Montana
Cancer Control Programs
Chronic Disease Prevention & Health Promotion Bureau

MONTANA CENTRAL TUMOR REGISTRY

ABSTRACTING MANUAL 2016

Cancer Surveillance and Epidemiology Program
Public Health and Safety Division
Department of Public Health and Human Services
PO Box 202952
Helena, MT 59620
Phone: 406 - 444 - 5442
Fax: 406 - 444 - 6557
Web: http://dphhs.mt.gov/publichealth/Cancer/TumorRegistry.aspx

Yellow highlights reflect changes in 2016

MONTANA DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

Blank Page

Table of Contents

General Principles

Patient Information

Cancer Information

Treatment Information

Outcomes

Appendix A – Definitions of Single and Subsequent Primaries for Hematologic Malignancies (for cases prior 2010)

Appendix B – Surgical Codes

Blank Page

General Principles

Blank Page

PREFACE

Construction of this manual is modeled from the Facility Oncology Registry Data Standards 2016 (FORDS) and the SEER Program Coding and Staging Manual 2016. Implementation of this manual will be required with cancer cases diagnosed on or after January 1, 2016. FORDS has been written to ensure that cancer registry data support the meaningful evaluation of patient diagnosis and treatment and that these data are collected with standardized quality control mechanisms.

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 U58/DP003925).

REQUIRED STATUS DEFINITIONS

Required – Field required by the MCTR Administrative Rules 37.8.1801 – 37.8.1808 or Public Law 102-515.
Required-H – Field historically required to be collected by the MCTR (time period usually described in Rationale).
Recommended – Field recommended to be collected, when available.
Optional – Field is not required but may be useful to the registry depending on the abstract status; i.e., Suspense Case or error Over-rides.

PURPOSE

Central cancer registries are organizations that 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 case, complete data, 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. 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)
- Medical Record Disease Index
- History and Physical
- Consultation Notes
- Progress Notes
- Discharge Summary
- Daily admissions and discharges
- Notes from physician's offices
- Diagnostic Imaging reports (X-ray, MRI, CAT scans)
- Surgery schedule
- Medical oncology logs
- Radiation oncology logs

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. Non-analytic cases are required to be reported to the MCTR.

A. All malignant neoplasms (including in-situ) (behavior code 2 or 3)
EXCEPTION: Basal Cell Carcinoma (BCC) or Squamous Cell Carcinoma (SCC) of skin (C44._).

NOTE: 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) must be included. 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 because of their in-situ classification. These cases are not required by the Commission on Cancer but are not excluded in the Montana Law or Administrative Rules.

B. All benign tumors of the brain (behavior code 0 or 1)
INCLUDES: meninges (C70._), brain (C71._), spinal cord, cranial nerves, and other parts of the CNS (C72._), pituitary gland (C75.1), craniopharyngeal duct (C75.2), and pineal gland (C75.3)

C. All carcinoid tumors (malignant, benign, and NOS)

D. Ambiguous Terms (*with indication of reportable cancer*) without additional information. As part of casefinding, all diagnostic reports should be reviewed to confirm whether a case is required. If the terminology is ambiguous, use the following terms to determine whether a particular case should be included. Words or phrases appear to be synonyms of these terms do not constitute a diagnosis. For example, "likely" does not constitute a diagnosis.

Ambiguous Terms that Constitute a Diagnosis:

Apparent(ly)	Most likely
Appears	Presumed
Comparable with	Probable
Compatible with	Suspect(ed)
Consistent with	Suspicious (for)
Favor	Typical (of)
Malignant appearing	Neoplasm or Tumor for C70.0-C72.9, C75.1-C75.3

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.

Ambiguous Terms that *Do Not* Constitute a Diagnosis *without additional information*:

Cannot be ruled out	Questionable
Equivocal	Rule out
Possible	Worrisome
Potentially malignant	

Examples of reportable ambiguous terms:

1. 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.
2. CT of brain *suspicious for neoplasm*. Neoplasm is reportable for C70.0-C72.9, C75.1-C75.3.
3. The pathology report states *suspicious for malignancy. Suspicious for malignancy* is indicative of cancer.

Examples of non-reportable ambiguous terms:

1. 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.
2. Mammogram notes p*ossible carcinoma* of the breast. "Possible" is not a diagnostic term for cancer.
3. Mammogram notes *suspicious* density. While "suspicious" can indicate a problem, "density" is not indicative of cancer.

Genetic findings in the absence of pathologic or clinical evidence of reportable disease are indicative of risk only and do not constitute a diagnosis.

Reportable ICD-9-CM and ICD-10-CM Codes (review for reportability)

ICD-9-CM Code	ICD-10-CM Code	Description
042	B20	AIDS (*review for AIDS-related malignancies*)
140.0 – 172.9 174.0 – 209.36 209.7	C00.0 – C43.9, C45.0 – C96.9	Malignant neoplasms **except 173.0 - 173.9 or C44.00 – C44.99**
209.00 – 209.69	D3Aa._	Carcinoid tumors (any behavior) and neuroendocrine tumor (malignant only)
225.0 – 225.9	D32.0 – D33.9	Benign neoplasms of brain and spinal cord
227.3 – 227.4	D35.2, D35.3	Benign neoplasm of pituitary gland, pineal body, and other intracranial endocrine-related structures
228.02	D18.02	Hemangioma of intracranial structures
228.1	D18.1	Lymphangioma (of brain, nervous system, and reportable endocrine glands only)
230.0 – 234.9	D00.0 – D09.9	Carcinoma in-situ except **232.0 - 232.9**
236.0	D39.0	Stromal endometriosis (8931/3 per ICD-O-3)
237.0 – 237.9	D42.0 – D42.9, D43.0 – D43.9, D44.3 – D44.5	Neoplasm of uncertain behavior of endocrine glands and nervous system **except 237.2 - 237.4**
238.4	D45	Polycythemia vera (9950/3)
238.6	D47.0 – D47.9	Solitary plasmacytoma (9731/3), extramedullary plasmacytoma (9734/3)
238.71 – 238.79	D46.0 – D47.9	Other lymphatic and hematopoietic diseases
239.6 – 239.7	D49.6	Neoplasms of unspecified behavior of brain and other parts of nervous system
273.2	C88.2	Gamma heavy chain disease (9762/3); Franklin's disease (9762/3)
273.3	C88.0	Waldenstrom's macroglobulinemia (9761/3)
277.89	C96.5, C96.6	Other specified disorders of metabolism. Reportable terms include Hand-Schuller-Christian disease; histiocytosis (acute) (chronic); histiocytosis X (chronic)
285.3	D64.81	Anemia due to antineoplastic chemotherapy
288.3	D72.1	Hypereosinophilic syndrome (9964/3). Diagnosis must be "hypereosonophilic syndrome" to be reportable
288.4	D76.1 – D76.3	Hemophagocytic syndrome (histiocytic syndromes)
289.6	D45	Familial polycythemia (synonym for polycythemia vera)
289.83	D75.81	Chronic Myelofibrosis (NOS) (9961/3),
338.3	G89.3	Neoplasm-related pain (acute) (chronic); Cancer associated pain; Pain due to malignancy
511.81	J91.0	Malignant pleural effusion
789.51	R18.0	Malignant ascites
990	T66	Effects of radiation, unspecified (radiation sickness)
V10.00 – V10.9	Z85.0_ – Z85.8_	Personal history of malignancy (*review for recurrence, subsequent cancers, and/or subsequent tx*)
V58.0 – V58.12	Z51.0, Z51.1_	Encounter or admission for radiotherapy, chemotherapy, or immunotherapy (*review for reportability*)
V66.1 – V66.2	Z51.89	Convalescence following radiotherapy or chemotherapy (*review for reportability*)
V67.1 – V67.2	Z08	Follow-up exam following radiotherapy or chemotherapy (*review for reportability*)
V86.0 – V86.1	Z17	Estrogen receptor positive or negative status [ER + / ER -]
E873.2	Y63.2	Failure in dosage, overdose of radiation in therapy (radiation sickness)
E879.2	Y84.2	Adverse effect of radiation therapy
E930.7	None	Adverse effect of antineoplastic antibiotics
E933.1	None	Adverse effect of antineoplastic and immunosuppressive drugs

Non-Reportable Cancers

A. Patients with a history of malignancy who are clinically free of disease when seen at your facility.
B. Patients with skin cancer that do not meet the histology requirements in the Reportable List.
C. 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.
D. 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.
E. 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.

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 policy of the MCTR does not release any patient identifying information to third parties. Data is released only in statistically summarized form so that individual patients, hospitals, or physicians cannot be identified. Further, statistically summarized information is released only to individuals or organizations who are qualified to perform and interpret data analyses and who employ safeguards against any unauthorized disclosure.

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.

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 for *Date of Most Definitive Surgical Resection of the Primary Site*, 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

MULTIPLE PRIMARIES

The most recent **SEER Multiple Primary and Histology Coding Rules** contain site-specific rules for lung, breast, colon, melanoma of the skin, head and neck, kidney, renal pelvis/ureter/bladder, and malignant and nonmalignant brain primaries. A separate set of rules addresses the specific and general rules for all other sites. The multiple primary rules guide and standardize the process of determining the number of primaries. The histology rules contain detailed histology and coding instructions.

If an invasive and an in situ tumor are identified as a single tumor according to the **SEER Multiple Primary and Histology Coding Rules** and they are located in different subsites, the primary site should be identified as the subsite in which the *invasive* tumor is located. If, however, the two tumors are both invasive, then code the subsite as ".9".

The **SEER Multiple Primary and Histology Coding Rules** do not apply to hematopoietic and lymphoid tumors. Use the **Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual** and the **Hematopoietic and Lymphoid Neoplasms Database** to code hematopoietic primaries (lymphoma and leukemia M9590-9989) diagnosed on January 1, 2010 or later. Use the tables in Appendix A only for hematopoietic and lymphoid cases diagnosed prior to 2010. Primary site and timing are not applicable for determining whether these malignancies represent one or more primaries.

Paired Organ Sites

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

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.

AMBIGUOUS TERMINOLOGY

If the wording in the patient record is ambiguous with respect to tumor spread, use the following guidelines.

List of Ambiguous Terms Describing Tumor Spread

Terms that Constitute Tumor Involvement/Extension
Adherent
Apparent
Compatible with
Consistent with
Encroaching upon
Fixation, fixed
Induration
Into
Onto
Out onto
Probable
Suspect
Suspicious
To

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.

Blank Page

Blank Page

Patient Information

Blank Page

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.

