 01/12	Required

Description

Records the date of the first recurrence.

Rationale

This data item is used to measure the efficacy of the first course of treatment.

Coding Instructions

- Record the date the physician diagnoses the first progression, metastasis, or recurrence of disease after a disease-free period.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Recurrence Date – 1st* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Recurrence Date – 1st* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *Date of Recurrence Date – 1st Flag* is used to explain why *Recurrence Date – 1st* is not a known date. See *Date of Recurrence Date – 1st Flag* for an illustration of the relationships among these items.

Recurrence Date – 1st Flag

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1861	2	New 01/10	Required

Description

This flag explains why there is no appropriate value in the corresponding date field, *Recurrence Date – 1st*.

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

- Leave this item blank if *Recurrence Date – 1st* has a full or partial date recorded.
- Code 12 if the *Recurrence Date – 1st* cannot be determined, but the patient did have recurrence following a disease-free period.
- Code 10 if it is unknown whether the patient had recurrence.
- Code 11 if the patient was never disease free, became disease free but had no recurrence, or was initially diagnosed at autopsy.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Definition
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if the patient was ever disease-free or had a first recurrence).
11	No proper value is applicable in this context (for example, patient became disease-free after treatment and never had a recurrence; or patient was never disease-free; autopsy only case).
12	A proper value is applicable but not known (for example, there was a recurrence, but the date is unknown).
(Blank)	A valid date is provided in item *Recurrence Date – 1st*.

Recurrence Type - 1st

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1880	2	01/10, 01/11, 01/15, 01/18	Required

Description

Identifies the type of first recurrence after a period of documented disease-free intermission or remission.

Rationale

This item is used to evaluate treatment efficacy and as a long-term prognostic factor.

Coding Instructions

- Code the type of first recurrence. First recurrence may occur well after completion of the first course of treatment or after subsequent treatment.
- Check the SEER *Multiple Primary and Histology Coding Rules Manual* or the Solid Tumor Rules to determine which subsequent tumors should be coded as recurrences.
- If the patient has never been disease-free (code 70), continue to track for disease-free status which may occur after subsequent treatment has been completed.
- If the patient is disease-free (code 00), continue to track until a recurrence occurs. First recurrence may occur well after completion of the first course of treatment.
- Once a recurrence has been recorded (code 04-62 or 88), subsequent recurrences are NOT to be recorded.
- Codes 00 through 70 are hierarchical; record the highest-numbered applicable response, with the following limits. The first time a patient converts from disease status (70) to disease free, change the code to 00. Then the first time a patient converts from 00 to a recurrence, then record the proper code for the recurrence. No further changes (other than corrections) should be made.
- If the tumor was originally diagnosed as in-situ, code recurrence to 06, 16, 17, 26, 27, 36, or 46 only. Do not use those codes for any other tumors. Codes 00, 88, or 99 may apply to any tumor.
- Codes 51-59 (organ or organ system of distant recurrence) apply only if all first occurrences were in a single category. There may be multiple metastases (or "seeding") within the distant location.
- Code lymphomas or leukemias that are in remission 00. If the patient relapses, then code recurrence as 59. If one of these is controlled by drugs (for example, Gleevec for CML), the patient is in remission.
- If there is more than one primary tumor and the physician is unable to decide which has recurred, code the recurrent disease for each tumor. If the recurrent primary is identified later, revise the codes as appropriate.

Code	Definition
00	Patient became disease-free after treatment and has not had a recurrence.
04	In-situ recurrence of an invasive tumor.
06	In-situ recurrence of an in-situ tumor.
10	Local recurrence, and there is insufficient information available to code 13-17. Local recurrence includes recurrence confined to the remnant of the organ of origin, to the organ of origin, to the anastomosis, or to scar tissue where the organ previously existed.
13	Local recurrence of an invasive tumor.
14	Trocar recurrence of an invasive tumor. Includes recurrence in the trocar path or entrance site following prior surgery.
15	Both local and trocar recurrence of an invasive tumor (both 13 and 14).
16	Local recurrence of an in-situ tumor, NOS
17	Both local and trocar recurrence of an in-situ tumor.
20	Regional recurrence, and there is insufficient information available to code 21-27.
21	Recurrence of an invasive tumor in adjacent tissue or organ(s) only.
22	Recurrence of an invasive tumor in regional lymph nodes only.
25	Recurrence of an invasive tumor in adjacent tissue or organ(s) and in regional lymph nodes (both 21 and 22) at the same time.

Code	Definition
26	Regional recurrence of an in-situ tumor, NOS.
27	Recurrence of an in-situ tumor in adjacent tissue or organ(s) and in regional lymph nodes at the same time.
30	Both regional recurrence of an invasive tumor in adjacent tissue or organ(s) and/or regional lymph nodes (20-25) **and** local and/or trocar recurrence (10, 13, 14, or 15).
36	Both regional recurrence of an in-situ tumor in adjacent tissue or organ(s) and/or regional lymph nodes (26 or 27) **and** local and/or trocar recurrence (16 or 17).
40	Distant recurrence, to a site not listed in 46-62 or there is insufficient information available to code 46-62.
46	Distant recurrence of an in-situ tumor.
51	Distant recurrence of an invasive tumor in the peritoneum only. Peritoneum includes peritoneal surfaces of all structures within the abdominal cavity and/or positive ascitic fluid.
52	Distant recurrence of an invasive tumor in the lung only. Lung includes the visceral pleura.
53	Distant recurrence of an invasive tumor in the pleura only. Pleura includes the pleural surface of all structures within the thoracic cavity and/or positive pleural fluid.
54	Distant recurrence of an invasive tumor in the liver only.
55	Distant recurrence of an invasive tumor in bone only. This includes bones other than the primary site.
56	Distant recurrence of an invasive tumor in the CNS only. This includes the brain and spinal cord, but **not** the external eye.
57	Distant recurrence of an invasive tumor in the skin only. This includes skin other than the primary site.
58	Distant recurrence of an invasive tumor in lymph node only. Refer to the staging scheme for a description of lymph nodes that are distant for a particular site.
59	Distant systemic recurrence of an invasive tumor only. This includes lymphoma, leukemia, bone marrow metastasis, carcinomatosis, generalized disease.
60	Distant recurrence of an invasive tumor in a single distant site (51-58) **and** local, trocar and/or regional recurrence (10-15, 20-25, or 30).
62	Distant recurrence of an invasive tumor in multiple sites (recurrences that can be coded to more than one category 51-59).
70	Since diagnosis, patient has never been disease-free. This includes cases with distant metastasis at diagnosis, systemic disease, unknown primary, or minimal disease that is not treated.
88	Disease has recurred, but the type of recurrence is unknown.
99	It is unknown whether the disease has recurred or if the patient was ever disease-free.

Examples:

Code	Reason
52	Distant recurrence in the lung.
62	Recurrence in liver, lung and bone.

Recurrence Distant Site 1

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1871	1		Required

Description

Identifies the distant site or sites in which the tumor has recurred.

Rationale

This item is used to evaluate treatment efficacy and as a long-term prognostic factor.

Coding Instructions

- When carcinomatosis is present, all three fields – Recurrence Distant Site 1, 2, and 3 are coded 9.

Code	Definition
0	None or none known
1	Peritoneum
2	Lung
3	Pleura
4	Liver
5	Bone
6	Central nervous system
7	Skin
8	Lymph nodes (distant)
9	Other, generalized, NOS, carcinomatosis

Recurrence Distant Site 2

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1872	1		Required

Description

Identifies the distant site or sites in which the tumor has recurred.

Rationale

This item is used to evaluate treatment efficacy and as a long-term prognostic factor.

Coding Instructions

- When carcinomatosis is present, all three fields – Recurrence Distant Site 1, 2, and 3 are coded 9.

Code	Definition
0	None or none known
1	Peritoneum
2	Lung
3	Pleura
4	Liver
5	Bone
6	Central nervous system
7	Skin
8	Lymph nodes (distant)
9	Other, generalized, NOS, carcinomatosis

Recurrence Distant Site 3

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1873	1		Required

Description

Identifies the distant site or sites in which the tumor has recurred.

Rationale

This item is used to evaluate treatment efficacy and as a long-term prognostic factor.

Coding Instructions

- When carcinomatosis is present, all three fields – Recurrence Distant Site 1, 2, and 3 are coded 9.

Code	Definition
0	None or none known
1	Peritoneum
2	Lung
3	Pleura
4	Liver
5	Bone
6	Central nervous system
7	Skin
8	Lymph nodes (distant)
9	Other, generalized, NOS, carcinomatosis

Follow-Up Contact - Name

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2394	60	01/10	Required

Description

Identifies a contact person available for contact if the patient is unavailable. First and last name, in natural order, of a person, other than the patient or a physician, who can be contacted to obtain follow-up information for the patient.

Rationale

Sometimes hospital registries carry out follow-up by contact the patient and other contacts by a letter for a phone call to ascertain their vital status. When a patient's current address is unknown or the patient is for some reason not to be contacted (e.g., patient is a minor child), the most current name, address and phone number of another contact, such as a relative or neighbor are needed. This information may also be useful for conducting epidemiological or research studies.

Coding Instructions

- Record the name of a contact person other than the patient's spouse or physician.

Follow-Up Contact - Relation

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
		25		Required

Description

Identifies the contact person's relationship to the patient.

Rationale

Sometimes hospital registries carry out follow-up by contact the patient and other contacts by a letter for a phone call to ascertain their vital status. When a patient's current address is unknown or the patient is for some reason not to be contacted (e.g., patient is a minor child), the most current name, address and phone number of another contact, such as a relative or neighbor are needed. This information may also be useful for conducting epidemiological or research studies.

Coding Instructions

- Record the relationship of the contact person (e.g., son, daughter, friend, mother, father, neighbor).

Follow-Up Contact - No & Street

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2392	60	01/10	Required

Description

Identifies the street address of the contact person.

Rationale

Sometimes hospital registries carry out follow-up by contact the patient and other contacts by a letter for a phone call to ascertain their vital status. When a patient's current address is unknown or the patient is for some reason not to be contacted (e.g., patient is a minor child), the most current name, address and phone number of another contact, such as a relative or neighbor are needed. This information may also be useful for conducting epidemiological or research studies.

Coding Instructions

- Record the number and street address or the rural mailing address of the contact person's usual residence.
- The address should be fully spelled out with standardized use of abbreviations and punctuation per U.S. Postal Service postal addressing standards. The USPS Postal Addressing Standards, Pub 28, November 2000 can be found on the Internet at *http://pe.usps.gov/cpim/ftp/pubs/pub28/pub28.pdf*.
- Abbreviations should be limited to those recognized by the Postal Service standard abbreviations. They include, but are not limited to:

  - AVE (avenue)
  - BLVD (boulevard)
  - CIR (circle)
  - CT (court)
  - DR (drive)
  - PLZ (plaza)
  - PARK (park)
  - PKWY (parkway)
  - RD (road)
  - SQ (square)
  - ST (street)
  - APT (apartment)
  - BLDG (building)
  - FL (floor)
  - STE (suite)
  - UNIT (unit)
  - RM (room)
  - DEPT (department)
  - N (north)
  - NE (northeast)
  - NW (northwest)
  - S (south)
  - SE (southeast)
  - SW (southwest)
  - E (east)
  - W (west)

  A complete list of recognized street abbreviations is provided in *Appendix C of USPS Pub 28*.

- Punctuation marks should be avoided, except when punctuation is necessary to convey the meaning. Punctuation normally is limited to periods when the period carries meaning (e.g., 39.2 RD), slashes for fractional addresses (e.g., 101 1/2 Main St), and hyphens when the hyphen carries meaning (e.g., 289-01 Montgomery Ave). Use of the pound sign (#) to designate address units should be avoided whenever possible. The preferred notation is as follows: 102 Main St Apt 101. If a pound sign is used, there must be a space between the pound sign and the secondary number (e.g., 425 Flower Blvd # 72).
- See "Residency Rules" on page 48 for further instructions.

Code	Definition
103 FIRST AVE SW APT 102	The use of capital letters is preferred by the USPS; use recognized USPS standardized abbreviations; do not use punctuation unless absolutely necessary to clarify an address; leave blanks between numbers and words.
UNKNOWN	If the contact person's address is unknown, enter UNKNOWN.

Follow-Up Contact - Supplemental

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2393	60	01/10	Required

Description

This data item provides the ability to store additional address information such as the name of a place or facility, a nursing home, or the name of an apartment complex. It can be used to generate a follow-up inquiry and must correspond to the other fields in the follow-up contact address. If the patient has multiple tumors, *Follow-Up Contact – Supplemental* should be the same.