Instructions for Coding
- 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 Hospital/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 Hospital	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

Number	NPI Number	ACoS Number	Facility Name	City
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
Path				
498	1790787935	9999999	Yellowstone Pathology Institute	Billings
493	1669597266	9999999	Northern Plains Pathology	Great Falls
495	1740364017	9999999	Western Montana Clinic	Missoula
491		9999999	St. Patrick Providence Pathology	Missoula
Phys				
200	1760485619	9999999	Tallman Dermatology	Billings
214	1093828378	9999999	Yellowstone Dermatology & Skin Cancer Cln	Billings
218	1720197817	9999999	MT Skin Cancer & Dermatology Center	Bozeman
220	1265477681	9999999	Big Sky Dermatology	Bozeman
202	1003900457	9999999	Advanced Dermatology of Butte	Butte
208	1720073596	9999999	Dermatology Office of Great Falls	Great Falls
210	1003902909	9999999	Helena Dermatology & Laser Clinic	Helena
212	1497896229	9999999	Associated Dermatology of Helena	Helena
204	1114093846	9999999	Dermatology Associates of Kalispell	Kalispell
104	1427034834	9999999	Glacier Oncology	Kalispell
206	1942217484	9999999	CPG Dermatology	Missoula
216	1518045731	9999999	Dermatology Provider of Missoula	Missoula

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.

Instructions for Coding
- 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.

Instructions for Coding
- 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.

Instructions for Coding

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.

Instructions for Coding

- 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.

Instructions for Coding

- 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 11-14)

(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.

Instructions for Coding
- 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.

Instructions for Coding
- 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.

Instructions for Coding

- 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.

Instructions for Coding
- 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.

Instructions for Coding
- 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.

Instructions for Coding
- 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.

Instructions for Coding

- 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.

Instructions for Coding
- 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*

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date of First Contact* and *Date of First Contact Flag.* ***In the table below, the lowercase letter "b" is used to represent each blank space***.

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 date	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12

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.

Instructions for Coding
- 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.

Instructions for Coding
- 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.

Instructions for Coding

- 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.

Instructions for Coding

- 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.

Instructions for Coding
- 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*

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date of Birth* and *Date of Birth Flag.* ***In the table below, the lowercase letter "b" is used to represent each blank space***.

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: 02181942)	CCYYMMDD (example: 19420218)	bb
Month and year known	MM99CCYY (example: 02991942)	CCYYMMbb (example: 194202bb)	bb
Year only known	9999CCYY (example: 99991942)	CCYYbbbb (example: 1942bbbb)	bb
Unknown date	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12

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.

Instructions for Coding
- 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.

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

Instructions for Coding
- Use the most specific code.
- This item corresponds to *Birthplace - Country*.
- See Appendix C 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.

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.

Instructions for Coding
- This item corresponds to *Birthplace – State*.
- See Appendix C 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 geographi9cal 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
Patient Address at Diagnosis 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.

Instructions for Coding

- 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 is normally limited to periods (i.e., 39.2 RD), slashes for fractional addresses (i.e., 101 ½ MAIN ST), and hyphens when a hyphen carries meaning (i.e., 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 (i.e., 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 52 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.

Instructions for Coding
- 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 52 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.

Instructions for Coding
- 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 52 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.

Instructions for Coding
- 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.

Instructions for Coding
- 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 52 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

City	County	Zip	City	County	Zip
Dayton	Lake	59914	De Borgia	Mineral	59830
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

City	County	Zip	City	County	Zip
Joliet	Carbon	59041	Joplin	Liberty	59531
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

City	County	Zip	City	County	Zip
Rapelje	Stillwater	59067	Ravalli	Lake	59863
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

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	90	3	01/04, 09/06, 01/10, 01/15	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.

Instructions for Coding

- For U.S. residents, use codes issued by the Federal Information Processing Standards (FIPS) publication, *Counties and Equivalent Entities of the United States, Its Possessions, and Associated areas*. This publication is available in a reference library or can be accessed on the Internet through the U.S. EPA's Envirofacts Data Warehouse and Applications Web site at *http://www.epa.gov/*.
- 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.

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.

Instructions for Coding
- 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 C 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*.

Instructions for Coding
- 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 is normally limited to periods (i.e., 39.2 RD), slashes for fractional addresses (i.e., 101 ½ MAIN ST), and hyphens when a hyphen carries meaning (i.e., 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 (i.e., 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 52 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.

Instructions for Coding
- 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 "Residence Rules" on page 52 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*.

Instructions for Coding
- 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 52 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*.

Instructions for Coding
- 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*.

Instructions for Coding
- 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 58-62 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.

Instructions for Coding
- This item corresponds to the other *Current State*.
- See Appendix C 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.

Instructions for Coding
- 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.

Instructions for Coding

- 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
	Initial diagnosis at reporting facility or in a staff physician's office	**by MCTR**
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
	Patient appears in person at reporting facility; both initial diagnosis and treatment elsewhere	**by MCTR**
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 (for example, a benign colon tumor) AND initial diagnosis AND part or all of first course treatment by reporting facility	
35	Case diagnosed before program'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 (for example, a benign colon tumor) 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)	
43*	Pathology or other lab specimens only	√
49*	Death certificate only	
	Unknown relationship to reporting facility	

Code	Definition	Reportable
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.

*Indicates *Class of Case* codes appropriate for abstracting cases from non-hospital sources such as physician offices, ambulatory surgery centers, freestanding pathology laboratories, or radiation therapy centers. When applied to these types of facilities, the non-hospital source is the reporting facility. The codes are applied the same way as if the case were reported from a hospital.

All accessioned cases are assigned a *Class of Case* based on the nature of involvement of the facility in the care of the patient.

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.

Modifications to Class of Case in 2010

Class of Case was redefined for use beginning in 2010. The codes in this manual allow differentiation between analytic and non-analytic cases and make additional distinctions. For analytic cases, the codes distinguish cases diagnosed in a staff physician's office from those diagnosed initially by the facility and patients fully treated at the facility from those partially treated by the reporting facility. Non-analytic cases are distinguished by whether the patient received care at the facility or did not personally appear there. Patients who received care from the facility are distinguished by the reasons a case may not be analytic: diagnosed prior to the patient's reference date, type of cancer that is not required by CoC to be abstracted, consultation, in-transit care, and care for recurrent or persistent disease. Patients who did not receive care from the reporting facility are distinguished by care given in one or more staff physician offices, care given through an agency whose cancer cases are abstracted by the reporting facility but are not part of it, pathology only cases, and death certificate only cases. Treatment in staff physician offices is now coded "treated elsewhere" because the hospital has no more responsibility over this treatment than it would if the patient were treated in another hospital.

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.

Instructions for Coding
- 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.

Instructions for Coding
- 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. SEER participants in San Francisco, San Jose-Monterey, and Los Angeles are permitted to use codes 14 and 20-97 for cases diagnosed after January 1, 1987.
- 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.

Instructions for Coding

- "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. SEER participants in San Francisco, San Jose-Monterey, and Los Angeles are permitted to use codes 14 and 20-97 for cases diagnosed after January 1, 1987.
- 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.

Instructions for Coding
- "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. SEER participants in San Francisco, San Jose-Monterey, and Los Angeles are permitted to use codes 14 and 20-97 for cases diagnosed after January 1, 1987.
- 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.

Instructions for Coding
- "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. SEER participants in San Francisco, San Jose-Monterey, and Los Angeles are permitted to use codes 14 and 20-97 for cases diagnosed after January 1, 1987.
- 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.

Instructions for Coding
- "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. SEER participants in San Francisco, San Jose-Monterey, and Los Angeles are permitted to use codes 14 and 20-97 for cases diagnosed after January 1, 1987.
- 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*.

Instructions for Coding
- 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.

Instructions for Coding
- 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.

Instructions for Coding
- 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.

Instructions for Coding

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.

Instructions for Coding

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.

Instructions for Coding
- 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.

Instructions for Coding
- 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.

Comorbidities and Complications

The registry record includes up to 10 comorbid conditions, factors influencing the health status of the patient, and treatment complications, to be copied from the patient record. All are secondary diagnoses. The information is recorded in the **International Classification of Diseases, Ninth Revision, Clinical Modification** (**ICD-9-CM)** code form, typically on the patient's discharge abstract or face sheet of the billing record. Registries should not combine use of ICD-9-CM and ICD-10-CM in a single record.

Three general categories of information are collected: comorbidities, complications, and factors influencing the health status of patients.

Comorbidities are preexisting medical conditions or conditions that were present at the time the patient was diagnosed with this cancer (for example, chronic conditions such as COPD, diabetes, and hypertension).

Complications are conditions that occur during the hospital stay, while the patient is being treated for the cancer (for example, postoperative urinary tract infection or pneumonia). Complications may also occur following the completion of therapy and be a cause for readmission to the hospital. Complications are identified by codes which classify environmental events, circumstances, and conditions as the cause of injury, poisoning, and other adverse effects. Only complication codes that describe adverse effects occurring during medical care are collected in this data item. They include misadventures to patients during surgical and medical care, and drugs and medicinal and biologic substances causing adverse effects in therapeutic use.

Factors influencing the health status of patients are circumstances or problems that are not themselves a current illness or injury (for example, women receiving post-menopausal hormone replacement therapy, or a history of malignant neoplasm). Only specific codes which describe health characteristics are collected in this data item. They include prophylactic measures, personal health history, pregnancy, contraception, artificial opening and other post-surgical states, and prophylactic organ removal.

Comorbidities and Complications 1

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	3110	5	06/05, 01/11, 01/12, 01/13	Recommended

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-9-CM. All are considered secondary diagnoses.

Rationale
Preexisting 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.

Instructions for Coding

- Use this item to record ICD-9-CM codes. Use *Secondary Diagnosis 1* to record ICD-10-CM codes. During the adoption of ICD-10-CM codes, it is possible that both will appear in the same patient record.
- 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 *Comorbidities and Complications* ICD-9-CM codes appearing on the "readmission" discharge abstract.
- If no secondary diagnoses were documented, then code 00000 in this data item, and leave the remaining *Comorbidities and Complications* data items blank.
- If fewer than 10 secondary diagnoses are listed, then code the diagnoses listed, and leave the remaining *Comorbidities and Complications* data items blank.

Code	Definition
00000	No comorbid conditions or complications documented.
00100-13980, 24000-99990	Comorbid conditions: Omit the decimal point between the third and fourth characters.
E8700-E8799, E9300-E9499	Complications: Omit the decimal point between the fourth and fifth characters.
V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, V5041-V5049	Factors affecting health status: Omit the decimal point between the fourth and fifth characters.