Rationale

Sometimes hospital registries carry out follow-up by contact the patient and other contacts by a letter for a phone call to ascertain their vital status. When a patient's current address is unknown or the patient is for some reason not to be contacted (e.g., patient is a minor child), the most current name, address and phone number of another contact, such as a relative or neighbor are needed. This information may also be useful for conducting epidemiological or research studies.

Coding Instructions

- Record the place or facility (i.e., a nursing home or name of an apartment complex) of the patient's usual residence when the tumor was diagnosed.
- See "Residency Rules" on page 48 for further instructions.

Code	Definition
VALLEYVIEW NURSING HOME	The use of capital letters is preferred by the USPS; use recognized USPS standardized abbreviations; do not use punctuation unless absolutely necessary to clarify an address; leave blanks between numbers and words.
(leave blank)	If this address space is not needed, then leave blank.

Follow-Up Contact - City

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1842	50	01/10	Required

Description

Name of the city of the follow-up contact's current usual residence. If the patient has multiple tumors, the follow-up contact city of residence should be the same for all tumors.

Rationale

Sometimes hospital registries carry out follow-up by contact the patient and other contacts by a letter for a phone call to ascertain their vital status. When a patient's current address is unknown or the patient is for some reason not to be contacted (e.g., patient is a minor child), the most current name, address and phone number of another contact, such as a relative or neighbor are needed. This information may also be useful for conducting epidemiological or research studies.

Coding Instructions

- Record the name of the city or town used in the contact person's mailing address.
- See "Residency Rules" in on page 48 for further instructions.

Code	Definition
CITY NAME	Do not use punctuation, special characters, or numbers. The use of capital letters is preferred by the USPS; it also guarantees consistent results in queries and reporting. Abbreviate where necessary.

Follow-Up Contact - State

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1844	2		Required

Description

USPS abbreviation for the state (including U.S. territories, commonwealths, or possessions), or Canada Post abbreviation for the Canadian province/territory of the follow-up contact's current usual residence. If the patient has multiple tumors, the follow-up contact state should be the same for all tumors.

Rationale

Sometimes hospital registries carry out follow-up by contact the patient and other contacts by a letter for a phone call to ascertain their vital status. When a patient's current address is unknown or the patient is for some reason not to be contacted (e.g., patient is a minor child), the most current name, address and phone number of another contact, such as a relative or neighbor are needed. This information may also be useful for conducting epidemiological or research studies.

Coding Instructions

- U.S. Postal Service abbreviation for the state, territory, commonwealth, U.S. possession, or Canadian province/territory in which the contact person resides.
- If the contact person is a foreign resident, then code either XX or YY depending on the circumstance.

Code	Definition
MT	If the state in which the contact person resides is Montana, then use the USPS code for the state of Montana.
XX	Resident of country other than the United States (including its territories, commonwealths, or possessions) or Canada, and country is known
YY	Resident of country other than the United States (including its territories, commonwealths, or possessions) or Canada, and country is unknown
ZZ	Resident of the United States, NOS (including its territories, commonwealths, or possessions); Canada, NOS; residence unknown

Common abbreviations (refer to the Zip Code directory for further listings)

State	Abbrev	State	Abbrev	State	Abbrev
Alabama	AL	Massachusetts	MA	Tennessee	TN
Alaska	AK	Michigan	MI	Texas	TX
Arizona	AZ	Minnesota	MN	Utah	UT
Arkansas	AR	Mississippi	MS	Vermont	VT
California	CA	Missouri	MO	Virginia	VA
Colorado	CO	Montana	MT	Washington	WA
Connecticut	CT	Nebraska	NE	West Virginia	VW
Delaware	DE	Nevada	NV	Wisconsin	WI
District of Columbia	DC	New Hampshire	NH	Wyoming	WY
Florida	FL	New Jersey	NJ	United States	US
Georgia	GA	New Mexico	NM	American Samoa	AS
Hawaii	HI	New York	NY	Guam	GU
Idaho	ID	North Carolina	NC	Puerto Rico	PR
Illinois	IL	North Dakota	ND	Virgin Islands	VI
Indiana	IN	Ohio	OH	Palau	PW
Iowa	IA	Oklahoma	OK	Micronesia	FM
Kansas	KS	Oregon	OR	Marshall Islands	MH
Kentucky	KY	Pennsylvania	PA	Outlying Islands	UM
Louisiana	LA	Rhode Island	RI	APO/FPO Armed Services America	AA
Maine	ME	South Carolina	SC	APO/FPO Armed Services Europe	AE
Maryland	MD	South Dakota	SD	APO/FPO Armed Services Pacific	AP

The following are abbreviations for Canadian provinces and territories:

Province/Territory	Abbrev	Province/Territory	Abbrev
Alberta	AB	Nunavut	NU
British Columbia	BC	Ontario	ON
Manitoba	MB	Prince Edward Island	PE
New Brunswick	NB	Quebec	QC
Newfoundland and Labrador	NF	Saskatchewan	SK
Northwest Territories	NT	Yukon	YT
Nova Scotia	NS	Canada	CD

Follow-Up Contact – Zip Code

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1846	9		Required

Description

Postal code for the address of the follow-up contact's current usual residence. If the patient has multiple tumors, the follow-up contact postal codes should be the same for all tumors. For U.S. residents, use either the 5-digit or the extended 9-digit ZIP code. Blanks follow the 5-digit code. For Canadian residents, use the 6-character, alphanumeric postal code. Blanks follow the 6-character code. When available, enter postal code for other countries.

Rationale

Sometimes hospital registries carry out follow-up by contact the patient and other contacts by a letter for a phone call to ascertain their vital status. When a patient's current address is unknown or the patient is for some reason not to be contacted (e.g., patient is a minor child), the most current name, address and phone number of another contact, such as a relative or neighbor are needed. This information may also be useful for conducting epidemiological or research studies.

Coding Instructions

- For U.S. residents, record the contact person's nine-digit extended postal code.
- For Canadian residents, record the six-character postal code.
- When available, record the postal code for other countries.
- See "Residency Rules" on page 48 for further instructions.

Code	Definition
(fill spaces)	The nine-digit U.S. extended postal code. Do not record hyphens.
59666_ _ _ _	When the nine-digit extended U.S. Zip Code is not available, record the five-digit postal code, left justified, followed by four blanks.
M6G2S8_ _ _	The six-character Canadian postal code left justified, followed by three blanks.
888888888	Resident of country other than the United States (including its possessions, etc.) or Canada **and** postal code unknown.
999999999	Resident of the United States (including its possessions, etc.) or Canada, **and** postal code is unknown.

Follow-Up Contact - Phone Num

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	n/a	10		Required

Description

Identifies the phone number of the contact person.

Rationale

Sometimes hospital registries carry out follow-up by contact the patient and other contacts by a letter for a phone call to ascertain their vital status. When a patient's current address is unknown or the patient is for some reason not to be contacted (e.g., patient is a minor child), the most current name, address and phone number of another contact, such as a relative or neighbor are needed. This information may also be useful for conducting epidemiological or research studies.

Coding Instructions

- Record the phone number of the contact person with the area code.

Follow-Up Contact - Phone Type

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	n/a	10		Required

Description

Identifies who the phone number belongs to.

Rationale

This data item may be used to identify who the patient's phone belongs to.

Coding Instructions

- Record who the phone number belongs to.

Type	Description
0	Parent
1	Patient
2	Son or daughter
3	Relative, NOS
9	Unknown whose phone number

Follow-Up Contact - Country

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1847	10	New 01/13	Required

Description

Identifies the country for the follow-up contact. The codes are based on International Organization for Standardization (ISO) 3166-1 alpha-3 country codes, with some custom codes. If the patient has multiple tumors, the country of follow-up contact residence should be the same for all tumors.

Rationale

The country code is part of the patient's demographic data and has multiple uses. It may be useful for understanding risk factors, assessment of patient prognosis, and chances for survival.

Coding Instructions

- This item corresponds to *Follow-up Contact - Country*.
- See Appendix B for a list of country codes and their respective state codes.
- This item was first defined for use in 2013; cases diagnosed before that date should be converted automatically by the registry's software.

Examples:

Code	Definition
USA	United States
CAN	Canada
ZZU	Place of birth is unknown, not mentioned in patient record

RMCDS Flag Fields

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	n/a	2		Optional

Description

RMCDS flags are used to flag field errors or inconsistencies that have been detected upon computer edit checks which have reviewed and determined to be correct.

Rationale

Edits in the RMCDS software check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the edits.

Coding Instructions

- Leave blank if the RMCDS edit program does not generate an error message.
- Leave blank and correct the code for any item documented for the edit if, on review, it is discovered to be incorrect.

Code	Description	
10	Age error Date of birth error Age inconsistency error	
20	Reporting source – patient status error Patient status – death status error Invalid autopsy code	Invalid patient status Invalid tumor status
30	Bad site number error Site not in book Bad histology number error Histology not in book Site – sex error In-situ with invalid site Illegal in-situ – histology Possible site – age error	Laterality error Stage histology error Possible dup tumors Possible site – histology – age error AJCC stage with invalid histology AJCC stage with invalid site AJCC stage with invalid site – histology Ste histology inconsistency error
40	Site histology inconsistency	
50	Any inconsistency (I)	
60	Follow-up hospital error Class of case – autopsy only error Bad hospital number error Unknown hospital number error Accession # & CTR # different Bad hospital date Class of case error Dx 2 yr < admit	Class of case autopsy only, but not dead Class of case autopsy but no autopsy code Class of case should not have Rx Chart number but no hospital Hospital date but no hospital Class of case but no hospital Duplicate hospital entry
01	Will force the case to appear on the error list	
02	Any warning (W)	
03	Any error (E)	
04	Any ACoS error	
09	Any error warning or inconsistency (no check will be done on the record)	

Override Acsn/Class/Seq

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1985	1	01/04, 01/09, 01/10	Required by CoC

Description

Used with the EDITS software to override the edit *Accession Number, Class of Case, Seq Number (CoC)*.

Rationale

Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

EDITS Use

The edit, *Accession Number, Class of Case, Seq Number (CoC)*, checks the following:

- If the case is the only case or the first of multiple cases diagnosed at the facility (*Sequence Number* = 00, 01, 60, or 61, and *Class of Case* = 00, 10, 12, 13, or 14), then the first 4 characters of the *Accession Number* must equal the year of the *Date of First Contact*.
- If the case is first diagnosed at autopsy (Class of Case = 38), and the case is the only case or the first of multiple cases for a patient (Sequence Number = 00, 01, 60, or 61), then the first 4 characters of the *Accession Number* must equal the year of the *Date of Last Contact or Death* AND must equal the year of the *Date of First Contact*.
- If the case is first diagnosed at autopsy (Class of Case = 38), and the case is the second or more case for a patient (*Sequence Number* is greater than 01 or greater than 61), then the year of the *Date of First Contact* must equal the year of *Date of Last Contact or Death*.

There are some exceptions to the above rules. *Override Acsn/Class/Seq* may be used to override the edit when the circumstances fit the following situation or one similar to it:

- The case may be the only or the first of multiple malignant cases for a patient (*Sequence Number* = 00 or 01), but there is an earlier benign case (with an earlier year of the *Date of First Contact*) for which the *Accession Number* applies.

Coding Instructions

- Leave blank if the EDITS program does not generate an error message for the edit *Accession Number, Class of Case, Seq Number (CoC)*.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if a review of all items in the error or warning message confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed and confirmed as reported.

Override HospSeq/DxConf

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1986	1	01/04, 01/09	Required by CoC

Description

Used with the EDITS software to override the edit *Diagnostic Confirm, Seq Num – Hosp (CoC)*.

Rationale

Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

EDITS Use

The edit, *Diagnostic Confirm, Seq Num - Hosp (CoC)*, checks the following:

- If any case is one of multiple primaries and is not microscopically confirmed or positive lab test/marker study, i.e., *Diagnostic Confirmation* > 5 and *Sequence Number* > 00 (more than one primary), review is required.
- If *Primary Site* specifies an ill-defined or unknown primary (C76.0-C76.8, C80.9), no further checking is done. If *Sequence Number* is in the range of 60 – 88, this edit is skipped.

It is important to verify that the non-microscopically-confirmed case is indeed a separate primary from any others that may have been reported. This edit forces review of multiple primary cancers when one of the primaries is coded to a site other than ill-defined or unknown and is not microscopically confirmed or confirmed by a positive lab test/marker study.

- If this edit failed and the suspect case is confirmed accurate as coded, and the number of primaries is correct, set the *Override HospSeq/DxConf* to 1. Do not set the override flag on the patient's other primary cancers.
- However, if it turns out that the non-microscopically-confirmed cancer is considered a manifestation of one of the patient's other cancers, delete the non-microscopically-confirmed case. Check the sequence numbers of remaining cases, correcting them if necessary. Also check for other data items on the remaining cases that may need to be changed as a result of the corrections, such as stage and treatment.