Examples:

Code	Reason (ICD-9-CM)
49600	COPD (ICD-9-CM code 496)
25001	Type 1 diabetes mellitus (ICD-9-CM code 250.01)
E8732	The patient was inadvertently exposed to an overdose of external beam radiation (ICD-9-CM code E873.2)
E9300	During hospitalization, the patient has an adverse reaction to Ampicillin, a semisynthetic form of penicillin (ICD-9-CM code E930.0)
V1030	The patient has a personal history of breast cancer (ICD-9-CM code V10.3)

Comorbidities and Complications 2

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	3120	5	01/11, 01/12, 01/13, 01/15	Recommended

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-9-CM codes. All are considered secondary diagnoses.

Rationale
Preexisting 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.

Instructions for Coding
- Use this item to record ICD-9-CM codes. Use *Secondary Diagnosis 2* to record ICD-10-CM codes. During the adoption of ICD-10-CM codes, it is possible that both will appear in the same patient record.
- If only one comorbid condition or complication is listed, then leave this data item blank.
- If only two comorbid conditions or complications are listed, then code the diagnoses listed and leave remaining *Comorbidities and Complications* items blank.
- For further coding instructions, see *Comorbidities and Complications 1*.

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 10 comorbid conditions or complications. *Note*: For comorbid conditions (ICD-9-CM codes 001-139.8 and 240-999.9) there is an assumed decimal point between the 3rd and 4th characters. *Note:* For complications (ICD-9-CM "E" codes) and factors influencing health status (ICD-9-CM "V" codes) there is an assumed decimal point between the fourth and fifth characters.
(leave blank)	Fewer than two comorbid conditions or complications documented.

Code	Definition
00100-13980, 24000-99990	Comorbid conditions: Omit the decimal point between the third and fourth characters.
E8700-E8799, E9300-E9499	Complications: Omit the decimal point between the fourth and fifth characters.
V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, V5041-V5049	Factors affecting health status: Omit the decimal point between the fourth and fifth characters.

Comorbidities and Complications 3

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	3130	5	01/11, 01/12, 01/13, 01/15	Recommended

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-9-CM codes. All are considered secondary diagnoses.

Rationale
Preexisting 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.

Instructions for Coding
- Use this item to record ICD-9-CM codes. Use *Secondary Diagnosis 3* to record ICD-10-CM codes. During the adoption of ICD-10-CM codes, it is possible that both will appear in the same patient record.
- If fewer than three comorbid conditions or complications are listed, then leave this data item blank.
- If only three comorbid conditions or complications are listed, then code the diagnoses listed and leave remaining *Comorbidities and Complications* items blank.
- For further coding instructions, see *Comorbidities and Complications 1*.

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 10 comorbid conditions or complications. *Note*: For comorbid conditions (ICD-9-CM codes 001-139.8 and 240-999.9) there is an assumed decimal point between the 3rd and 4th characters. *Note:* For complications (ICD-9-CM "E" codes) and factors influencing health status (ICD-9-CM "V" codes) there is an assumed decimal point between the fourth and fifth characters.
(leave blank)	Fewer than three comorbid conditions or complications documented.

Code	Definition
00100-13980, 24000-99990	Comorbid conditions: Omit the decimal point between the third and fourth characters.
E8700-E8799, E9300-E9499	Complications: Omit the decimal point between the fourth and fifth characters.
V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, V5041-V5049	Factors affecting health status: Omit the decimal point between the fourth and fifth characters.

Comorbidities and Complications 4

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	3140	5	01/11, 01/12, 01/13, 01/15	Recommended

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-9-CM codes. All are considered secondary diagnoses.

Rationale
Preexisting 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.

Instructions for Coding
- Use this item to record ICD-9-CM codes. Use *Secondary Diagnosis 4* to record ICD-10-CM codes. During the adoption of ICD-10-CM codes, it is possible that both will appear in the same patient record.
- If fewer than four comorbid conditions or complications are listed, then leave this data item blank.
- If only four comorbid conditions or complications are listed, then code the diagnoses listed and leave remaining *Comorbidities and Complications* items blank.
- For further coding instructions, see *Comorbidities and Complications 1*.

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 10 comorbid conditions or complications. *Note*: For comorbid conditions (ICD-9-CM codes 001-139.8 and 240-999.9) there is an assumed decimal point between the 3rd and 4th characters. *Note:* For complications (ICD-9-CM "E" codes) and factors influencing health status (ICD-9-CM "V" codes) there is an assumed decimal point between the fourth and fifth characters.
(leave blank)	Remaining unused fields.

Code	Definition
00100-13980, 24000-99990	Comorbid conditions: Omit the decimal point between the third and fourth characters.
E8700-E8799, E9300-E9499	Complications: Omit the decimal point between the fourth and fifth characters.
V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, V5041-V5049	Factors affecting health status: Omit the decimal point between the fourth and fifth characters.

Comorbidities and Complications 5

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	3150	5	01/11, 01/12, 01/13, 01/15	Recommended

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-9-CM codes. All are considered secondary diagnoses.

Rationale
Preexisting 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.

Instructions for Coding
- Use this item to record ICD-9-CM codes. Use *Secondary Diagnosis 5* to record ICD-10-CM codes. During the adoption of ICD-10-CM codes, it is possible that both will appear in the same patient record.
- If fewer than five comorbid conditions or complications are listed, then leave this data item blank.
- If only five comorbid conditions or complications are listed, then code the diagnoses listed and leave remaining *Comorbidities and Complications* items blank.
- For further coding instructions, see *Comorbidities and Complications 1*.

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 10 comorbid conditions or complications. *Note*: For comorbid conditions (ICD-9-CM codes 001-139.8 and 240-999.9) there is an assumed decimal point between the 3rd and 4th characters. *Note:* For complications (ICD-9-CM "E" codes) and factors influencing health status (ICD-9-CM "V" codes) there is an assumed decimal point between the fourth and fifth characters.
(leave blank)	Fewer than five comorbid conditions or complications documented.

Code	Definition
00100-13980, 24000-99990	Comorbid conditions: Omit the decimal point between the third and fourth characters.
E8700-E8799, E9300-E9499	Complications: Omit the decimal point between the fourth and fifth characters.
V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, V5041-V5049	Factors affecting health status: Omit the decimal point between the fourth and fifth characters.

Comorbidities and Complications 6

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	3160	5	01/11, 01/12, 01/13, 01/15	Recommended

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-9-CM codes. All are considered secondary diagnoses.

Rationale
Preexisting 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.

Instructions for Coding
- Use this item to record ICD-9-CM codes. Use *Secondary Diagnosis 6* to record ICD-10-CM codes. During the adoption of ICD-10-CM codes, it is possible that both will appear in the same patient record.
- If fewer than six comorbid conditions or complications are listed, then leave this data item blank.
- If only six comorbid conditions or complications are listed, then code the diagnoses listed and leave remaining *Comorbidities and Complications* items blank.
- For further coding instructions, see *Comorbidities and Complications 1*.

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 10 comorbid conditions or complications. *Note*: For comorbid conditions (ICD-9-CM codes 001-139.8 and 240-999.9) there is an assumed decimal point between the 3rd and 4th characters. *Note:* For complications (ICD-9-CM "E" codes) and factors influencing health status (ICD-9-CM "V" codes) there is an assumed decimal point between the fourth and fifth characters.
(leave blank)	Fewer than six comorbid conditions and complications documented.

Code	Definition
00100-13980, 24000-99990	Comorbid conditions: Omit the decimal point between the third and fourth characters.
E8700-E8799, E9300-E9499	Complications: Omit the decimal point between the fourth and fifth characters.
V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, V5041-V5049	Factors affecting health status: Omit the decimal point between the fourth and fifth characters.

Comorbidities and Complications 7

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	3161	5	01/11, 01/12, 01/13, 01/15	Recommended

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-9-CM codes. All are considered secondary diagnoses.

Rationale
Preexisting 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.

Instructions for Coding
- Use this item to record ICD-9-CM codes. Use *Secondary Diagnosis 7* to record ICD-10-CM codes. During the adoption of ICD-10-CM codes, it is possible that both will appear in the same patient record.
- *Comorbidities and Complications 7* is to be used for patients diagnosed on or after January 1, 2006.
- If fewer than seven comorbid conditions or complications are listed, then leave this data item blank.
- If only seven comorbid conditions or complications are listed, then code the diagnoses listed and leave remaining *Comorbidities and Complications* items blank.
- For further coding instructions, see *Comorbidities and Complications 1*.

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 10 comorbid conditions or complications. *Note*: For comorbid conditions (ICD-9-CM codes 001-139.8 and 240-999.9) there is an assumed decimal point between the 3rd and 4th characters. *Note:* For complications (ICD-9-CM "E" codes) and factors influencing health status (ICD-9-CM "V" codes) there is an assumed decimal point between the fourth and fifth characters.
(leave blank)	Fewer than seven comorbid conditions and complications documented.

Code	Definition
00100-13980, 24000-99990	Comorbid conditions: Omit the decimal point between the third and fourth characters.
E8700-E8799, E9300-E9499	Complications: Omit the decimal point between the fourth and fifth characters.
V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, V5041-V5049	Factors affecting health status: Omit the decimal point between the fourth and fifth characters.

Comorbidities and Complications 8

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	3162	5	01/11, 01/12, 01/13, 01/15	Recommended

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-9-CM codes. All are considered secondary diagnoses.

Rationale
Preexisting 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.

Instructions for Coding
- Use this item to record ICD-9-CM codes. Use *Secondary Diagnosis 8* to record ICD-10-CM codes. During the adoption of ICD-10-CM codes, it is possible that both will appear in the same patient record.
- *Comorbidities and Complications 8* is to be used for patients diagnosed on or after January 1, 2006.
- If fewer than eight comorbid conditions or complications are listed, then leave this data item blank.
- If only eight comorbid conditions or complications are listed, then code the diagnoses listed and leave remaining *Comorbidities and Complications* items blank.
- For further coding instructions, see *Comorbidities and Complications 1*.

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 10 comorbid conditions or complications. *Note*: For comorbid conditions (ICD-9-CM codes 001-139.8 and 240-999.9) there is an assumed decimal point between the 3rd and 4th characters. *Note:* For complications (ICD-9-CM "E" codes) and factors influencing health status (ICD-9-CM "V" codes) there is an assumed decimal point between the fourth and fifth characters.
(leave blank)	Fewer than eight comorbid conditions and complications documented.

Code	Definition
00100-13980, 24000-99990	Comorbid conditions: Omit the decimal point between the third and fourth characters.
E8700-E8799, E9300-E9499	Complications: Omit the decimal point between the fourth and fifth characters.
V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, V5041-V5049	Factors affecting health status: Omit the decimal point between the fourth and fifth characters.

Comorbidities and Complications 9

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	3163	5	01/11, 01/12, 01/13, 01/15	Recommended

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-9-CM codes. All are considered secondary diagnoses.

Rationale
Preexisting 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.

Instructions for Coding
- Use this item to record ICD-9-CM codes. Use *Secondary Diagnosis 9* to record ICD-10-CM codes. During the adoption of ICD-10-CM codes, it is possible that both will appear in the same patient record.
- *Comorbidities and Complications #9* is to be used for patients diagnosed on or after January 1, 2006.
- If fewer than nine comorbid conditions or complications are listed, then leave this data item blank.
- If only nine comorbid conditions or complications are listed, then code the diagnoses listed and leave remaining *Comorbidities and Complications* items blank.
- For further coding instructions, see *Comorbidities and Complications 1*.

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 10 comorbid conditions or complications. *Note*: For comorbid conditions (ICD-9-CM codes 001-139.8 and 240-999.9) there is an assumed decimal point between the 3rd and 4th characters. *Note:* For complications (ICD-9-CM "E" codes) and factors influencing health status (ICD-9-CM "V" codes) there is an assumed decimal point between the fourth and fifth characters.
(leave blank)	Fewer than nine comorbid conditions and complications documented.

Code	Definition
00100-13980, 24000-99990	Comorbid conditions: Omit the decimal point between the third and fourth characters.
E8700-E8799, E9300-E9499	Complications: Omit the decimal point between the fourth and fifth characters.
V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, V5041-V5049	Factors affecting health status: Omit the decimal point between the fourth and fifth characters.

Comorbidities and Complications 10

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	3164	5	01/11, 01/12, 01/13, 01/15	Recommended

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-9-CM. All are considered secondary diagnoses.

Rationale
Preexisting 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.

Instructions for Coding
- Use this item to record ICD-9-CM codes. Use *Secondary Diagnosis 10* to record ICD-10-CM codes. During the adoption of ICD-10-CM codes, it is possible that both will appear in the same patient record.
- *Comorbidities and Complications 10* is to be used for patients diagnosed on or after January 1, 2006.
- If fewer than ten comorbid conditions or complications are listed, then leave this data item blank.
- For further coding instructions, see *Comorbidities and Complications 1*.

Code	Definition
(fill spaces)	Report the ICD-9-CM codes for up to 10 comorbid conditions or complications. *Note*: For comorbid conditions (ICD-9-CM codes 001-139.8 and 240-999.9) there is an assumed decimal point between the 3rd and 4th characters. *Note:* For complications (ICD-9-CM "E" codes) and factors influencing health status (ICD-9-CM "V" codes) there is an assumed decimal point between the fourth and fifth characters.
(leave blank)	Fewer than ten comorbid conditions and complications documented.

Code	Definition
00100-13980, 24000-99990	Comorbid conditions: Omit the decimal point between the third and fourth characters.
E8700-E8799, E9300-E9499	Complications: Omit the decimal point between the fourth and fifth characters.
V0720-V0739, V1000-V1590, V2220-V2310, V2540, V4400-V4589, V5041-V5049	Factors affecting health status: Omit the decimal point between the fourth and fifth characters.

Secondary Diagnosis 1

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

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.

Instructions for Coding

- Use this item to record ICD-10-CM codes. Use *Comorbidities and Complications 1* to record ICD-9-CM codes. During the adoption of ICD-10-CM codes, it is possible that both will appear in the same patient record.
- Note that, while the ICD-9-CM *Comorbidities and Complications* codes were to be followed by zeroes if they did not fill the field, 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

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	3782	7	New 01/13, 01/15	Recommended

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.

Instructions for Coding

- Use this item to record ICD-10-CM codes. Use *Comorbidities and Complications 2* to record ICD-9-CM codes. During the adoption of ICD-10-CM codes, it is possible that both will appear in the same patient record.
- Note that, while the ICD-9-CM *Comorbidities and Complications* codes were to be followed by zeroes if they did not fill the field, 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

Secondary Diagnosis 3

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	3784	7	New 01/13, 01/15	Recommended

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.

Instructions for Coding

- Use this item to record ICD-10-CM codes. Use *Comorbidities and Complications 3* to record ICD-9-CM codes. During the adoption of ICD-10-CM codes, it is possible that both will appear in the same patient record.
- Note that, while the ICD-9-CM *Comorbidities and Complications* codes were to be followed by zeroes if they did not fill the field, 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

Secondary Diagnosis 4

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	3786	7	New 01/13, 01/15	Recommended

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.

Instructions for Coding

- Use this item to record ICD-10-CM codes. Use *Comorbidities and Complications 4* to record ICD-9-CM codes. During the adoption of ICD-10-CM codes, it is possible that both will appear in the same patient record.
- Note that, while the ICD-9-CM *Comorbidities and Complications* codes were to be followed by zeroes if they did not fill the field, 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

Secondary Diagnosis 5

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	3788	7	New 01/13, 01/15	Recommended

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.

Instructions for Coding

- Use this item to record ICD-10-CM codes. Use *Comorbidities and Complications 5* to record ICD-9-CM codes. During the adoption of ICD-10-CM codes, it is possible that both will appear in the same patient record.
- Note that, while the ICD-9-CM *Comorbidities and Complications* codes were to be followed by zeroes if they did not fill the field, 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

Secondary Diagnosis 6

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	3790	7	New 01/13, 01/15	Recommended

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.

Instructions for Coding

- Use this item to record ICD-10-CM codes. Use *Comorbidities and Complications 6* to record ICD-9-CM codes. During the adoption of ICD-10-CM codes, it is possible that both will appear in the same patient record.
- Note that, while the ICD-9-CM *Comorbidities and Complications* codes were to be followed by zeroes if they did not fill the field, 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

Secondary Diagnosis 7

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	3792	7	New 01/13, 01/15	Recommended

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.

Instructions for Coding

- Use this item to record ICD-10-CM codes. Use *Comorbidities and Complications 7* to record ICD-9-CM codes. During the adoption of ICD-10-CM codes, it is possible that both will appear in the same patient record.
- Note that, while the ICD-9-CM *Comorbidities and Complications* codes were to be followed by zeroes if they did not fill the field, 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

Secondary Diagnosis 8

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	3794	7	New 01/13, 01/15	Recommended

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.

Instructions for Coding

- Use this item to record ICD-10-CM codes. Use *Comorbidities and Complications 8* to record ICD-9-CM codes. During the adoption of ICD-10-CM codes, it is possible that both will appear in the same patient record.
- Note that, while the ICD-9-CM *Comorbidities and Complications* codes were to be followed by zeroes if they did not fill the field, 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

Secondary Diagnosis 9

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	3796	7	New 01/13, 01/15	Recommended

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.

Instructions for Coding

- Use this item to record ICD-10-CM codes. Use *Comorbidities and Complications 9* to record ICD-9-CM codes. During the adoption of ICD-10-CM codes, it is possible that both will appear in the same patient record.
- Note that, while the ICD-9-CM *Comorbidities and Complications* codes were to be followed by zeroes if they did not fill the field, 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

Secondary Diagnosis 10

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	3798	7	New 01/13, 01/15	Recommended

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.

Instructions for Coding

- Use this item to record ICD-10-CM codes. Use *Comorbidities and Complications 10* to record ICD-9-CM codes. During the adoption of ICD-10-CM codes, it is possible that both will appear in the same patient record.
- Note that, while the ICD-9-CM *Comorbidities and Complications* codes were to be followed by zeroes if they did not fill the field, 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.

Instructions for Coding

- 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.

Instructions for Coding

- 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	Optional

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.

Instructions for Coding
- 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	Optional

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.

Instructions for Coding
- 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".

Instructions for Coding

- 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

Blank Page

Blank Page

Blank Page

Cancer Information

Blank Page

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.

Instructions for Coding
- 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.

Instructions for Coding

- 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.

Instructions for Coding

- *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*

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date of Initial Diagnosis* and *Date of Diagnosis Flag*. ***In the table below, the lowercase letter "b" is used to represent each blank space***.

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 date	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12

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**.

Instructions for Coding
- 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 instructions for coding 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. Appendix A has the former table for use for tumors diagnosed prior to January 1, 2010, for determining unique or same hematopoietic tumors.

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.

Instructions for Coding

- 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 Instructions for Coding in ICD-O-3, pages 20-40 and in the current *Multiple Primary and Histology Coding 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*.
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.

Instructions for Coding

- 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.

Instructions for Coding 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).

Instructions for Coding 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.

Path Number

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
Path Report Number 1 - 5	7090-7094	20	01/15	Recommended

Description
Records the pathology number first used to report this case.

Rationale
Describes the first pathology report contributing to this cancer abstract. The pathology report number provides a cross reference that identifies the specimen at the pathology facility. It may be useful for follow back with the pathology facility.

Instructions for Coding
- Record the pathology number.

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.**

Instructions for Coding
- 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**.

Instructions for Coding
- 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.

Instructions for Coding

- 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 *Multiple Primary and Histology Coding 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 instructions for coding 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/) 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).

Instructions for Coding

- 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/Differentiation

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	440	1	01/12, 01/13, 01/14, 01/15	Required

Description
Describes the tumor's resemblance to normal tissue. Well differentiated (Grade I) is the most like normal tissue, and undifferentiated (Grade IV) is the least like normal tissue. Grades 5-8 define particular cell lines for lymphomas and leukemias.

Rationale
This data item is useful for prognosis. These are coding instructions for **cases diagnosed 1/1/2014** and forward.

Instructions for Coding
- Consult the applicable version of FORDS for instructions for cases diagnosed prior to 2014.
- When there is no tissue diagnosis, it may be possible to establish grade through magnetic resonance imaging (MRI) or positron emission tomography (PET). When available, code grade based on the recorded findings from these imaging reports.

Hematopoietic and Lymphoid Neoplasms

Cell Indicator (Codes 5, 6, 7, 8, 9)

Cell Indicator (Codes 5, 6, 7, 8) describes the lineage or phenotype of the cell. Codes 5, 6, 7, and 8 are used only for hematopoietic and lymphoid neoplasms. Code 9 indicates cell type not determined, not stated, or not applicable; unknown primary; high grade dysplasia.