Coding Instructions

- Leave blank if the EDITS program does not generate an error message for the edit *Diagnostic Confirm, Seq Num – Hosp (CoC)*.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if a review of all items in the error or warning message confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed and confirmed as reported.

Override COC - Site/Type

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1987	1	01/04, 01/09	Required by CoC

Description

Used with the EDITS software to override the edit *Primary Site, Morphology – Type ICDO2 (CoC)* and/or the edit *Primary Site, Morphology – Type ICDO3 (CoC)*.

Rationale

Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

EDITS Use

There are multiple versions of the edits of the type, *Primary Site, Morphology – Type*, which check for "usual" combinations of site and ICD-O-2 or ICD-O-3 histology. The SEER version of the edit is more restrictive than the CoC edit, and thus uses a different override flag. The CoC version of the edit will accept Override CoC Site/Type or Override Site/Type as equivalent.

- The Site/Histology Validation List (available on the SEER Website) contains those histologies commonly found in the specified primary site. Histologies that occur only rarely or never are not included. These edits require review of all combinations *not* listed.
- Since basal and squamous cell carcinomas of non-genital skin sites are not reportable to SEER, these site/histology combinations do not appear on the SEER validation list. For the CoC version of the edit, if *Primary Site* is in the range C44.0-C44.9 (skin), and the ICD-O-3 histology is in the range 8000-8005 (neoplasms, malignant, NOS), 8010-8046 (epithelial carcinomas), 8050-8084 (papillary and squamous cell carcinomas), or 8090-8110 (basal cell carcinomas), no further editing is done. No override is necessary for these cases in the CoC version of the edit.

Review of these cases requires investigating whether the combination is biologically implausible or there are cancer registry coding conventions that would dictate different codes for the diagnosis. Review of these rare combinations often results in changes to the primary site and/or morphology, rather than a decision that the combination is correct.

Coding Instructions

- Leave blank if the EDITS program does not generate an error message for the edits of the type *Primary Site, Morphology – Type*.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if a review of all items in the error or warning message confirms they are correct and coded in conformance with coding rules.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed and confirmed as reported.

Override HospSeq/Site

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1988	1	01/04, 01/09, 01/11	Required by CoC

Description

Used with the EDITS software to override the edit *Seq Num – Hosp, Primary Site, Morph ICDO2 (CoC)* and/or the edit *Seq Num – Hosp, Primary Site, Morph ICDO3 (CoC)*.

Rationale

Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

EDITS Use

Edits of the type, *Seq Num – Hosp, Primary Site, Morph*, differ in the use of ICD-O-2 or ICD-O-3 morphology. They force review of multiple primary cancers when one of the primaries is coded to a site-morphology combination that could indicate a metastatic site rather than a primary site. If *Sequence Number* indicates the person has had more than one primary, then any case with one of the following site-histology combinations requires review:

- C76.0-C76.8 (Ill-defined sites) or C80.9 (unknown primary) and ICD-O-2 or ICD-O-3 histology < 9590. (Look for evidence that the unknown or ill-defined primary is a secondary site from one of the patient's other cancers. For example, a clinical discharge diagnosis of "abdominal carcinomatosis" may be attributable to the patient's primary ovarian cystadenocarcinoma already in the registry and should not be entered as a second primary.)
- Lymph node primary sites (C77.0-C77.9) for histologies other than lymphomas or hematopoietic primary sites for histologies not in range for hematopoietic disease. (That combination is most likely a metastatic lesion. Check whether the lesion could be a manifestation of one of the patient's other cancers.)
- Any site and ICD-O-2 histology in the range 9720-9723, 9740-9741 or ICD-O-3 histology in the range 9740-9758. (Verify that these diagnoses are coded correctly and are indeed separate primaries from the others.)

If it turns out that the suspect tumor is a manifestation of one of the patient's other cancers, delete the metastatic or secondary case, re-sequence remaining cases, and correct the coding on the original case as necessary.

Coding Instructions

- Leave blank if the EDITS program does not generate an error message for the edit *Seq Num – Hosp, Primary Site, Morph*.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if a review of all items in the error or warning message confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed and confirmed as reported.

Override Site/TNM-Stage Group

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1989	1	01/09, 01/10. 01/12, 01/15	Required

Description

Used with the EDITS software to override the edit *Primary Site, AJCC Stage Group* - for AJCC staging editions 6 and later.

Rationale

This override flag allows identification of pediatric cancers that were staged according to a system other than the **AJCC** staging manual (which is predominantly directed toward adult staging) if they are not also **AJCC**-staged. In that situation an otherwise-stageable case may be coded 88 (not applicable) for all **AJCC** items.

EDITS Use

Edits of this type, *Primary Site, AJCC Stage Group*, checks that the pathologic and clinical AJCC stage group codes are valid for the site and histology group according to the applicable *AJCC Cancer Staging Manual*, using the codes described for the items *Clinical Stage Group* and *Pathologic Stage Group*. Combinations of site and histology not represented in any AJCC schema must be coded 88. Unknown codes must be coded 99. Blanks are not permitted.

Since pediatric cases whose sites and histologies have an AJCC scheme may be coded according to a pediatric scheme instead, *Override Site/TNM-Stage Group* is used to indicate pediatric cases not coded according to the AJCC manual. Pediatric stage groups should *not* be recorded in the *Clinical Stage Group* or *Pathologic Stage Group* items. When neither clinical nor pathologic AJCC staging is used for pediatric cases, code all AJCC items 88. When any AJCC components of either is used to stage a pediatric case, follow the Coding Instructions AJCC items and leave *Override Site/TNM-Stage Group* blank.

Coding Instructions

- Leave blank if the EDITS program does not generate an error message for the edit *Primary Site, AJCC Stage Group*.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if the case is confirmed to be a pediatric case that was coded using a pediatric coding system.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed and confirmed as reported.

Override Age/Site/Morph

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1990	1	01/04, 01/09, 01/10, 01/15	Required

Description

Used with the EDITS software to override the edits *Age, Primary Site, Morphology*; *Age, Primary Site, Morphology ICDO3-Adult*; *and Age, Primary Site, Morph ICDO3-Pediatric*.

Rationale

Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

EDITS Use

Edits of the type, *Age, Primary Site, Morphology*; *Age, Primary Site, Morphology ICDO3-Adult*; *and Age, Primary Site, Morph ICDO3-Pediatric* require review if a site-morphology combination occurs in an age group for which it is extremely rare or if the cancer was diagnosed in utero.

If the edit generates an error or warning message, check that the primary site and histologic type are coded correctly and that the age, date of birth, and date of diagnosis are correct.

Coding Instructions

- Leave blank if the EDITS program does not generate an error message for the *Age, Primary Site, Morphology*; *Age, Primary Site, Morphology ICDO3-Adult*; *and Age, Primary Site, Morph ICDO3-Pediatric* edits.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 for an unusual occurrence of a particular age/site/histology combination for a given age has been confirmed by review to be correct.
- Code 2 if the case was diagnosed in utero.
- Code 3 if both conditions apply.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed; age, site and morphology combination confirmed as reported.
2	Reviewed; diagnosis in utero.
3	Reviewed; both conditions apply.

Override TNM Stage

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1992	1	New 01/18	Required

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

- Primary Site, TNM Clin Stage Valid A- Ed 7 (CoC)
- Primary Site, TNM Clin Stage Valid B- Ed 7 (CoC)
- Primary Site, TNM Path Stage Valid A- Ed 7 (CoC)
- Primary Site, TNM Path Stage Valid B- Ed 7 (CoC)

These edits check T, N, and M combinations against stage group. Adding this over-ride allows the edit to pass when combinations of T, N, and M are entered that are not included in the stage tables used with the edits.

Rationale

This over-ride will allow registrars to enter combination of T, N, and M with a stage group that differs from the combinations documented in the AJCC Staging Manual.

Coding Instructions

- Leave blank if the EDITS program does not generate an error message for the edit.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if a review of all items in the error or warning message confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed and confirmed as reported.

Override TNM Tis

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1993	1	New 01/18	Required

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software:

- TNM Clin T, N, M, In Situ (CoC)
- TNM Path T, N, M, In Situ (CoC)

If the patient has a T value indicating in situ/ noninvasive, this edit verifies that the N, M, and stage group reflect in situ/noninvasive disease. However, there are certain circumstances where AJCC does allow a T value indicating in situ/noninvasive and N, M, and/or stage group that indicates invasive disease. An over-ride is required to accommodate these situations.

Rationale

This over-ride will allow registrars to enter combination of T, N, and M with a stage group that differs from the combinations documented in the AJCC Staging Manual.

Coding Instructions

- Leave blank if the EDITS program does not generate an error message for the edit.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if a review of all items in the error or warning message confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed and confirmed as reported.

Override TNM 3

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1994	1	New 01/18	Optional

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

Coding Instructions

- Leave blank if the EDITS program does not generate an error message for the edit.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if a review of all items in the error or warning message confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed and confirmed as reported.

Override Surg/DxConf

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2020	1	01/04, 01/09, 01/15	Required

Description

Used with the EDITS software to override the edits *Surgery of Primary Site, Diag Conf (SEER IF76)*; *Surgery, Diag Conf (SEER IF46); and/or Surg Site 98-02, Diag Conf (SEER 106)*.

Rationale

Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

EDITS Use

Edits of the type, *Surgery of Primary Site, Diag Conf*, check that cases with a primary site surgical procedure coded 20-90 are histologically confirmed.

If the patient had a surgical procedure, most likely there was a microscopic examination of the cancer.

- Verify the surgery and diagnostic confirmation codes and correct any errors.
- Sometimes there are valid reasons why no microscopic confirmation is achieved with the surgery, for example, the tissue removed may be inadequate for evaluation.

Coding Instructions

- Leave blank if the EDITS program does not generate an error message for the edits of the type, *Surgery of Primary Site, Diag Conf*.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if a review of all items in the error or warning message confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed and confirmed as reported.

Override Site/Type

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2030	1	01/04, 01/09, 01/10, 01/15	Required

Description

Used with the EDITS software to override the edits of the type *Primary Site, Morphology-Type and Primary Site, Morphology-Type, Behavior ICDO3.*

Rationale

Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

EDITS Use

There are multiple versions of the edits of the type, *Primary Site, Morphology – Type*, which check for "usual" combinations of site and ICD-O-2 or ICD-O-3 histology. The SEER version of the edit is more restrictive than the CoC edit, and thus uses a different override flag. The CoC version of the edit will accept *Override CoC Site/Type* or *Override Site/Type* as equivalent.

- The Site/Histology Validation List (available on the SEER Website) contains those histologies commonly found in the specified primary site. Histologies that occur only rarely or never are not included. These edits require review of all combinations *not* listed.
- Since basal and squamous cell carcinomas of non-genital skin sites are not reportable to SEER, these site/histology combinations do not appear on the SEER validation list. For the CoC version of the edit, if *Primary Site* is in the range C44.0-C44.9 (skin), and the ICD-O-3 histology is in the range 8000-8005 (neoplasms, malignant, NOS), 8010-8046 (epithelial carcinomas), 8050-8084 (papillary and squamous cell carcinomas), or 8090-8110 (basal cell carcinomas), no further editing is done. No override is necessary for these cases in the CoC version of the edit.

Review of these cases requires investigating whether the combination is biologically implausible or there are cancer registry coding conventions that would dictate different codes for the diagnosis. Review of these rare combinations often results in changes to the primary site and/or morphology, rather than a decision that the combination is correct.

Coding Instructions

- Leave blank if the EDITS program does not generate an error message for the edit *Primary Site, Morphology-Type*.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if a review of all items in the error or warning message confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed and confirmed as reported.

Override Histology

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2040	1	01/04, 01/09, 01/15	Required

Description

Used with the EDITS software to override any of the five edits: *Diagnostic Confirmation, Behavior ICDO2 (SEERIF31)*; *Diagnostic Confirmation, Behavior ICDO3 (SEER IF31)*; *Morphology – Type/Behavior ICDO2 (SEER MORPH)*; *Morphology – Type/Behavior ICDO3 (SEER MORPH)*; and/or *Morph (1973-91) ICD-O-1 (SEER MORPH*).

Rationale

Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

EDITS Use

I. Edits of the type, *Diagnostic Confirmation, Behavior Code*, differ in the use of ICD-O-2 or ICD-O-3 and check that, for in-situ cases (Behavior=2), *Diagnostic Confirmation* specifies microscopic confirmation (1, 2, or 4). The distinction between in-situ and invasive is very important to a registry, since prognosis is so different. Since the determination that a neoplasm has not invaded surrounding tissue, i.e., is in-situ, is made microscopically, cases coded in-situ in behavior should have a microscopic confirmation code. **Note**: Very rarely will a physician designate a case noninvasive or in-situ without microscopic evidence.