Coding Grade for Hematopoietic and Lymphoid Neoplasms

http://seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules

1. Determine the histology based on the current Hematopoietic and Lymphoid Neoplasm Manual.

2. Determine the Cell Indicator by using "Grade of Tumor Rules" within the current Hematopoietic and Lymphoid Neoplasm Manual to code the grade.

Grade codes for hematopoietic and lymphoid neoplasms

Terminology	Grade Code
T-cell; T-precursor	5
B-Cell; Pre-B; B-precursor	6
Null cell; Non T-non B	7
NK cell (natural killer cell)	8
Grade unknown, not stated, or not applicable	9

Solid tumors

Grade, Differentiation (Codes 1, 2, 3, 4, 9)

Pathologic examination determines the grade, or degree of differentiation, of the tumor. For these cancers, the grade is a measurement of how closely the tumor cells resemble the parent tissue (organ of origin). Well-differentiated tumor cells closely resemble the tissue from the organ of origin. Poorly differentiated and undifferentiated tumor cells are disorganized and abnormal looking; they bear little (poorly differentiated) or no (undifferentiated) resemblance to the tissue from the organ of origin. These similarities/differences may be based on pattern (architecture), cytology, nuclear (or nucleolar) features, or a combination of these elements, depending upon the grading system that is used. Some grading systems use only pattern, for example Gleason grading in prostate. Others use only a nuclear grade (usually size, amount of chromatin, degree of irregularity, and mitotic activity). Fuhrman's grade for kidney is based only on nuclear features. Most systems use a combination of pattern and cytologic and nuclear features; for example Nottingham's for breast combines numbers for pattern, nuclear size and shape, and mitotic activity. The information from this data item is useful for determining prognosis and treatment.

Pathologists describe the tumor grade using three systems or formats:

1. Two levels of similarity; also called a two-grade system
2. Three levels of similarity; also called a three-grade system (code according to "Coding for solid tumors)."
    a. Grade I, well
    b. Grade II, moderately
    c. Grade III, poorly (undifferentiated carcinoma is usually separated from this system, since "poorly" bears some, albeit little, similarity to the host tissue, while "undifferentiated" has none, e.g. Undifferentiated carcinoma).
3. Four levels of similarity; also called a four-grade system. The four-grade system describes the tumor as
    a. Grade I; also called well-differentiated
    b. Grade II; also called moderately differentiated
    c. Grade III; also called poorly differentiated
    d. Grade IV; also called undifferentiated or anaplastic

Breast and prostate grades may convert differently than other sites. These exceptions are noted in "Coding for Solid Tumors", #7-8 below.

Coding for Solid Tumors

1. Systemic treatment and radiation can alter a tumor's grade. Therefore, it is important to code grade based on information prior to neoadjuvant therapy even if grade is unknown.

2. Code the grade from the primary tumor only.
    a. Do NOT code grade based on metastatic tumor or recurrence. In the rare instance that tumor tissue extends contiguously to an adjacent site and tissue from the primary site is not available, code grade from the contiguous site.
    b. If primary site is unknown, code grade to 9.

3. Code the grade shown below (6th digit) for specific histologic terms that imply a grade.
    - Carcinoma, undifferentiated (8020/3<u>4</u>)
    - Carcinoma, anaplastic (8021/3<u>4</u>)
    - Thymic carcinoma, well diff (8585/3<u>1</u>)
    - Sertoli-Leydig cell tumor, poorly diff (8631/3<u>3</u>)
    - Undifferentiated sarcoma (8805/3<u>4</u>)
    - Seminoma, anaplastic (9062/3<u>4</u>)
    - Malignant teratoma, undiff (9082/3<u>4</u>)
    - Malignant teratoma, intermed type (9083/3<u>2</u>)
    - Intraosseous osteosarcoma, well diff (9187/3<u>1</u>)
    - Astrocytoma, anaplastic (9401/3<u>4</u>)
    - Retinoblastoma, differentiated (9511/3<u>1</u>)
    - Retinoblastoma, undifferentiated (9512/3<u>4</u>)

4. In situ and/or combined in situ/invasive components:

a. If a grade is given for an in situ tumor, code it. Do NOT code grade for dysplasia such as high grade dysplasia.

b. If there are both in situ and invasive components, code only the grade for the invasive portion even if its grade is unknown.

5. If there is more than one grade, code the highest grade within the applicable system. Code the highest grade even if it is only a focus. Code grade in the following priority order using the first applicable system:

a. special grade systems for the sites listed in Coding for Solid Tumors #6

b. differentiation: use Coding for Solid Tumors #7: 2-, 3-, or 4- grade system

c. nuclear grade: use Coding for Solid Tumors #7: 2-, 3-, or 4- grade system

d. If it isn't clear whether it is a differentiation or nuclear grade and a 2-, 3-, or 4- grade system was used, code it.

e. Terminology (use Coding for Solid Tumors #8)

6. Use information from the special grade systems first. If no special grade can be coded, continue with Coding for Solid Tumors #7-9.

Special grade systems for solid tumors

Grade information based on CS Site-specific factors for breast, prostate, heart, mediastinum, peritoneum, retroperitoneum, soft tissue, and kidney parenchyma is used to code grade. See **Special Grade System Rules** section below for details on how to use this information to code grade.

CS Schema	Special grade system
Breast	Nottingham or Bloom-Richardson (BR) Score/Grade (SSF7)
Prostate	Gleason's Score on Needle Core Biopsy/Transurethral Resection of Prostate (TURP) (SSF 8)
Prostate	Gleason's Score on Prostatectomy/Autopsy (SSF 10)
Heart, Mediastinum	Grade for Sarcomas (SSF 1)
Peritoneum	Grade for Sarcomas (SSF 1)
Retroperitoneum	Grade for Sarcomas (SSF 1)
Soft Tissue	Grade for Sarcomas (SSF 1)
Kidney Parenchyma	Fuhrman Nuclear Grade (SSF 6)

Do not use these tables to code grade for any other groups including WHO (CNS tumors), WHO/ISUP (bladder, renal pelvis), or FIGO (female gynecologic sites) grades.

7. Use the Two-, Three- or Four-grade system information

a. Two-grade system

Term	Description	Grade Code	Exception for Breast and Prostate Grade Code
1/2, I/II	Low grade	2	1
2/2, II/II	High grade	4	3

In transitional cell carcinoma for bladder, the terminology high grade TCC and low grade TCC are coded in the two-grade system.

b. Three-grade system

Term	Description	Grade Code	Exception for Breast and Prostate Grade Code
1/3	Low grade	2	1
2/3	Intermediate grade	3	2
3/3	High grade	4	3

c. Four-grade system: Any four-grade system including Edmondson and Steiner grade for liver.

Term	Description	Grade Code
1/4	Grade I; Well differentiated	1
2/4	Grade II; Moderately differentiated	2
3/4	Grade III; Poorly differentiated	3
4/4	Grade IV; Undifferentiated	4

8. Terminology: use the 'Description' column or the 'Grade' column to code grade. Breast and prostate use the same grade code with a few noted exceptions.

Description	Grade	Assign Grade Code	Exception for Breast and Prostate Grade Code
Differentiated, NOS	I	1	
Well differentiated	I	1	
Only stated as 'Grade I'	I	1	
Fairly well differentiated	II	2	
Intermediate differentiation	II	2	
Low grade	I-II	2	1
Mid differentiated	II	2	
Moderately differentiated	II	2	
Moderately well differentiated	II	2	
Partially differentiated	II	2	
Partially well differentiated	I-II	2	1
Relatively or generally well differentiated	II	2	
Only stated as 'Grade II'	II	2	
Medium grade, intermediate grade	II-III	3	2
Moderately poorly differentiated	III	3	
Moderately undifferentiated	III	3	
Poorly differentiated	III	3	
Relatively poorly differentiated	III	3	
Relatively undifferentiated	III	3	
Slightly differentiated	III	3	
Dedifferentiated	III	3	
Only stated as 'Grade III'	III	3	
High grade	III-IV	4	3
Undifferentiated, anaplastic, not differentiated	IV	4	
Only stated as 'Grade IV'	IV	4	
Non-high grade		9	

9. If no description fits or grade is unknown prior to neoadjuvant therapy, code as a 9 (unknown).

SPECIAL GRADE SYSTEMS RULES

Breast (site: breast excluding lymphomas; CS schema: breast)

Use Bloom Richardson (BR) or Nottingham score/grade to code grade based on CSv2 site-specific factor 7 (SSF 7) as stated below. If your registry does not collect this SSF, use the description in the table below to determine grade. If you collect this SSF, codes 030-130 could be automatically converted into the grade field.

BR could also be referred to as: Bloom-Richardson, modified Bloom-Richardson, BR, BR grading, Scarff-Bloom-Richardson, SBR grading, Elston-Ellis modification of Bloom-Richardson score, Nottingham modification of Bloom-Richardson score, Nottingham modification of Scarff-Bloom-Richardson, Nottingham-Tenovus grade, or Nottingham grade.

Code the tumor grade using the following priority order
a. BR scores 3-9
b. BR grade (low, intermediate, high)

BR score may be expressed as a range, 3-9. The score is based on three morphologic features: degree of tubule formation/histologic grade, mitotic activity, nuclear pleomorphism/nuclear grade of tumor cells. If a report uses words such as low, intermediate, or high rather than numbers, use the table below to code grade.

If only a grade of 1 through 4 is given with no information on the score and it is unclear if it is a Nottingham or BR Grade, do not use the table below. Continue with the next priority according to "Coding for Solid Tumors" #7 above.
Code the highest score if multiple scores are reported (exclude scores from tests after neoadjuvant therapy began). Examples: different scores may be reported on multiple pathology reports for the same primary cancer; different scores may be reported for multiple tumors assigned to the same primary cancer.

CS Site-Specific Factor 7
Nottingham or Bloom-Richardson (BR) Score/Grade

Description	CS Code	Grade Code
Score of 3	030	1
Score of 4	040	1
Score of 5	050	1
Score of 6	060	2
Score of 7	070	2
Score of 8	080	3
Score of 9	090	3
Low Grade, Bloom-Richardson (BR) grade 1, score not given	110	1
Medium (Intermediate) Grade, BR grade 2, score not given	120	2
High Grade, BR grade 3, score not given	130	3

Kidney Parenchyma (Site: kidney parenchyma excluding lymphomas; CS schema: KidneyParenchyma): Fuhrman Nuclear Grade

The Fuhrman Nuclear Grade should be used to code grade for kidney parenchyma only based on CSv2 SSF 6 as stated below. Do not use for kidney renal pelvis. Do not use for kidney renal pelvis. If your registry does not collect this SSF, use the description in the table to determine grade. If you collect this SSF, the information could be automatically converted into the grade field if it is coded 010-040. Fuhrman nuclear grade is a four-grade system based on nuclear diameter and shape, the prominence of nucleoli, and the presence of chromatin clumping in the highest grade.