If an edit of the type, *Diagnostic Confirmation, Behavior Code*, gives an error message or warning, check that *Behavior Code* and *Diagnostic Confirmation* have been coded correctly. Check carefully for any cytologic or histologic evidence that may have been missed in coding.

II. Edits of the type, *Morphology – Type/Behavior*, perform the following overrideable check:

- Codes listed in ICD-O-2 or ICD-O-3 with behavior codes of only 0 or 1 are considered valid, since use of the behavior matrix of ICD-O-2 and ICD-O-3 allows for the elevation of the behavior of such histologies when the tumor is in-situ or malignant. This edit forces review of these rare cases to verify that they are indeed in-situ or malignant.

If a *Morphology-ype/Behavior* edit produces an error or warning message and the case is one in which the 4-digit morphology code is one that appears in ICD-O-2 or ICD-O-3 only with behavior codes of 0 of 1, verify the coding of morphology and that the behavior should be coded malignant or in-situ. The registrar may need to consult a pathologist or medical advisor.

Exceptions to the above: If year of *Date of Diagnosis* > 2000, then a behavior code of 1 is valid for the following ICD-O-2 histologies and no override flag is needed: 8931, 9393, 9538, 9950, 9960-9962, 9980-9984, 9989. Similarly, the following ICD-O-3 histologies are valid with a behavior code of 1: 8442, 8451, 8462, 8472, and 8473.

Note: The *Morphology – Type/Behavior* edits are complex and perform several additional types of checks. No other aspects of their checks are subject to override.

Coding Instructions

- Leave blank if the EDITS program does not generate an error message for the *Diagnostic Confirmation, Morph or Morphology – Type/Behavior* edits.
- Leave blank and correct any errors for the case if an item id discovered to be incorrect.
- Code 1, 2, or 3 as indicated if a review of all items in the error or warning message confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed and confirmed as reported for edits of the type, Morphology-Type/Behavior.
2	Reviewed and confirmed as reported for edits of the type Diagnostic Confirmation, Behavior Code.
3	Reviewed and conditions 1 and 2 above both apply

Override Leuk/Lymphoma

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2070	1	01/04, 01/09, 01/10, 01/15	Required

Description

Used with the EDITS software to override the edits *Diagnostic Confirmation, Histology.*

Rationale

Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

EDITS Use

Edits of the type, *Diagnostic Confirmation, Histology*, differ in use of ICD-O-2 or ICD-O-3 and check the following:

- Since lymphoma and leukemia are almost exclusively microscopic diagnoses, this edit forces review of any cases of lymphoma that have diagnostic confirmation of direct visualization or clinical, and any leukemia with a diagnostic confirmation of direct visualization.
- For lymphomas, *Diagnostic Confirmation* cannot be 6 (direct visualization) or 8 (clinical).
- For leukemia and other hematopoietic neoplasms, *Diagnostic Confirmation* cannot be 6 (direct visualization).

If an edit of the type, *Diagnostic Confirmation, Histology*, produces an error or warning message, check that the *Histology* and *Diagnostic Confirmation* are correctly coded. Remember that positive hematologic findings and bone marrow specimens are included as histologic confirmation (code 1 in *Diagnostic Confirmation*) for leukemia.

Coding Instructions

- Leave blank if the EDITS program does not generate an error message for the *Diagnostic Confirmation, Histology* edits.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if a review of all items in the error or warning message confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed and confirmed as reported.

Override Site/Behavior

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2071	1	01/04, 01/09, 01/15	Required

Description

Used with the EDITS software to override the edits *Primary Site, Behavior Code ICDO2 (SEER IF39)*; and/or *Primary Site, Behavior Code ICDO3 (SEER IF39)*.

Rationale

Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

EDITS Use

Edits of the type, *Primary Site, Behavior Code,* require review of the following primary sites with a behavior of in-situ (ICD-O-2 or ICD-O-3 behavior = 2):

C26.9	Gastrointestinal tract, NOS	C68.9	Urinary system, NOS
C39.9	Ill-defined sites within respiratory system	C72.9	Nervous system, NOS
C55.9	Uterus, NOS	C75.9	Endocrine gland, NOS
C57.9	Female genital tract, NOS	C76.0-C76.8	Ill-defined sites
C63.9	Male genital organs, NOS	C80.9	Unknown primary site

Since the designation of in-situ is very specific and almost always requires microscopic confirmation, ordinarily specific information should also be available regarding the primary site. Conversely, if inadequate information is available to determine a specific primary site, it is unlikely that information about a cancer being in-situ is reliable.

- If a specific in-situ diagnosis is provided, try to obtain a more specific primary site. A primary site within an organ system can sometimes be identified based on the diagnostic procedure or treatment given or on the histologic type. If a more specific site cannot be determined, it is usually preferable to code a behavior code of 3. In the exceedingly rare situation in which it is certain that the behavior is in-situ and no more specific-site code is applicable, set *Override Site/Behavior* to 1.

Coding Instructions

- Leave blank if the EDITS program does not generate an error message for the *Primary Site, Behavior* edits.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if a review of all items in the error or warning message confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed and confirmed as reported.

Override Site/Lat/Morph

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2074	1	01/04, 01/09, 01/15	Required

Description

Used with the EDITS software to override the edits *Laterality, Primary Site, Morph ICDO2 (SEER IF42)*; and/or *Laterality, Primary Site, Morph ICDO3 (SEER IF42)*.

Rationale

Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

EDITS Use

Edits of the type, *Laterality, Primary Site, Morph*, differ in whether they produce a warning or an error message and in use of ICD-O-2 or ICD-O-3 morphology do the following:

- If the *Primary Site* is a paired organ and *Behavior Code* is in-situ (2), then *Laterality* must be 1, 2, or 3.
- If diagnosis year is less than 1988 and *Histology* is greater than or equal to 9590, then no further editing is performed. If diagnosis year is greater than 1987 and *Histology* equals 9140, 9700, 9701, 9590-9980, then no further editing is performed.

The intent of this edit is to force a review of in-situ cases for which *Laterality* is coded 4 (bilateral) or 9 (unknown laterality) as to origin.

- In rare instances when the tumor is truly midline (9) or the rate combination is otherwise confirmed correct, enter code 1 for *Override Site/Lat/Morph*.

Coding Instructions

- Leave blank if the EDITS program does not generate an error message for the *Laterality, Primary Site, Morphology* edits.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if a review of all items in the error or warning message confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed and confirmed as reported.

Override Name/Sex

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2078	1	New 01/18	Required

Description

Some computer edits identify errors. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

This over-ride is used with the following edit in the NAACCR Metafile of the EDITS software: Sex, Name-First, Date of Birth (NAACCR).

Rationale

Some edits check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future. See Chapter IV, Recommended Data Edits and Software Coordination of Standards. Over-ride flag as used in the EDITS Software Package Edits of the type Sex, Name does not allow extremely rare or nonexistent combinations of first name and sex, such as John/female.

Coding Instructions

- Leave blank if the program does not generate an error message for the edit Sex, Name-First, Date of Birth (NAACCR).
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if a review of all items in the error or warning message confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed and confirmed as reported.

Override SeqNo/DxConf

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2000	1	01/09, 01/15	Required

Description

Used with CoC Metafile and the EDITS software to override the edit Sequence Number and Diagnostic Confirmation.

Rationale

Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

Coding Instructions

- Leave blank if the EDITS program does not generate an error message for the edit *Sequence Number and Diagnostic Confirmation*.
- Leave blank and correct the code for any item documented for the edit *Sequence Number and Diagnostic Confirmation* if, on review, it is discovered to be incorrect.
- Code 1 if a review of all items documented for the edit *Sequence Number and Diagnostic Confirmation* confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed and confirmed as reported.

Override Site/Lat/SeqNo

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2010	1	01/09, 01/15	Required

Description

Used with CoC Metafile and the EDITS software to override the edit Site, Laterality, and Sequence Number.

Rationale

Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

Coding Instructions

- Leave blank if the EDITS program does not generate an error message for the edit *Site, Laterality, and Sequence Number*.
- Leave blank and correct the code for any item documented for the edit *Site, Laterality, and Sequence Number* if, on review, it is discovered to be incorrect.
- Code 1 if a review of all items documented for the edit Site, Laterality, and Sequence Number confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed and confirmed as reported.

Override Report Source

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2050	1	01/09, 01/15	Required

Description

Used with CoC Metafile and the EDITS software to override the edit Report Source.

Rationale

Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

Coding Instructions

- Leave blank if the EDITS program does not generate an error message for the edit Report Source.
- Leave blank and correct the code for any item documented for the edit *Report Source* if, on review, it is discovered to be incorrect.
- Code 1 if a review of all items documented for the edit Report Source confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed and confirmed as reported.

Override Ill-Defined Site

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2060	1	01/09, 01/15	Required

Description

Used with CoC Metafile and the EDITS software to override the edit Ill-defined Site.

Rationale

Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

Coding Instructions

- Leave blank if the EDITS program does not generate an error message for the edit Ill-defined Site.
- Leave blank and correct the code for any item documented for the edit Ill-defined Site if, on review, it is discovered to be incorrect.
- Code 1 if a review of all items documented for the edit Ill-defined Site confirms that all are correct.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed and confirmed as reported.

Appendix A
Surgery Codes

ORAL CAVITY
Lip C00.0-C00.9, Base of Tongue C01.9, Other Parts of Tongue C02.0-C02.9, Gum C03.0-C03.9, Floor of Mouth C04.0-C04.9, Palate C05.0-C05.9, Other Parts of Mouth C06.0-C06.9
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10-14.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26-27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Wide excision, NOS

Code 30 includes:
Hemiglossectomy
Partial glossectomy

40 Radical excision of tumor, NOS
- 41 Radical excision of tumor ONLY
- 42 Combination of 41 WITH resection in continuity with mandible (marginal, segmental, hemi-, or total resection)
- 43 Combination of 41 WITH resection in continuity with maxilla (partial, subtotal, or total resection)

Codes 40-43 include:
Total glossectomy
Radical glossectomy

Specimen sent to pathology from surgical events 20-43.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

PAROTID AND OTHER UNSPECIFIED GLANDS
Parotid Gland C07.9, Major Salivary Glands C08.0-C08.9
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10-14.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26-27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision

30 Less than total parotidectomy, NOS; less than total removal of major salivary gland, NOS
- 31 Facial nerve spared
- 32 Facial nerve sacrificed
- 33 Superficial lobe ONLY
  - 34 Facial nerve spared
  - 35 Facial nerve sacrificed
- 36 Deep lobe (Total)
  - 37 Facial nerve spared
  - 38 Facial nerve sacrificed

40 Total parotidectomy, NOS; total removal of major salivary gland, NOS
- 41 Facial nerve spared
- 42 Facial nerve sacrificed

50 Radical parotidectomy, NOS; radical removal of major salivary gland, NOS
- 51 WITHOUT removal of temporal bone
- 52 WITH removal of temporal bone
- 53 WITH removal of overlying skin (requires graft or flap coverage)

80 Parotidectomy, NOS

Specimen sent to pathology from surgical events 20-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

PHARYNX
Tonsil C09.0-C09.9, Oropharynx C10.0-C10.9, Nasopharynx C11.0-C11.9 Pyriform Sinus C12.9, Hypopharynx C13.0-C13.9, Pharynx C14.0
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Stripping

No specimen sent to pathology from surgical events 10-15.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26-27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

- 25 Laser excision
- 28 Stripping

30 Pharyngectomy, NOS
- 31 Limited/partial pharyngectomy; tonsillectomy, bilateral tonsillectomy
- 32 Total pharyngectomy

40 Pharyngectomy WITH laryngectomy OR removal of contiguous bone tissue, NOS (does NOT include total mandibular resection)
- 41 WITH Laryngectomy (laryngopharyngectomy)
- 42 WITH bone
- 43 With both 41 and 42

50 Radical pharyngectomy (includes total mandibular resection), NOS
- 51 WITHOUTH laryngectomy
- 52 WITH laryngectomy

Specimen sent to pathology from surgical events 20-52.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

ESOPHAGUS
C15.0-C15.9
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10-14.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26-27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Partial esophagectomy

40 Total esophagectomy, NOS

50 Esophagectomy, NOS WITH laryngectomy and/or gastrectomy, NOS
- 51 WITH laryngectomy
- 52 WITH gastrectomy, NOS
- 53 Partial gastrectomy
- 54 Total gastrectomy
- 55 Combination of 51 WITH any of 52-54

80 Esophagectomy, NOS

Specimen sent to pathology from surgical events 20-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

STOMACH
C16.0-C16.9
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None, no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10-14.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy
- Any combination of 20 or 26-27 WITH
  - 21 Photodynamic therapy (PDT)
  - 22 Electrocautery
  - 23 Cryosurgery
  - 24 Laser ablation
- 25 Laser excision

30 Gastrectomy, NOS (partial, subtotal, hemi-)
- 31 Antrectomy, lower (distal-less than 40% of stomach)***
- 32 Lower (distal) gastrectomy (partial, subtotal, hemi-)
- 33 Upper (proximal) gastrectomy (partial, subtotal, hemi-)

Code 30 includes:
Partial gastrectomy, including a sleeve resection of the stomach
Billroth I: anastomosis to duodenum (duodenostomy)
Billroth II: anastomosis to jejunum (jejunostomy)

40 Near-total or total gastrectomy, NOS
- 41 Near-total gastrectomy
- 42 Total gastrectomy

Any total gastrectomy may follow a previous partial resection of the stomach.

50 Gastrectomy, NOS WITH removal of a portion of esophagus
- 51 Partial or subtotal gastrectomy
- 52 Near total or total gastrectomy

Codes 50-52 are used for gastrectomy resection when only portions of esophagus are included in procedure.

60 Gastrectomy with a resection in continuity with the resection of other organs, NOS***
- 61 Partial or subtotal gastrectomy, in continuity with the resection of other organs***
- 62 Near total or total gastrectomy, in continuity with the resection of other organs***
- 63 Radical gastrectomy, in continuity with the resection of other organs***

Codes 60-63 are used for gastrectomy resections with organs other than esophagus. Portions of esophagus may or may not be included in the resection.

80 Gastrectomy, NOS

Specimen sent to pathology from surgical events 20-80.

90 Surgery, NOS

99 Unknown if surgery performed, death certificate ONLY

*** Incidental splenectomy NOT included

COLON
C18.0-C18.9
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site*.

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10-14.

20 Local tumor excision, NOS
- 27 Excisional biopsy
- 26 Polypectomy, NOS
- 28 Polypectomy-endoscopic
- 29 Polypectomy-surgical excision
- Any combination of 20 or 26-29 WITH
  - 21 Photodynamic therapy (PDT)
  - 22 Electrocautery
  - 23 Cryosurgery
  - 24 Laser ablation
- 25 Laser excision

30 Partial colectomy, segmental resection
- 32 Plus resection of contiguous organ; example: small bowel, bladder

40 Subtotal colectomy/hemicolectomy (total right or left colon and a portion of transverse colon)
- 41 Plus resection of contiguous organ; example: small bowel, bladder

50 Total colectomy (removal of colon from cecum to the rectosigmoid junction; may include a portion of the rectum)
- 51 Plus resection of contiguous organ; example: small bowel, bladder

60 Total proctocolectomy (removal of colon from cecum to the rectosigmoid junction, including the entire rectum)
- 61 Plus resection of contiguous organ; example: small bowel, bladder

70 Colectomy or coloproctotectomy with resection of contiguous organ(s), NOS (where there is not enough information to code 32, 41, 51, or 61)

Code 70 includes: Any colectomy (partial, hemicolectomy, or total) WITH a resection of any other organs in continuity with the primary site. Other organs may be partially or totally removed. Other organs may include, but are not limited to, oophorectomy, partial proctectomy, rectal mucosectomy, or pelvic exenteration.

80 Colectomy, NOS

Specimen sent to pathology from surgical events 20-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

RECTOSIGMOID
C19.9
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Code removal/surgical ablation of single or multiple liver metastases under the date item *Surgical Procedure/Other Site*.

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser ablation

No specimen sent to pathology from surgical events 10-14.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Combination of 20 or 26-27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Wedge or segmental resection; partial proctosigmoidectomy, NOS
- 31 Plus resection of contiguous organs; example: small bowel, bladder

Procedures coded 30 include, but are not limited to:

Anterior resection
Hartmann operation
Low anterior resection (LAR)
Partial colectomy, NOS
Rectosigmoidectomy, NOS
Sigmoidectomy

40 Pull through WITH sphincter preservation (colo-anal anastomosis)

50 Total proctectomy

51 Total colectomy

55 Total colectomy WITH ileostomy, NOS
- 56 Ileorectal reconstruction
- 57 Total colectomy WITH other pouch; example: Koch pouch

60 Total proctocolectomy, NOS
- 65 Total proctocolectomy WITH ileostomy, NOS
- 66 Total proctocolectomy WITH ileostomy and pouch

Removal of the colon from cecum to the rectosigmoid or a portion of the rectum.

70 Colectomy or proctocolectomy resection in continuity with other organs; pelvic exenteration

80 Colectomy, NOS; Proctectomy, NOS

Specimen sent to pathology from surgical events 20-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

RECTUM
C20.9
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Code removal/surgical ablation of single or multiple liver metastases under the date item *Surgical Procedure/Other Site*.

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10-14.

20 Local tumor excision, NOS
- 27 Excisional biopsy
- 26 Polypectomy

Any combination of 20 or 26-27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

- 25 Laser excision
- 28 Curette and fulguration

30 Wedge or segmental resection; partial proctectomy, NOS

Procedures coded 30 include, but are not limited to:
Anterior resection
Hartmann operation
Low anterior resection (LAR)
Transsacral rectosigmoidectomy
Total mesorectal excision (TME)

40 Pull through WITH sphincter preservation (coloanal anastomosis)

50 Total proctectomy

Procedure coded 50 includes, but is not limited to:
Abdominoperineal resection (Miles Procedure)

60 Total proctocolectomy, NOS

70 Proctectomy or proctocolectomy with resection in continuity with other organs; pelvic exenteration

80 Proctectomy, NOS

Specimen sent to pathology from surgical events 20-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

ANUS
C21.0-C21.8
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Thermal Ablation

No specimen sent to pathology from surgical events 10-15.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy
- Any combination of 20 or 26-27 WITH
  - 21 Photodynamic therapy (PDT)
  - 22 Electrocautery
  - 23 Cryosurgery
  - 24 Laser ablation
- 25 Laser excision

60 Abdominal perineal resection, NOS (APR; Miles procedure)
- 61 APR and sentinel node excision
- 62 APR and unilateral inguinal lymph node dissection
- 63 APR and bilateral inguinal lymph node dissection

The lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery*.

Specimen sent to pathology from surgical events 20-63.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

LIVER AND INTRAHEPATIC BILE DUCTS
C22.0-C22.1
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Alcohol (Percutaneous Ethanol Injection-PEI)
- 16 Heat-Radio-frequency ablation (RFA)
- 17 Other (ultrasound, acetic acid)

No specimen sent to pathology from surgical events 10-17.

20 Wedge or segmental resection, NOS
- 21 Wedge resection
- 22 Segmental resection, NOS
  - 23 One
  - 24 Two
  - 25 Three
  - 26 Segmental resection AND local tumor destruction

30 Lobectomy, NOS
- 36 Right lobectomy
- 37 Left lobectomy
- 38 Lobectomy AND local tumor destruction

50 Extended lobectomy, NOS (extended: resection of a single lobe plus a segment of another lobe)
- 51 Right lobectomy
- 52 Left lobectomy
- 59 Extended lobectomy AND local tumor destruction

60 Hepatectomy, NOS
- 61 Total hepatectomy and transplant

65 Excision of a bile duct (for an intra-hepatic bile duct primary only)
- 66 Excision of an intrahepatic bile duct PLUS partial hepatectomy

75 Extrahepatic bile duct and hepatectomy WITH transplant

Specimen sent to pathology from surgical events 20-75.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

PANCREAS
C25.0-C25.9
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

25 Local excision of tumor, NOS

30 Partial pancreatectomy, NOS; example: distal

35 Local or partial pancreatectomy and duodenectomy
- 36 WITHOUT distal/partial gastrectomy
- 37 WITH partial gastrectomy (Whipple)

40 Total pancreatectomy

60 Total pancreatectomy and subtotal gastrectomy or duodenectomy

70 Extended pancreatoduodenectomy

80 Pancreatectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

LARYNX
C32.0-C32.9
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Stripping

No specimen sent to pathology from surgical events 10-15.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy
- Any combination of 20 or 26-27 WITH
  - 21 Photodynamic therapy (PDT)
  - 22 Electrocautery
  - 23 Cryosurgery
  - 24 Laser ablation
- 25 Laser excision
- 28 Stripping

30 Partial excision of the primary site, NOS; subtotal/partial laryngectomy NOS; hemilaryngectomy NOS
- 31 Vertical laryngectomy
- 32 Anterior commissure laryngectomy
- 33 Supraglottic laryngectomy

40 Total or radical laryngectomy, NOS
- 41 Total laryngectomy ONLY
- 42 Radical laryngectomy ONLY

50 Pharyngolaryngectomy

80 Laryngectomy, NOS

Specimen sent to pathology from surgical events 20-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

LUNG
C34.0-C34.9
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS
Unknown whether a specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).

15 Local tumor destruction or excision, NOS
12 Laser ablation or cryosurgery
13 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
No specimen sent to pathology from surgical events 12-13 and 15.

20 Excision or resection of less than one lobe, NOS
23 Excision, NOS
24 Laser excision
25 Bronchial sleeve resection ONLY
21 Wedge resection
22 Segmental resection, including lingulectomy
Specimen sent to pathology from surgical events 20-25.

30 Resection of lobe or bilobectomy, but less than the whole lung (partial pneumonectomy, NOS)
33 Lobectomy WITH mediastinal lymph node dissection
The lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery*.

45 Lobe or bilobectomy extended, NOS
46 WITH chest wall
47 WITH pericardium
48 WITH diaphragm

55 Pneumonectomy, NOS
56 WITH mediastinal lymph node dissection (radical pneumonectomy)
The lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery*.

65 Extended pneumonectomy
66 Extended pneumonectomy plus pleura or diaphragm

70 Extended radical pneumonectomy
The lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery*.

80 Resection of lung, NOS

Specimen sent to pathology from surgical events 20-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

HEMATOPOIETIC/RETICULOENDOTHELIAL/ IMMUNOPROLIFERATIVE/MYELOPROLIFERATIVE DISEASE
C42.0, C42.1, C42.3, C42.4 (with any histology) or M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992 (with any site)

Code

98 All hematopoietic/reticuloendothelial/immunoproliferative/myeloproliferative disease sites and/or histologies, WITH or WITHOUT surgical treatment.

Surgical procedures for hematopoietic/reticuloendothelial/immunoproliferative/ myeloproliferative primaries are to be recorded using the data item *Surgical Procedure/Other Site*.

BONES, JOINTS, AND ARTICULAR CARTILAGE PERIPHERAL NERVES AND AUTONOMIC NERVOUS SYSTEM CONNECTIVE, SUBCUTANEOUS, AND OTHER SOFT TISSUES
Bones C40.0-C41.9, Nerves C47.0-C47.9, Connective C49.0-C49.9
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS

Unknown whether a specimen was sent to pathology for surgical event coded 19 (principally for cases diagnosed prior to January 1, 2003).

15 Local tumor destruction

No specimen sent to pathology from surgical event 15.

25 Local excision

26 Partial resection

30 Radical excision or resection of lesion WITH limb salvage

40 Amputation of limb
- 41 Partial amputation of limb
- 42 Total amputation of limb

50 Major amputation, NOS
- 51 Forequarter, including scapula
- 52 Hindquarter, including ilium/hip bone
- 53 Hemipelvectomy, NOS
- 54 Internal hemipelvectomy

Specimen sent to pathology from surgical events 25-54.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

SPLEEN
C42.2
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS
Unknown whether a specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).

21 Partial splenectomy

22 Total splenectomy

80 Splenectomy, NOS

Specimen sent to pathology from surgical events 25-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

SKIN
C44.0-C44.9
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser ablation

No specimen sent to pathology from surgical events 10-14.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26-27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Biopsy of primary tumor followed by a gross excision of the lesion (does not have to be done under the same anesthesia)
- 31 Shave biopsy followed by a gross excision of the lesion
- 32 Punch biopsy followed by a gross excision of the lesion
- 33 Incisional biopsy followed by a gross excision of the lesion
- 34 Mohs surgery, NOS
- 35 Mohs with 1-cm margin or less
- 36 Mohs with more than 1-cm margin

45 Wide excision or re-excision of lesion or minor (local) amputation with the margins more than 1 cm, NOS. Margins MUST be microscopically negative.
- 46 WITH margins more than 1 cm and less than or equal to 2 cm
- 47 WITH margins greater than 2 cm

If the excision or re-excision has microscopically confirmed negative margins less than 1 cm OR the margins are more than 1 cm or more but are not microscopically confirmed, use the appropriate code, 20-36.

60 Major amputation

Specimen sent to pathology from surgical events 20-60.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

BREAST
C50.0-C50.9
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction, NOS
No specimen was sent to pathology for surgical event coded 19 (principally for cases diagnosed prior to January 1, 2003).