Description	CS Code	Grade Code
Grade 1	010	1
Grade 2	020	2
Grade 3	030	3
Grade 4	040	4

SoftTissue (sites excluding lymphomas: soft tissue, heart, mediastinum, peritoneum, and retroperitoneum; for CS users: SoftTissue, HeartMediastinum, Peritoneum, Retroperitoneum schemas): Grade for Sarcomas

The Grade for Sarcomas should be used to code grade based on CSv2 SSF 1 as stated below. If your registry does not collect this SSF, use the description in the table to determine grade. If you collect this SSF, the information could be automatically converted into the grade field if it is coded 010-200. The grading system of the French Federation of Cancer Centers Sarcoma Group (FNCLCC) is the preferred system.

Record the grade from any three-grade sarcoma grading system the pathologist uses. For terms such as "well differentiated" or "poorly differentiated," go to Coding for Solid Tumors #8.

In some cases, especially for needle biopsies, grade may be specified only as "low grade" or "high grade." The numeric grade takes precedence over “low grade” or “high grade.”

Description	CS Code	Grade Code
Specified as Grade 1 [of 3]	010	2
Specified as Grade 2 [of 3]	020	3
Specified as Grade 3 [of 3]	030	4
Grade stated as low grade, NOS	100	2
Grade stated as high grade, NOS	200	4

Prostate (site: prostate excluding lymphomas; CS schema: prostate)

Use the highest Gleason score from the biopsy/TURP or prostatectomy/autopsy. Use a known value over an unknown value. Exclude results from tests performed after neoadjuvant therapy began. This information is collected in CSv2 SSF 8 (Gleason score from biopsy/TURP) and SSF 10 (Gleason score from prostatectomy/autopsy) as stated below. Use the table below to determine grade even if your registry does not collect these SSFs. If you collect these SSFs, the information could be converted into the grade field automatically.

Usually prostate cancers are graded using Gleason score or pattern. Gleason grading for prostate primaries is based on a 5-component system (5 histologic patterns). Prostatic cancer generally shows two main histologic patterns. The primary pattern, the pattern occupying greater than 50% of the cancer, is usually indicated by the first number of the Gleason grade, and the secondary pattern is usually indicated by the second number. These two numbers are added together to create a pattern score, ranging from 2 to 10. If there are two numbers, assume that they refer to two patterns (the first number being the primary pattern and the second number the secondary pattern), and sum them to obtain the score. If only one number is given on a particular test and it is less than or equal to 5 and not specified as a score, do not use the information because it could refer to either a score or a grade. If only one number is given and it is greater than 5, assume that it is a score and use it. If the pathology

report specifies a specific number out of a total of 10, the first number given is the score. Example: The pathology report says Gleason 3/10. The Gleason score would be 3.

Gleason score	CS Code	Grade Code	AJCC 7th	SEER 2003-2013	AJCC 6th	SEER prior 2003
2	002	1	G1	G1	G1	G1
3	003	1	G1	G1	G1	G1
4	004	1	G1	G1	G1	G1
5	005	1	G1	G2	G2	G2
6	006	1	G1	G2	G2	G2
7	007	2	G2	G3	G3	G2
8	008	3	G3	G3	G3	G3
9	009	3	G3	G3	G3	G3
10	010	3	G3	G3	G3	G3

Historic Perspective

Historical perspective on long term trends in prostate grade: The relationship of Gleason score to grade changed for 1/1/2014+ diagnoses in order to have the grade field in sync with AJCC 7th ed. Analysis of prostate grade before 2014 based solely on the grade field is not recommended. In Collaborative Stage (CS), Gleason score was originally coded in CSv1 in one field (SSF 6) and then it was split into two fields in CSv2 based on the tissue used for the test: needle biopsy/TURP (SSF 8) and prostatectomy/autopsy (SSF 10). For trends using data back to 2004, if one collected the various CS Gleason scores, one could design a recode to have the same criteria as the data collected 2014+. The original grade field would NOT be changed, but for analyses this recode could be based on the CS SSFs and the original grade code.

Computer algorithm to derive grade for prostate based on SSF 8 and SSF 10: if SSF 8 or SSF 10 has known values for Gleason's, the information could be used to automatically derive the grade field.

SSF8 Code	SSF10 002	SSF10 003	SSF10 004	SSF10 005	SSF10 006	SSF10 007	SSF10 008	SSF10 009	SSF10 010	SSF10 988	SSF10 998	SSF10 999
002	1	1	1	1	1	2	3	3	3	*	1	1
003	1	1	1	1	1	2	3	3	3	*	1	1
004	1	1	1	1	1	2	3	3	3	*	1	1
005	1	1	1	1	1	2	3	3	3	*	1	1
006	1	1	1	1	1	2	3	3	3	*	1	1
007	2	2	2	2	2	2	3	3	3	*	2	2
008	3	3	3	3	3	3	3	3	3	*	3	3
009	3	3	3	3	3	3	3	3	3	*	3	3
010	3	3	3	3	3	3	3	3	3	*	3	3
988	*	*	*	*	*	*	*	*	*	*	*	*
998	1	1	1	1	1	2	3	3	3	*	*	*
999	1	1	1	1	1	2	3	3	3	*	*	*

*Grade can't be automatically calculated based on SSF 8 and SSF10; Go to step 7.

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**.

Instructions for Coding
- 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.

SEER Summary Stage 2000

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	759	1	09/04, 01/09, 01/16	Required

Description

Code for 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

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.

From 2004 through 2015, Derived SS2000 was relied on for the value of SEER Summary Stage 2000 as generated by the Collaborative Staging algorithm. Effective with cases diagnosed January 1, 2016, directly-assigned SEER Summary Stage is required to be recorded in its accredited cancer program cancer registries.

Instructions for Coding

- Refer to the site and histology-specific definitions of categories and coding instructions in the *SEER Summary Staging Manual 2000.*
- Use code 8 for benign and borderline brain/CNS cases

Code	Definition
0	In-situ
1	Localized
2	Regional, direct extension only
3	Regional, lymph nodes only
4	Regional, direct extension and regional lymph nodes
5	Regional, NOS
7	Distant
8	Not applicable
9	Unstaged

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.

Instructions for Coding

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 isinvasive. 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.

Instructions for Coding

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 overallping 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.

Instructions for Coding

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 overallping 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.

Instructions for Coding

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 overallping 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.

Instructions for Coding

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 overallping 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.

Instructions for Coding

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 overallping 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	Required

Description

This data item identifies whether other metastatic involvement, other than bone, brain, liver, lung or distant lymph nodes exist. 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.

Instructions for Coding

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 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)

    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 overallping 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); for example, when there is documentation of carcinomatosis but a specified site is not mentioned as a metastatic site. 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
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.

Clinical T

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	940	4	09/06, 01/09, 01/10, 01/16	Required

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.

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.

Beginning in 2016, new T, N, and M categories were implemented. These new categories have been generated by adding the prefixes of "c" and "p" to existing valid clinical and pathologic T, N, and M categories respectively, and modifying, adding and deleting specific categories. The new categories enable registrars to comply with AJCC clinical and pathologic staging/classification timeframe rules while abstracting. The new categories will be used for cases of all diagnosis years abstracted using NAACCR version 16-compliant (and later) software. 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.

Instructions for Coding
- The clinical T staging element must be recorded 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* code this item based on the best available information, without necessarily requiring additional contact with the physician.
- 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 not staged according to the AJCC Manual, code 88 for clinical and pathologic T, N, and M, as well as, stage group.
- For lung, occult carcinoma is coded TX.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.

Code	Definition	Code	Definition	Code	Definition
(blank)	Not recorded	c1B	cT1b	c3	cT3
cX	cTX	c1B1	cT1b1	c3A	cT3a
c0	cT0	c1B2	cT1b2	c3B	cT3b
pA	pTa	c1C	cT1c	c3C	cT3c
pIS	pTis	c1D	cT1d	c3D	cT3d
pISU	pTispu	c2	cT2	c4	cT4
pISD	pTispd	c2A	cT2a	c4A	cT4a
c1M1	cT1mi, cT1mic	c2A1	cT2a1	c4B	cT4b
c1	cT1	c2A2	cT2a2	c4C	cT4c
c1A	cT1a	c2B	cT2b	c4D	cT4d
c1A1	cT1a1	c2C	cT2c	c4E	cT4e
c1A2	cT1a2	c2D	cT2d	88	Not applicable

Clinical N

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	950	4	01/08, 01/09, 01/10, 01/16	Required

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.

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.

Beginning in 2016, new T, N, and M categories were implemented. These new categories have been generated by adding the prefixes of "c" and "p" to existing valid clinical and pathologic T, N, and M categories respectively, and modifying, adding and deleting specific categories. The new categories enable registrars to comply with AJCC clinical and pathologic staging/classification timeframe rules while abstracting. The new categories will be used for cases of all diagnosis years abstracted using NAACCR version 16-compliant (and later) software. 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

Instructions for Coding
- The clinical N staging element must be recorded 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 coding of clinical N.
- 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* code this item based on the best available information, without necessarily requiring additional contact with the physician.
- 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 not staged according to the AJCC Manual, code 88 for clinical and pathologic T, N, and M, as well as, stage group.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.

Code	Definition	Code	Definition	Code	Definition
(blank)	Not recorded	c1B	cN1b	c3	cN3
cX	cNX	c1C	cN1c	c3A	cN3a
c0	cN0	c2	cN2	c3B	cN3b
c0A	cN0a	c2A	cN2a	c3C	cN3c
c0B	cN0b	c2B	cN2b	c4	cN4
c1	cN1	c2C	cN2c	88	Not applicable
c1A	cN1a				

Clinical M

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	960	4	01/09, 01/10, 01/11, 01/16	Required

Description
Identifies the presence or absence of distant metastasis (M) of the tumor known ***prior*** to the start of any 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.