20 Partial mastectomy, NOS; less than total mastectomy, NOS
- 21 Partial mastectomy WITH nipple resection
- 22 Lumpectomy or excisional biopsy
- 23 Reexcision of the biopsy site for gross or microscopic residual disease
- 24 Segmental mastectomy (including wedge resection, quadrantectomy, tylectomy)

Procedures coded 20-24 remove the gross primary tumor and some of the breast tissue (breast-conserving or preserving). There may be microscopic residual tumor.

30 Subcutaneous mastectomy
A subcutaneous mastectomy, also called a nipple sparing mastectomy, is the removal of breast tissue without the nipple and areolar complex or overlying skin. It is performed to facilitate immediate breast reconstruction. Cases coded 30 may be considered to have undergone breast reconstruction.

40 Total (simple) mastectomy
- 41 WITHOUT removal of uninvolved contralateral breast
- 43 Reconstruction, NOS
  - 44 Tissue
  - 45 Implant
  - 46 Combined (Tissue and Implant)
- 42 WITH removal of uninvolved contralateral breast
- 47 Reconstruction, NOS
  - 48 Tissue
  - 49 Implant
  - 75 Combined (Tissue and Implant)

A total (simple) mastectomy removes all breast tissue, the nipple, and areolar complex. An axillary dissection is not done, but sentinel lymph nodes may be removed.

For single primaries only, code removal of involved contralateral breast under the data item *Surgical Procedure/Other Site*.

If contralateral breast reveals a second primary, each breast is abstracted separately. The surgical procedure is coded 41 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed on that site.

Reconstruction that is planned as part of first course treatment is coded 43-49 or 75, whether it is done at the time of mastectomy or later.

76 Bilateral mastectomy for a single tumor involving both breasts, as for bilateral inflammatory carcinoma.

50 Modified radical mastectomy
- 51 WITHOUT removal of uninvolved contralateral breast
- 53 Reconstruction, NOS
  - 54 Tissue
  - 55 Implant
  - 56 Combined (Tissue and Implant)
- 52 WITH removal of uninvolved contralateral breast
  - 57 Reconstruction, NOS
  - 58 Tissue
  - 59 Implant
  - 63 Combined (Tissue and Implant)

Removal of all breast tissue, the nipple, the areolar complex, and variable amounts of breast skin in continuity with the axilla. The specimen may or may not include a portion of the pectoralis major muscle.

If contralateral breast reveals a second primary, it is abstracted separately. The surgical procedure is coded 51 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed on that site.

For single primaries only, code removal of involved contralateral breast under the data item *Surgical Procedure/Other Site*.

- 60 Radical mastectomy, NOS
- 61 WITHOUT removal of uninvolved contralateral breast
  - 64 Reconstruction, NOS
  - 65 Tissue
  - 66 Implant
  - 67 Combined (Tissue and Implant)
- 62 WITH removal of uninvolved contralateral breast
  - 68 Reconstruction, NOS
  - 69 Tissue
  - 73 Implant
  - 74 Combined (Tissue and Implant)

70 Extended radical mastectomy
- 71 WITHOUT removal of uninvolved contralateral breast
- 72 WITH removal of uninvolved contralateral breast

80 Mastectomy, NOS

Specimen sent to pathology for surgical events coded 20-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

CERVIX UTERI
C53.0-C53.9
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

For invasive cancers, dilation and curettage is coded as an Incisional biopsy (02) under the data item *DX/Stage Procedure*.

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Loop Electrocautery Excision Procedure (LEEP)
- 16 Laser ablation
- 17 Thermal ablation

No specimen sent to pathology from surgical events 10-17.

20 Local tumor excision, NOS
- 26 Excisional biopsy, NOS
- 27 Cone biopsy
- 24 Cone biopsy WITH gross excision of lesion
- 29 Trachelectomy; removal of cervical stump; cervicectomy
- Any combination of 20, 24, 26, 27, or 29 WITH
  - 21 Electrocautery
  - 22 Cryosurgery
  - 23 Laser ablation or excision
- 25 Dilatation and curettage; endocervical curettage (for in-situ only)
- 28 Loop Electrocautery Excision Procedure (LEEP)

30 Total hysterectomy (simple, pan-) WITHOUT removal of tubes and ovaries
Total hysterectomy removes both the corpus and cervix uteri and may also include a portion of vaginal cuff.

40 Total hysterectomy (simple, pan-) WITH removal of tubes and/or ovary
Total hysterectomy removes both the corpus and cervix uteri and may also include a portion of vaginal cuff.

50 Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy
- 51 Modified radical hysterectomy
- 52 Extended hysterectomy
- 53 Radical hysterectomy; Wertheim procedure
- 54 Extended radical hysterectomy

60 Hysterectomy, NOS, WITH or WITHOUT removal of tubes and ovaries
- 61 WITHOUT removal of tubes and ovaries
- 62 WITH removal of tubes and ovaries

70 Pelvic exenteration
- 71 Anterior exenteration

Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.

72 Posterior exenteration
Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.

73 Total exenteration
Includes removal of all pelvic contents and pelvic lymph nodes.

74 Extended exenteration
Includes pelvic blood vessels or bony pelvis

Specimen sent to pathology from surgical events 20-74.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

CORPUS UTERI
C54.0-C55.9
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

For invasive cancers, dilation and curettage is coded as an incisional biopsy (02) under the data item *DX/Stage Procedure*.

Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS
Unknown whether a specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Loop Electrocautery Excision Procedure (LEEP)
- 16 Thermal ablation

No specimen sent to pathology from surgical events 10-16.

20 Local tumor excision, NOS; simple excision, NOS
- 24 Excisional biopsy
- 25 Polypectomy
- 26 Myomectomy

Any combination of 20 or 24-26 WITH
- 21 Electrocautery
- 22 Cryosurgery
- 23 Laser ablation or excision

30 Subtotal hysterectomy/supracervical hysterectomy/fundectomy WITH or WITHOUT removal of tube(s) and ovary(ies)
- 31 WITHOUT tube(s) and ovary(ies)
- 32 WITH tube(s) and ovary(ies)

40 Total hysterectomy (simple, pan-) WITHOUT removal of tube(s) and ovary(ies)
Removes both the corpus and cervix uteri. It may also include a portion of the vaginal cuff.

50 Total hysterectomy (simple, pan-) WITH removal of tube(s) and/or ovary(ies)
Removes both the corpus and cervix uteri. It may also include a portion of the vaginal cuff.

60 Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy
- 61 Modified radical hysterectomy
- 62 Extended hysterectomy
- 63 Radical hysterectomy; Wertheim procedure
- 64 Extended radical hysterectomy

65 Hysterectomy, NOS, WITH or WITHOUT removal of tube(s) and ovary(ies)
- 66 WITHOUT removal of tube(s) and ovary(ies)
- 67 WITH removal of tube(s) and ovary(ies)

75 Pelvic exenteration
- 76 Anterior exenteration

Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.

77 Posterior exenteration
Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.

78 Total exenteration
Includes removal of all pelvic contents and pelvic lymph nodes.

79 Extended exenteration
Includes pelvic blood vessels or bony pelvis.

Specimen sent to pathology from surgical events 20-79.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

OVARY
C56.9
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

17 Local tumor destruction, NOS
No specimen sent to pathology from surgical event 17.

25 Total removal of tumor or (single) ovary, NOS
- 26 Resection of ovary (wedge, subtotal, or partial) ONLY, NOS; unknown if hysterectomy done
- 27 WITHOUT hysterectomy
- 28 WITH hysterectomy

35 Unilateral (salpingo-)oophorectomy; unknown if hysterectomy done
- 36 WITHOUT hysterectomy
- 37 WITH hysterectomy

50 Bilateral (salpingo-)oophorectomy; unknown if hysterectomy done
- 51 WITHOUT hysterectomy
- 52 WITH hysterectomy

55 Unilateral or bilateral (salpingo-)oophorectomy WITH OMENTECTOMY, NOS; partial or total; unknown if hysterectomy done
- 56 WITHOUT hysterectomy
- 57 WITH hysterectomy

60 Debulking; cytoreductive surgery, NOS
- 61 WITH colon (including appendix) and/or small intestine resection (not incidental)
- 62 WITH partial resection of urinary tract (not incidental)
- 63 Combination of 61 and 62

Debulking is a partial or total removal of the tumor mass and can involve the removal of multiple organ sites. It may include removal of ovaries and/or the uterus (a hysterectomy). The pathology report may or may not identify ovarian tissue. A Debulking is usually found by another treatment modality such as chemotherapy.

70 Pelvic exenteration, NOS
- 71 Anterior

Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.

72 Posterior
Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.

73 Total
Includes removal of all pelvic contents and pelvic lymph nodes.

74 Extended exenteration
Includes pelvic blood vessels or bony pelvis.

80 (Salpingo-)oophorectomy, NOS

Specimen sent to pathology from surgical events 25-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

PROSTATE
C61.9
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Do not code an orchiectomy in this field. For prostate primaries, orchiectomies are coded in the data item *Transplant/Endocrine*.

Codes

00 None; no surgery of primary site; autopsy ONLY

18 Local tumor destruction or excision, NOS

19 Transurethral resection (TURP), NOS, and no specimen sent to pathology or unknown if sent

Unknown whether a specimen was sent to pathology for surgical events coded 18 or 19 (principally for cases diagnosed prior to January 1, 2003).

10 Local tumor destruction, NOS
- 14 Cryoprostatectomy
- 15 Laser ablation
- 16 Hyperthermia
- 17 Other method of local tumor destruction

No specimen sent to pathology from surgical events 10-17.

20 Local tumor excision, NOS
- 21 Transurethral resection (TURP), NOS, with specimen sent to pathology
- 22 TURP-cancer is incidental finding during surgery for benign disease
- 23 TURP-patient has suspected/known cancer

Any combination of 20-23 WITH
- 24 Cryosurgery
- 25 Laser
- 26 Hyperthermia

30 Subtotal, segmental, or simple prostatectomy, which may leave all or part of the capsule intact

50 Radical prostatectomy, NOS; total prostatectomy, NOS
Excised prostate, prostatic capsule, ejaculatory ducts, seminal vesicle(s) and may include a narrow cuff of bladder neck.

70 Prostatectomy WITH resection in continuity with other organs; pelvic exenteration
Surgeries coded 70 are any prostatectomy WITH resection in continuity with any other organs. The other organs may be partially or totally removed. Procedures may include, but are not limited to, cystoprostatectomy, radical cystectomy, and prostatectomy.

80 Prostatectomy, NOS

Specimen sent to pathology from surgical events 20-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

TESTIS
C62.0-C62.9
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

12 Local tumor destruction, NOS

No specimen sent to pathology from surgical event 12.

20 Local or partial excision of testicle

30 Excision of testicle WITHOUT cord

40 Excision of testicle WITH cord/or cord not mentioned (radical orchiectomy)

80 Orchiectomy, NOS (unspecified whether partial or total testicle removed)

Specimen sent to pathology from surgical events 20-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

KIDNEY, RENAL PELVIS, AND URETER
Kidney C64.9, Renal Pelvis C65.9, Ureter C66.9
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Thermal ablation

No specimen sent to pathology for surgical events 10-15.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26-27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Partial or subtotal nephrectomy (kidney or renal pelvis) or partial ureterectomy (ureter)

Procedures coded 30 include, but are not limited to:
Segmental resection
Wedge resection

40 Complete/total/simple nephrectomy-for kidney parenchyma
Nephroureterectomy
Includes bladder cuff for renal pelvis or ureter.

50 Radical nephrectomy
May include removal of a portion of vena cava, adrenal gland(s), Gerota's fascia, perinephric fat, or partial/total ureter.

70 Any nephrectomy (simple, subtotal, complete, partial, total, radical) in continuity with the resection of other organ(s) (colon, bladder)
The other organs, such as colon or bladder, may be partially or totally removed.

80 Nephrectomy, NOS
Ureterectomy, NOS

Specimen sent to pathology from surgical events 20-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

BLADDER
C67.0-C67.9
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Intravesical therapy
- 16 Bacillus Calmette-Guerin (BCG) or other immunotherapy

Also code the introduction of immunotherapy in the immunotherapy items. If immunotherapy is followed by surgery of the type coded 20-80 code that surgery instead and code the immunotherapy only as immunotherapy.

No specimen sent to pathology from surgical events 10-16.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Combination of 20 or 26-27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Partial cystectomy

50 Simple/total/complete cystectomy

60 Complete cystectomy with reconstruction
- 61 Radical cystectomy PLUS ileal conduit
- 62 Radical cystectomy PLUS continent reservoir or pouch, NOS
- 63 Radical cystectomy PLUS abdominal pouch (cutaneous)
- 64 Radical cystectomy PLUS in-situ pouch (orthotopic)

When the procedure is described as a pelvic exenteration for males, but the prostate is not removed, the surgery should be coded as a cystectomy (code 60-64).

70 Pelvic exenteration, NOS
- 71 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 60-64).

- 72 Posterior exenteration

For females, also includes removal of vagina, rectum and anus. For males, also includes prostate, rectum and anus.

- 73 Total exenteration

Includes all tissue and organs for an anterior and posterior exenteration.

- 74 Extended exenteration

Includes pelvic blood vessels or bony pelvis.

80 Cystectomy, NOS

Specimen sent to pathology from surgical events 20-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

BRAIN
Meninges C70.0-C70.9, Brain C71.0-C71.9, Spinal Cord, Cranial Nerves and Other Parts of Central Nervous System C72.0-C72.9
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Do not code laminectomies for spinal cord primaries.

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Tumor destruction, NOS
No specimen sent to pathology from surgical event 10.

Do not record stereotactic radiosurgery (SRS), Gamma knife, Cyber knife, or Linac radiosurgery as surgical destruction. All of these modalities are recorded in the radiation treatment fields.

20 Local excision (biopsy) of lesion or mass
- 21 Subtotal resection of tumor, lesion or mass in brain
- 22 Resection of tumor of spinal cord or nerve

30 Radical, total, gross resection of tumor, lesion or mass in brain

40 Partial resection of lobe of brain, when the surgery cannot be coded as 20-30

55 Gross total resection of lobe of brain (lobectomy)

Codes 30-55 are not applicable for spinal cord or spinal nerve primary sites.

Specimen sent to pathology from surgical events 20-55.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

THYROID GLAND
C73.9
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

13 Local tumor destruction, NOS

No specimen sent to pathology from surgical event 13.

25 Removal of less than a lobe, NOS
- 26 Local surgical excision
- 27 Removal of a partial lobe ONLY

20 Lobectomy and/or isthmectomy
- 21 Lobectomy ONLY
- 22 Isthmectomy ONLY
- 23 Lobectomy WITH isthmus

30 Removal of a lobe and partial removal of the contralateral lobe

40 Subtotal or near total thyroidectomy

50 Total thyroidectomy

80 Thyroidectomy, NOS

Specimen sent to pathology from surgical events 25-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

LYMPH NODES
C77.0-C77.9
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS
Unknown whether a specimen was sent to pathology for surgical events coded to 19 (principally for cases diagnosed prior to January 1, 2003).

15 Local tumor destruction, NOS
No specimen sent to pathology from surgical event 15.

25 Local tumor excision, NOS
Less than a full chain, includes an excisional biopsy of a single lymph node.

30 Lymph node dissection, NOS
- 31 One chain
- 32 Two or more chains

40 Lymph node dissection, NOS PLUS splenectomy
- 41 One chain
- 42 Two or more chains

50 Lymph node dissection, NOS and partial/total removal of adjacent organ(s)
- 51 One chain
- 52 Two or more chains

60 Lymph node dissection, NOS and partial/total removal of adjacent organ(s) PLUS splenectomy
(Includes staging laparotomy for lymphoma.)
- 61 One chain
- 62 Two or more chains

Specimen sent to pathology for surgical events 25-62.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

ALL OTHER SITES
C14.2-C14.8, C17.0-C17.9, C23.9, C24.0-C24.9, C26.0-C26.9 C30.0-C30.1, C31.0-C31.9, C33.9, C37.9, C38.0-C38.8, C39.0-C39.9, C48.0-C48.8, C51.0-C51.9, C52.9, C57.0-C57.9, C58.9, C60.0-C60.9, C63.0-C63.9, C68.0-C68.9, C69.0-C69.9, C74.0-C74.9, C75.0-C75.9
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from surgical events 10-14.

- 20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26-27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Simple/partial surgical removal of primary site

40 Total surgical removal of primary site; enucleation
- 41 Total enucleation (for eye surgery only)

50 Surgery stated to be “Debulking”

60 Radical surgery
Partial or total removal of the primary site WITH a resection in continuity (partial or total removal) with other organs.

Specimen sent to pathology from surgical events 20-60.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

UNKNOWN AND ILL-DEFINED PRIMARY SITES
C76.0-C76.8, C80.9
(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Code

98 All unknown and ill-defined disease sites, WITH or WITHOUT surgical treatment.

Surgical procedures for unknown and ill-defined primaries are to be recorded using the data item *Surgical Procedure/Other Site*.

Appendix B
Countries and States

Geographic Area	Country Code	State or Province Code
Preferred: Specific Codes for Use where detail is known		
United States (state and armed forces codes)		
Alabama	USA	AL
Alaska	USA	AK
Arizona	USA	AZ
Arkansas	USA	AR
Armed Forces Americas	USA	AA
Armed Forces Canada, Europe, Middle East, Africa	USA	AE
Armed Forces Pacific	USA	AP
California	USA	CA
Colorado	USA	CO
Connecticut	USA	CT
Delaware	USA	DE
District of Columbia	USA	DC
Florida	USA	FL
Georgia	USA	GA
Hawaii	USA	HI
Idaho	USA	ID
Illinois	USA	IL
Indiana	USA	IN
Iowa	USA	IA
Kansas	USA	KS
Kentucky	USA	KY
Louisiana	USA	LA
Maine	USA	ME
Maryland	USA	MD
Massachusetts	USA	MA
Michigan	USA	MI
Minnesota	USA	MN
Mississippi	USA	MS
Missouri	USA	MO
Montana	USA	MT
Nebraska	USA	NE
Nevada	USA	NV
New Hampshire	USA	NH
New Jersey	USA	NJ
New Mexico	USA	NM
New York	USA	NY
North Carolina	USA	NC
North Dakota	USA	ND
Ohio	USA	OH
Oklahoma	USA	OK
Oregon	USA	OR
Pennsylvania	USA	PA
Rhode Island	USA	RI
South Carolina	USA	SC
South Dakota	USA	SD
Tennessee	USA	TN
Texas	USA	TX
Utah	USA	UT
Vermont	USA	VT
Virginia	USA	VA

Geographic Area	Country Code	State or Province Code
Washington	USA	WA
West Virginia	USA	WV
Wisconsin	USA	WI
Wyoming	USA	WY
Canada (province and territory codes)		
Alberta	CAN	AB
British Columbia	CAN	BC
Manitoba	CAN	MB
New Brunswick	CAN	NB
Newfoundland and Labrador	CAN	NL
Northwest Territories	CAN	NT
Nova Scotia	CAN	NS
Nunavut	CAN	NU
Ontario	CAN	ON
Prince Edward Island	CAN	PE
Quebec	CAN	QC
Saskatchewan	CAN	SK
Yukon Territory	CAN	YT
Afghanistan	AFG	XX
Aland Islands	ALA	XX
Albania	ALB	XX
Algeria	DZA	XX
American Samoa	ASM	AS
Andorra	AND	XX
Angola (Sao Tome, Principe, Cabinda)	AGO	XX
Anguilla	AIA	XX
Antarctica	ATA	XX
Antigua and Barbuda	ATG	XX
Argentina	ARG	XX
Armenia	ARM	XX
Aruba	ABW	XX
Australia	AUS	XX
Australia and Australian New Guinea	AUS	XX
Austria	AUT	XX
Azerbaijan	AZE	XX
Bahamas	BHS	XX
Bahrain	BHR	XX
Bangladesh (East Pakistan)	BGD	XX
Barbados	BRB	XX
Belgium	BEL	XX
Belize (British Honduras)	BLZ	XX
Benin	BEN	XX
Bermuda	BMU	XX
Bhutan	BTN	XX
Bolivia, Plurinational State of	BOL	XX
Bonaire, Saint Eustatius and Saba	BES	XX
Bosnia and Herzogovina	BIH	XX
Botswana	BWA	XX
Bouvet Island	BVT	XX
Brazil	BRA	XX
British Indian Ocean Territory	IOT	XX

Geographic Area	Country Code	State or Province Code
Virgin Islands, British	VGB	XX
Brunei Darussalam	BND	XX
Bulgaria	BGR	XX
Burkina Faso	BFA	XX
Burma (Myanmar)	MMR	XX
Burundi (Urundi)	BDI	XX
Byelorus (Byelorussian SSR, White Russia)	BLR	XX
Cambodia	KHM	XX
Cameroon	CMR	XX
Panama (Canal Zone)	PAN	XX
Cape Verde	CPV	XX
Cayman Islands	CYM	XX
Central African Republic	CAF	XX
Ceylon (Sri Lanka)	LKA	XX
Chad	TCD	XX
Chile	CHL	XX
China (Peoples Republic of China)	CHN	XX
Christmas Island	CXR	XX
Cocos (Keeling) Islands	CCK	XX
Colombia	COL	XX
Comoros	COM	XX
Congo	COG	XX
Cook Islands	COK	XX
Costa Rica	CRI	XX
Cote d'Ivoire	CIV	XX
Croatia	HRV	XX
Cuba	CUB	XX
Curacao	CUW	XX
Cyprus	CYP	XX
Czech Republic	CZE	XX
Denmark, Faroe Islands	DNK	XX
Djibouti	DJI	XX
Dominica	DMA	XX
Dominican Republic	DOM	XX
Ecuador	ECU	XX
Egypt (United Arab Republic)	EGY	XX
El Salvador	SLV	XX
England	ENG	XX
Equatorial Guinea	GNQ	XX
Eritrea	ERI	XX
Estonian SSR (Estonia)	EST	XX
Ethiopia	ETH	XX
Falkland Islands (Malvinas)	FLK	XX
Faroe Islands	FRO	XX
Fiji	FJI	XX
Finland	FIN	XX
France, Corsica, Monaco	FRA	XX
French Guiana	GUF	XX
French Polynesia	PYF	XX
French Southern Territories	ATF	XX
Gabon	GAB	XX
Gambia	GMB	XX
Georgia	GEO	XX

Geographic Area	Country Code	State or Province Code
Germany (East and West)	DEU	XX
Ghana	GHA	XX
Gibraltar	GIB	XX
Greece	GRC	XX
Greenland	GRL	XX
Grenada	GRD	XX
Guadeloupe	GLP	XX
Guam	GUM	GU
Guatemala	GTM	XX
Guernsey	GGY	XX
Guinea	GIN	XX
Guinea Bissau	GNB	XX
Guyana (British Guiana)	GUY	XX
Haiti	HTI	XX
Heard Island and McDonald Islands	HMD	XX
Honduras	HND	XX
Hong Kong	HKG	XX
Hungary	HUN	XX
Iceland	ISL	XX
India	IND	XX
Indonesia (Dutch East Indies)	IDN	XX
Iran (Persia)	IRN	XX
Iraq	IRQ	XX
Ireland (Eire) (Ireland NOS, Republic of Ireland)	IRL	XX
Isle of Man	IMN	XX
Israel	ISR	XX
Italy (Sardinia, Sicily), San Marino, Vatican City	ITA	XX
Jamaica	JAM	XX
Japan	JPN	XX
Jersey	JEY	XX
Johnston Atoll	UMI	UM
Jordan (Transjordan) and former Arab Palestine	JOR	XX
Kazakhstan	KAZ	XX
Kenya	KEN	XX
Kiribati (Canton, Enderbury, Gilbert, S Lines, Phoenix)	KIR	XX
Kuwait	KWT	XX
Kyrgyzstan	KGZ	XX
Laos, Lao People's Democratic Republic	LAO	XX
Latvian SSR (Latvia)	LVA	XX
Lebanon	LBN	XX
Lesotho	LSO	XX
Liberia	LBR	XX
Libya (Tripoli, Tripolitania, Cyrenaica), Libyan Arab Jamahiriya	LBY	XX
Liechtenstein	LIE	XX
Lithuania (Lithuanian SSR)	LTU	XX
Luxembourg	LUX	XX
Macao (Macau)	MAC	XX
Macedonia	MKD	XX
Madagascar (Malagasy Republic)	MDG	XX
Malawi (Nyasaland)	MWI	XX
Malaysia	MYS	XX
Mali	MLI	XX
Malta	MLT	XX