Beginning in 2016, new T, N, and M categories were implemented. These new categories have been generated by adding the prefixes of "c" and "p" to existing valid clinical and pathologic T, N, and M categories respectively, and modifying, adding and deleting specific categories. The new categories enable registrars to comply with AJCC clinical and pathologic staging/classification timeframe rules while abstracting. The new categories will be used for cases of all diagnosis years abstracted using NAACCR version 16-compliant (and later) software. 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

Instructions for Coding
- The clinical M staging element must be recorded for *Class of Case* 10-22.
- It is strongly recommended that the clinical M staging element be recorded for *Class of Case* 00 cases if the patient's workup at the facility allows coding of clinical M.
- Record clinical M as documented by the first treating physician or managing physician in the medical record.
- If the managing physician has not recorded clinical M, registrars *will* code this item based on the best available information, without necessarily requiring additional contact with the physician.
- 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 not staged according to the AJCC Manual, code 88 for clinical and pathologic T, N, and M, as well as, stage group.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.

Code	Definition	Code	Definition
(blank)	Not recorded	p1	pM1
c0	cM0	p1A	pM1a
c0I+	cM0(i+)	p1B	pM1b
c1	cM1	p1C	pM1c
c1A	cM1a	p1D	pM1d
c1B	cM1b	p1E	pM1e
c1C	cM1c	88	Not applicable
c1D	cM1d		
c1E	cM1e		

Clinical Stage Group

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	970	4	01/09, 01/10, 01/11, 01/16	Required

Description
Identifies the anatomic extent of disease based on the T, N, and M elements known **prior** to the start of any 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.

Instructions for Coding
- 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* code this item based on the best available information, without necessarily requiring additional contact with the physician.
- 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 not staged according to the AJCC Manual, code 88 for clinical and pathologic T, N, and M, as well as, stage group.
- To assign stage group when some, but not all, of the T, N, and/or M components can be determined, interpret the missing components as "X".
- If the value does not fill all 4 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.

Code	Definition	Code	Definition	Code	Definition
0	Stage 0	1S	Stage IS	3C1	Stage IIIC1
0A	Stage 0A	2	Stage II	3C2	Stage IIIC2
0IS	Stage 0is	2A	Stage IIA	4	Stage IV
1	Stage I	2A1	Stage IIA1	4A	Stage IVA
1A	Stage IA	2A2	Stage IIA2	4A1	Stage IVA1
1A1	Stage IA1	2B	Stage IIB	4A2	Stage IVA2
1A2	Stage IA2	2C	Stage IIC	4B	Stage IVB
1B	Stage IB	3	Stage III	4C	Stage IVC
1B1	Stage IB1	3A	Stage IIIA	OC	Occult
1B2	Stage IB2	3B	Stage IIIB	88	Not applicable
1C	Stage IC	3C	Stage IIIC	99	Unknown

Clinical Stage Descriptor

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	980	1	09/06, 01/09, 01/10, 01/16	Required

Description

Identifies the AJCC clinical stage (prefix/suffix) descriptor of the tumor ***prior*** to the start of any therapy.

Rationale

Stage descriptors identify special cases that need separate analysis. The descriptors are adjuncts to and do not change the stage group. 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.

Instructions for Coding

- Record the clinical stage (prefix/suffix) descriptor as documented by the first treating physician or the managing physician in the medical record.
- If the managing physician has not recorded the descriptor, registrars *will* code 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 staging rules.
- Previous editions of FORDS included a code 4 for y-classification, and a note that it was not applicable for clinical stage. Code 4 has been removed from the list of valid codes.

Code	Label	Definition
0	None	There are no prefix or suffix descriptors that would be used for this case.
1	E-Extranodal, lymphomas only	A lymphoma case involving an extranodal site.
2	S-Spleen, lymphomas only	A lymphoma case involving the spleen.
3	M-Multiple primary tumors in a single site	This is one primary with multiple tumors in the primary site at the time of diagnosis.
5	E&S-Extranodal and spleen, lymphomas only	A lymphoma case with involvement of both an Extranodal site and the spleen.
9	Unknown; not stated in the patient record	A prefix or suffix would describe this stage, but it is not known which would be correct.

Clinical Staged By

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	990	1	09/06, 01/09, 01/10, 01/16	Required

Description
Identifies the person who documented the clinical AJCC staging elements and the Stage Group.

Rationale
Data captured in this field can be used to evaluate the accuracy and completeness of physician staging and form the basis for quality management and improvement studies.

In 2016, this data item was expanded to 2 characters and additional categories were added to document additional, more detailed sources of staging assignment and help in targeting training. The implementation of the new codes included data conversion and redefinition of "unknown" from "unknown stage" to unknown who assigned the stage ("9-Unknown; not stated in patient record" was converted to "99-Staged but unknown who assigned stage").

Instructions for Coding
- Record the role of the person who documented the clinical AJCC staging data items and the Stage Group.
- If code 10-20 is used, then all of the staging elements (T, N, and M) and Stage Group must be assigned by the same person.
- If the tumor was not staged, or stage is unknown, use code 00.
- If the physician who assigned the stage cannot be identified as a surgeon, radiation oncologist, or medical oncologist, use code 10. Examples include: dentist, gynecologist, or urologist.
- If it is clear from the treatment provided that the physician providing the stage information is a surgeon, use code 11. Example: Urologist provides stage information from surgical resection of tumor – code as surgeon – 11.
- If a pathologist assigns T and/or N, and the registrar determines M and determines the stage group from other portsions of the record, use code 30.
- If staging was obtained from outside the facility, code the role of the person who staged it if known (codes 10-40); otherwise use code 50.
- If applicable, the Staging Elements (T, N, M) and the Stage Group must be recorded.
    - Exception: Lymphoma does not have TNM elements – only assigning Stage Group is applicable.
- The staging source may be different for clinical vs. pathologic stage.

Code	Label	Definition
00	Not staged	Clinical staging was not assigned; no information was found in the medical record to assign clinical stage.
10	Physician, NOS, or physician type not specified in codes 11-15	Clinical staging assigned by a physician not described under codes 11-15 (i.e., cancer committee chair, cancer liaison physician or registry physician advisor).
11	Surgeon	Clinical staging assigned by the surgeon only.
12	Radiation Oncologist	Clinical staging assigned by the radiation oncologist only.
13	Medical Oncologist	Clinical staging assigned by the medical oncologist only.
14	Pathologist	Clinical staging assigned by the pathologist only.
15	Multiple physicians, tumor board, etc.	Clinical staging assigned by multiple physicians such as during a tumor board meeting.
20	Cancer Registrar	Clinical staging assigned by the cancer registrar only.
30	Cancer Registrar and physician	Clinical staging assigned by the cancer registrar and any of the physicians specified in codes 10-15. This would include the cancer registrar assigning the stage and a physician approving it.
40	Nurse, physician assistant, or other non-physician medical staff	Clinical staging assigned by medical non-physician staff such as a nurse of physician assistant (PA).
50	Staging assigned at another facility	Clinical staging assigned at another facility, person's role unknown.
60	Staging by Central Registry including consolidation of multiple sources	Clinical staging assigned by Central Registry personnel based on information from one facility or multiple facilities.
88	Case is not eligible for staging	The site/histology combination is not defined in the AJCC Manual.
99	Staged but unknown who assigned stage	A stage was found in the medical record but it is unknown who assigned it.

Examples:

Code	Reason
10	Initial staging is assigned by the Primary Care General Practitioner.
15	During tumor conference after discussion among pathologist, radiologist and surgeon, the facilitator announces the final TNM and stage group.
30	Only information on staging in medical record states, T1, nodes negative, registrar enters the listed T, N0 and adds the M and the stage group in the abstract.
40	Nurse practitioner documents all staging elements.
40	Staging is entered into the medical record by a physician assistant (PA).
50	Patient transfers to your facility, there is a completed staging form in the chart, copies received from the transferring facility, but the staging form is not signed.
60	Uploaded data to central registry from two facilities; there is no documentation listing stage, just a comment saying the patient has a late stage cancer. The central registry enters the TNM and stage group based on the consolidated records from the two facilities.
88	A child is diagnosed with Neuroblastoma.

Pathologic T

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	880	4	01/09, 01/10, 01/15, 01/16	Required

Description

Evaluates the primary tumor (T) and reflects the tumor size and/or extension 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.

Beginning in 2016, new T, N, and M categories were implemented. These new categories have been generated by adding the prefixes of "c" and "p" to existing valid clinical and pathologic T, N, and M categories respectively, and modifying, adding and deleting specific categories. The new categories enable registrars to comply with AJCC clinical and pathologic staging/classification timeframe rules while abstracting. The new categories will be used for cases of all diagnosis years abstracted using NAACCR version 16-compliant (and later) software. 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

Instructions for Coding

- The pathologic T staging element must be recorded for *Class of Case* 10-22.
- Code pathologic T as documented by the treating physician(s) or the managing physician in the medical record.
- If the managing physician has not recorded pathologic T, registrars *will* code this item based on the best available information, without necessarily requiring additional contact with the physician.
- 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 not staged according to the AJCC Manual, code 88 for clinical and pathologic T, N, and M, as well as, stage group.
- Truncate the least significant subdivision of the category from the right as needed.
- For lung, occult carcinoma is coded TX.

Code	Definition	Code	Definition	Code	Definition
(blank)	Not recorded	p1B	pT1b	p3	pT3
pX	pTX	p1B1	pT1b1	p3A	pT3a
p0	pT0	p1B2	pT1b2	p3B	pT3b
pA	pTa	p1C	pT1c	p3C	pT3c
pIS	pTis	p1D	pT1d	p3D	pT3d
pISU	pTispu	p2	pT2	p4	pT4
pISD	pTispd	p2A	pT2a	p4A	pT4a
p1MI	pT1mi, pT1 mic	p2A1	pT2a1	p4B	pT4b
p1	pT1	p2A2	pT2a2	p4C	pT4c
p1A	pT1a	p2B	pT2b	p4D	pT4d
p1A1	pT1a1	p2C	pT2c	p4E	pT4e
p1A2	pT1a2	p2D	pT2d	88	Not applicable

Pathologic N

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	890	4	01/09, 01/10, 01/15, 01/16	Required

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.

Beginning in 2016, new T, N, and M categories were implemented. These new categories have been generated by adding the prefixes of "c" and "p" to existing valid clinical and pathologic T, N, and M categories respectively, and modifying, adding and deleting specific categories. The new categories enable registrars to comply with AJCC clinical and pathologic staging/classification timeframe rules while abstracting. The new categories will be used for cases of all diagnosis years abstracted using NAACCR version 16-compliant (and later) software. 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

Instructions for Coding

- The pathologic N staging element must be recorded for *Class of Case* 10-22.
- Code pathologic N as documented by the treating physician(s) or managing physician in the medical record.
- If the managing physician has not recorded pathologic N, registrars *will* code this item based on the best available information, without necessarily requiring additional contact with the physician.
- 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 not staged according to the AJCC Manual, code 88 for clinical and pathologic T, N, and M, as well as, stage group.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.