Geographic Area	Country Code	State or Province Code
Mariana Islands (Trust Territory of Pacific Islands)	MNP	MP
Marshall Islands (Trust Territory Pacific Islands)	MHL	MH
Martinique	MTQ	XX
Mauritania	MRT	XX
Mauritius	MUS	XX
Mayotte	MYT	XX
Mexico	MEX	XX
Micronesia (Fed States of) (Carolina, Trust Territory of Pacific)	FSM	FM
Mid-East Asia NOS, Maldives	MDV	XX
Midway Islands, U.S. Minor Outlying Islands	UMI	UM
Moldova	MDA	XX
Monaco	MCO	XX
Mongolia	MNG	XX
Montenegro	MNE	XX
Montserrat	MSR	XX
Morocco	MAR	XX
Mozambique	MOZ	XX
Namibia	NAM	XX
Nampo-Shoto, Southern (Japan)	JPN	XX
Nauru	NRU	XX
Nepal, Bhutan, Sikkim	NPL	XX
Netherlands	NLD	XX
New Caledonia	NCL	XX
New Zealand	NZL	XX
Nicaragua	NIC	XX
Niger	NER	XX
Nigeria	NGA	XX
Niue	NIU	XX
Norfolk Island	NFK	XX
North Korea	PRK	XX
Northern Ireland (Ulster)	NIR	XX
Norway (Svalbard, Jan Mayen)	NOR	XX
Oman	OMN	XX
Pakistan (West Pakistan)	PAK	XX
Palau (Trust Territory of Pacific Islands)	PLW	PW
Palestine Territory, Occupied	PSE	XX
Panama	PAN	XX
Papua New Guinea	PNG	XX
Paraguay	PRY	XX
Peru	PER	XX
Philippines (Philippine Islands)	PHL	XX
Pitcairn Islands	PCN	XX
Poland	POL	XX
Portugal (Madeira Islands, Azores, Cape Verde Islands)	PRT	XX
Puerto Rico	PRI	PR
Qatar	QAT	XX
Republic of South Africa	ZAF	XX
Reunion	REU	XX
Romania	ROU	XX
Russian SFSR (Russia)	RUS	XX
Rwanda (Ruanda)	RWA	XX
Ryukyu Islands (Japan)	JPN	XX
Samoa	WSM	XX

Geographic Area	Country Code	State or Province Code
San Marino	SMR	XX
Sao Tome & Principe	STP	XX
Saudi Arabia	SAU	XX
Scotland	SCT	XX
Senegal	SEN	XX
Serbia	SRB	XX
Seychelles	SYC	XX
Sierra Leone	SLE	XX
Singapore	SGP	XX
Sint-Maarten	SXM	XX
Slovakia	SWK	XX
Slovenia	SVN	XX
Solomon Islands	SLB	XX
Somalia (Somali Republic, Somaliland)	SOM	XX
South Georgia and the South Sandwich Islands	SGS	XX
South Sudan	SSD	XX
Spain (Canary Islands, Balearic Islands), Andorra	ESP	XX
St Pierre and Miquelon	SPM	XX
St. Barthelemy	BLM	XX
St. Helena, Ascension and Tristan da Cunha	SHN	XX
St. Kitts and Nevis	KNA	XX
St. Lucia	LCA	XX
St. Vincent and the Grenadines	VCT	XX
Sudan	SDN	XX
Surinamne (Dutch Guiana)	SUR	XX
Svalbard and Jan Mayen	SJM	XX
Swan Islands	UMI	UM
Swaziland	SWZ	XX
Sweden	SWE	XX
Switzerland	CHE	XX
Syria	SYR	XX
Taiwan (Formosa) (Republic of China)	TWN	XX
Tajikistan	TJK	XX
Tanzania (Tanganyika, Zanzibar)	TZA	XX
Thailand (Siam)	THA	XX
Tibet	CHN	XX
Timor-Leste	TLS	XX
Togo	TGO	XX
Tokelau Islands (New Zealand)	TKL	XX
Tonga	TON	XX
Trinidad and Tobago	TTO	XX
Tunisia	TUN	XX
Turkey	TUR	XX
Turkmenistan	TKM	XX
Turks and Caicos	TCA	XX
Tuvalu (Ellice Islands)	TUV	XX
U.S. Virgin Islands	VIR	VI
Uganda	UGA	XX
Ukraine	UKR	XX
United Arab Emirates	ARE	XX
Uruguay	URY	XX
Uzbekistan	UZB	XX
Vanuatu	VLT	XX

Geographic Area	Country Code	State or Province Code
Holy See (Vatican City State)	VAT	XX
Venezuela, Bolivarian Republic of	VEN	XX
Vietnam (Tonkin, Annam, Cochin China)	VNM	XX
Wake Island	UMI	UM
Wales	WLS	XX
Wallis and Fotuna	WLF	XX
Western Sahara	ESH	XX
Yemen	YEM	XX
Zaire (Congo-Leopoldville, Belgian Congo, Congo/Kinshasa)	COD	XX
Zambia (Northern Rhodesia)	ZMB	XX
Zimbabwe (Rhodesia, Southern Rhodesia)	ZWE	XX
General: Codes to Use in the Absence of More Specific Information		
United States, NOS	USA	US
Canada, NOS	CAN	CD
Africa, NOS (Central, Equatorial)	ZZF	YY
Asia, NOS	ZZA	YY
Asian and Arab Countries	ZZA	YY
Atlantic, Caribbean Area	ZZN	YY
Baltic Republic(s), NOS (Baltic States, NOS)	ZZE	YY
Central America	ZZC	XX
Czechoslovakia	CSK	XX
East Asia	ZZA	YY
Europe, NOS (Central, Eastern, Northern, Southern, Western)	ZZE	YY
Latin America, NOS	ZZU	YY
Near East	ZZA	YY
North America, NOS	ZZN	YY
Other Atlantic/Caribbean Area (not on detailed list)	ZZN	YY
Other Mainland Europe (not on detailed list)	ZZE	YY
Other Mediterranean Isles (not on detailed list)	ZZE	YY
Other Pacific Area (not on first list)	ZZP	YY
Pacific Area, NOS	ZZP	YY
Pacific Islands, NOS	ZZP	YY
Romance-Language Countries	ZZE	YY
South America, NOS	ZZS	YY
South American Islands	ZZS	YY
United Kingdom, NOS	GBR	XX
Yugoslavia	YUG	XX
Not U.S., but no other information	ZZX	YY
Unknown, no mention in patient record	ZZU	ZZ
Obsolete: State/Province or Country Codes that must NOT be used for current coding (may have been assigned during conversion, so may be present in pre-2013 data)		
New England and New Jersey	USA	NN
Maritime Provinces (New Brunswick, Newfound, Nova Scotia, PE)	CAN	MM
Northwest Territories, Yukon Territory	CAN	YN
Prairie Provinces (Alberta, Manitoba, Saskatchewan)	CAN	PP
African Coastal Islands (previously in South Africa, NOS)	XIF	YY
Arabian Peninsula	XAP	YY

Geographic Area	Country Code	State or Province Code
Caucasian Republics of the USSR	XCR	YY
China, NOS	XCH	YY
East Africa	XEF	YY
England, Channel Islands, Isle of Man	XEN	XX
Ethiopia (Abyssinia), Eritrea	XET	YY
Germanic Countries	XGR	YY
Indochina	XSE	YY
Israel and former Jewish Palestine	XIS	YY
Korea (Not Specified whether North or South)	KOR	XX
Malaysia, Singapore, Brunei	XMS	YY
Melanesian Islands, Solomon Islands	XML	YY
Micronesian Islands	XMC	YY
North Africa	XNF	YY
North American Islands	XNI	YY
Other Asian Republics of the USSR	XOR	YY
Other Caribbean Islands	XCB	YY
Other West African Countries	XWF	YY
Polynesian Islands	XPL	YY
Republic of South Africa, Botswana, Lesotho, Namibia, Swaziland	XSF	YY
Scandinavia	XSC	YY
Slavic Countries	XSL	XX
South Africa, NOS	XSF	YY
Southeast Asia	XSE	YY
Sundanese Countries	XSD	YY
Ukraine and Moldavia	XUM	YY
West Africa, NOS (French Africa, NOS)	XSF	YY

Appendix C
Changes to 2018 Abstracting Manual

Changes to MCTR Abstracting Manual 2018

Yellow highlights in manual reflect the changes outlined below.

Sections removed from 2016 Reporting Manual

Collaborative Staging sections and related fields
Comorbidities and Complications sections (use Secondary Diagnoses 1-10 for ICD-10-CM codes)
Grade section and referenced the Grade Manual
AJCC 7th edition TNM Clinical and Pathological sections to accommodate AJCC 8th edition
SEER Summary Stage 2000 to accommodate SEER Summary Stage 2018
CS Site Specific Factors to accommodate Site-Specific Data Indicators (SSDIs)
Radiation fields to accommodate revised radiation fields

Page	Variable	Change
8		Added List of Resources necessary for 2018 abstracting
9-10		Revised Preface; Summarized Changes to the 2018 Manual (modified, removed, and new fields)
11		Revised Required Status Definitions; Revised Purpose, Revised Casefinding
12-13		Revised and reformatted Reportable List
14		Added Ambiguous Terminology Lists
15		Revised Reportable ICD-10-CM Codes List
16		Updated Confidentiality paragraph
17		Revised Multiple Primaries and Paired Organs paragraphs
46-47	Place of Birth – State & Country	Changed Appendix C to Appendix B
49	Street Address at DX	Revised Coding Instructions
59	County at Diagnosis – Reported	Name of field changed, revised Coding Instructions
60	Address at DX – Country	Changed Appendix C to Appendix B
61	Current Street Address	Revised Coding Instructions
67	Current Address – Country	Changed Appendix C to Appendix B
70	Class of Case	Revised codes 34, 35, and 36
86-87	Secondary Diagnosis 1-10	Changed Required Status to Required by CoC
91-92	NPI-Facility Referred From & To	Changed Required Status to Required by CoC
101	Primary Site	Updated Coding Instructions
110	Histology	Updated Coding Instructions
113	Grade Clinical	New Field
114	Grade Pathological	New Field
115	Grade Post Therapy	New Field
117	Summary Stage 2018	New Field
130-131	Mets at Diagnosis – Other	Revised Description, coding Instructions, added Code 2
134	AJCC TNM Clin T	New Field
135	AJCC TNM Clin T Suffix	New Field
136	AJCC TNM Clin N	New Field
137	AJCC TNM Clin N Suffix	New Field
138	AJCC TNM Clin M	New Field
139	AJCC TNM Clin Stage Group	New Field
140	AJCC TNM Path T	New Field
141	AJCC TNM Path T Suffix	New Field
142	AJCC TNM Path N	New Field
143	AJCC TNM Path N Suffix	New Field
144	AJCC TNM Path M	New Field
145	AJCC TNM Path Stage Group	New Field
146	AJCC TNM Post Therapy T	New Field
147	AJCC TNM Post Therapy T Suffix	New Field
148	AJCC TNM Post Therapy N	New Field
149	AJCC TNM Post Therapy N Suffix	New Field

Page	Variable	Change
150	AJCC TNM Post Therapy M	New Field
151	AJCC TNM Post Therapy Stage Group	New Field
152-155	Lymph-Vascular Invasion	Revised Coding Instructions
156-157	Date Sentinel LN Biopsy & Flag	New Field
158	Sentinel LN Examined	New Field
159-160	Sentinel LN Positive	New Field
161-162	Date Regional LN Dissection & Flag	New Field
163-164	Regional LN Positive	Revised Coding Instructions
165-166	Regional LN Examined	Revised Coding Instructions
167-169	Site-Specific Data Items	New Fields
199	Surgery of Primary Site	Changed Appendix B to Appendix A
202-203	Date of Surgical Discharge & Flag	Changed Required Status to Required by CoC
206-207	Date Radiation Ended & Flag	Changed Required Status to Required by CoC
207-222	Phase I Radiation Fields	New Fields
223-238	Phase II Radiation Fields	New Fields
239-253	Phase III Radiation Fields	New Fields
254	Number of Phases	New Field
255	Radiation Treatment Disc Early	New Field
256	Total Dose	New Field
257	Location of Radiation Treatment	Changed Required Status to Required by CoC; revised Coding Instructions
277-278	Date of Systemic Treatment & Flag	Changed Required Status to Required by CoC
285	Palliative Care	Changed Required Status to Required by CoC
287	Surgical Approach 2010	Changed Required Status to Required by CoC
289	Readmission to Hosp w/in 30 days	Changed Required Status to Required by CoC; revised Coding Instructions
290	Surgical Margins	Changed Required Status to Required by CoC
303-304	Date Last Cancer (tumor) Status & Flag	New Field
306	Cancer Status	Revised Description
309-310	Place of Death – State & Country	Changed Appendix C to B
324	Next Follow-up Source	Changed Required Status to Required by CoC
327	Recurrence Type	Revised Coding Instructions
332-342	Follow-up Contact Fields	Changed Required Status to Required
334	Follow-Up Contact – No and Street	Revised Coding Instructions
344	Override Acsn/Class/Seq	Changed Required Status to Required by CoC
345	Override HospSeq/DxConf	Changed Required Status to Required by CoC
346	Override CoC – Site/Type	Changed Required Status to Required by CoC
347	Override HospSeq/Site	Changed Required Status to Required by CoC
350	Override TNM Stage	New Field
351	Override TNM Tis	New Field
352	Override TNM 3	New Field
359	Override Name/Sex	New Field
381	Skin	Clarified codes 45-47

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