Code	Definition	Code	Definition	Code	Definition
(blank)	Not recorded	p0A	pN0a	p2C	pN2c
pX	pNX	p0B	pN0b	p3	pN3
c0	cN0	p1	pN1	p3A	pN3a
p0	pN0	p1A	pN1a	p3B	pN3b
p0I-	pN0i-	p1B	pN1b	p3C	pN3c
p0I+	pN0i+	p1C	pN1c	p4	pN4
p0M-	pN0m-	p2	pN2	88	Not applicable
p0m+	pN0m+	p2A	pN2a		
p1MI	pN1mi	p2B	pN2b		

Pathologic M

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	900	4	01/09, 01/10, 01/15, 01/16	Required

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.

Beginning in 2016, new T, N, and M categories were implemented. These new categories have been generated by adding the prefixes of "c" and "p" to existing valid clinical and pathologic T, N, and M categories respectively, and modifying, adding and deleting specific categories. The new categories enable registrars to comply with AJCC clinical and pathologic staging/classification timeframe rules while abstracting. The new categories will be used for cases of all diagnosis years abstracted using NAACCR version 16-compliant (and later) software. 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

Instructions for Coding
- The pathologic M staging element must be recorded for *Class of Case* 10-22.
- Code pathologic M as documented by the treating physician(s) or the managing physician in the medical record.
- If the managing physician has not recorded pathologic M, registrars *will* code this item based on the best available information, without necessarily requiring additional contact with the treating physician(s)
- 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 not staged according to the AJCC Manual, code 88 for clinical and pathologic T, N, and M, as well as, stage group.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.

Code	Definition	Code	Definition
(blank)	Not recorded	c1	cM1
c0	cM0	c1A	cM1a
c0I+	cM0(i+)	c1B	cM1b
p1	pM1	c1C	cM1c
p1A	pM1a	c1D	cM1d
p1B	pM1b	c1E	cM1e
p1C	pM1c	88	Not applicable
p1D	pM1d		
p1E	pM1e		

Pathologic Stage Group

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	910	4	01/09, 01/10, 01/11, 01/15	Required

Description

Identifies the anatomic extent of disease based on the T, N, and M elements 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.

Instructions for Coding

- Record the pathologic 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 pathologic stage, registrars *will* code this item based on the best available information, without necessarily requiring additional contact with the physician(s).
- 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 not staged according to the AJCC Manual, code 88 for clinical and pathologic T, N, and M, as well as, stage group.
- To assign stage group when some, but not all, of the T, N, and/or M components can be determined, interpret the missing components as "X".
- If pathologic M is coded as either X or blank and clinical M is coded as 0, 1, 1A, 1B, or 1C, then the combination of staging elements pT, pN, and cM may be used to complete the pathologic stage group.
- If the value does not fill all 4 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.

Code	Definition	Code	Definition	Code	Definition
0	Stage 0	1S	Stage IS	3C1	Stage IIIC1
0A	Stage 0A	2	Stage II	3C2	Stage IIIC2
0IS	Stage 0is	2A	Stage IIA	4	Stage IV
1	Stage I	2A1	Stage IIA1	4A	Stage IVA
1A	Stage IA	2A2	Stage IIA2	4A1	Stage IVA1
1A1	Stage IA1	2B	Stage IIB	4A2	Stage IVA2
1A2	Stage IA2	2C	Stage IIC	4B	Stage IVB
1B	Stage IB	3	Stage III	4C	Stage IVC
1B1	Stage IB1	3A	Stage IIIA	OC	Occult
1B2	Stage IB2	3B	Stage IIIB	88	Not applicable
1C	Stage IC	3C	Stage IIIC	99	Unknown

Pathologic Stage Descriptor

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	920	1	09/06, 01/09, 01/10, 01/16	Required

Description
Identifies the AJCC pathologic stage (prefix/suffix) descriptor of the tumor ***following*** the completion of any therapy.

Rationale
Stage descriptors identify special cases that need separate analysis. The descriptors are adjuncts to and do not change the stage group. 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.

Instructions for Coding
- Record the pathologic stage (prefix/suffix) descriptor as documented by the first treating physician or the managing physician in the medical record.
- If the managing physician has not recorded the descriptor, registrars *will* code 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 staging rules.

Code	Label	Definition
0	None	There are no prefix or suffix descriptors that would be used for this case.
1	E-Extranodal, lymphomas only	A lymphoma case involving an extranodal site.
2	S-Spleen, lymphomas only	A lymphoma case involving the spleen.
3	M-Multiple primary tumors in a single site	This is one primary with multiple tumors in the primary site at the time of diagnosis.
4	Y-Classification after initial multimodality therapy	Neoadjuvant treatment given before staging.
5	E&S-Extranodal and spleen, lymphomas only	A lymphoma case with involvement of both an Extranodal site and the spleen.
6	M&Y-Multiple primary tumors and initial multimodality therapy	A case meeting the parameters of both codes 3 (multiple primary tumors in a single site) and 4 (classification after initial multimodality therapy).
9	Unknown; not stated in the patient record	A prefix or suffix would describe this stage, but it is not known which would be correct.

Pathologic Staged By

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	930	1	09/06, 01/09, 01/10, 01/16	Required

Description
Identifies the person who recorded the pathologic AJCC staging elements.

Rationale
Data captured in this field can be used to evaluate the accuracy and completeness of physician staging and form the basis for quality management and improvement studies.

In 2016, this data item was expanded to 2 characters and additional categories were added to document additional, more detailed sources of staging assignment and help in targeting training. The implementation of the new codes included data conversion and redefinition of "unknown" from "unknown stage" to unknown who assigned the stage ("9-Unknown; not stated in patient record" was converted to "99-Staged but unknown who assigned stage").

Instructions for Coding
- Record the role of the person who documented the pathologic AJCC staging data items and the Stage Group.
- If the case does not meet the criteria for pathologic staging, the tumor was not staged, or stage is unknown, use code 00.
- If code 10-20 is used, then all of the staging elements (T, N, and M) and Stage Group must be assigned by the same person.
- If the physician who assigned the stage cannot be identified as a surgeon, radiation oncologist, or medical oncologist, use code 10. Examples include: dentist, gynecologist, or urologist.
- If it is clear from the treatment provided that the physician providing the stage information is a surgeon, use code 11.
- If a pathologist assigns T and/or N, and the registrar determines M and determines the stage group from other portsions of the record, use code 30.
- If staging was obtained from outside the facility, code the role of the person who staged it if known (codes 10-40); otherwise use code 50.
- If applicable, the Staging Elements (T, N, M) and the Stage Group must be recorded.
    - Exception: Lymphoma does not have TNM elements – only assigning Stage Group is applicable.
- The staging source may be different for clinical vs. pathologic stage.

Code	Label	Definition
00	Not staged	Pathologic staging was not assigned; no information was found in the medical record to assign pathologic stage.
10	Physician, NOS, or physician type not specified in codes 11-15	Pathologic staging assigned by a physician not described under codes 11-15 (i.e., cancer committee chair, cancer liaison physician or registry physician advisor).
11	Surgeon	Pathologic staging assigned by the surgeon only.
12	Radiation Oncologist	Pathologic staging assigned by the radiation oncologist only.
13	Medical Oncologist	Pathologic staging assigned by the medical oncologist only.
14	Pathologist	Pathologic staging assigned by the pathologist only.
15	Multiple physicians, tumor board, etc.	Pathologic staging assigned by multiple physicians such as during a tumor board meeting.
20	Cancer Registrar	Pathologic staging assigned by the cancer registrar only.
30	Cancer Registrar and physician	Pathologic staging assigned by the cancer registrar and any of the physicians specified in codes 10-15. This would include the cancer registrar assigning the stage and a physician approving it.
40	Nurse, physician assistant, or other non-physician medical staff	Pathologic staging assigned by medical non-physician staff such as a nurse of physician assistant (PA).
50	Staging assigned at another facility	Pathologic staging assigned at another facility, person's role unknown.
60	Staging by Central Registry including consolidation of multiple sources	Pathologic staging assigned by Central Registry personnel based on information from one facility or multiple facilities.
88	Case is not eligible for staging	The site/histology combination is not defined in the AJCC Manual.
99	Staged but unknown who assigned stage	A stage was found in the medical record but it is unknown who assigned it.

.

Lymph-Vascular Invasion

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1182	1	New 01/10, 01/11, 01/15	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. This field is used by CS algorithm to map AJCC T for some primary sites.

Instructions for Coding
- Refer to the current **CS Manual** for coding instructions.

Regional Lymph Nodes Positive

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

Description

Records the exact number of regional lymph nodes examined by the pathologist and found to contain metastases. Beginning with cases diagnosed on or after January 1, 2004, this item is a component of the Collaborative Stage System (CS). In 2016, use of CS was discontinued, however this data item continues to be required.

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.

Instructions for Coding

- Refer to the site/histology-specific instructions in the current *CS Manual* for codes and instructions for coding.
- When the definition of regional nodes differs between the AJCC Cancer Staging Manual and the SEER Program Coding and Staging Manual use the AJCC definition.

Regional Lymph Nodes Examined

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

Description

Records the total number of regional lymph nodes that were removed and examined by the pathologist. Beginning with cases diagnosed on or after January 1, 2004, this item is a component of the Collaborative Stage System (CS). In 2016, use of CS was discontinued, however this data item continues to be required.

Rationale

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

Instructions for Coding

- Refer to the site/histology-specific instructions in the current *CS Manual* for codes and instructions for coding.
- When definition of regional nodes differs between the AJCC Cancer Staging Manual and the SEER Program Coding and Staging Manual, use the AJCC definition.

CS Site-Specific Factor 1

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2880	3	01/09, 01/10, 01/11, 01/12	Required

Description
Identifies additional information needed to generate stage or prognostic factors that have an effect on stage or survival.

Rationale
For cases diagnosed from 2004 through 2015, site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Effective for cases diagnosed January 1, 2016 and later, site-specific factors are used to record additional staging information needed to assign AJCC clinical and pathologic stage, to document biomarkers and prognostics factors of clinical significance, and for research purposes. This data is required on a site-specific basis for cases diagnosed January 1, 2016 and later.

Instructions for Coding
- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.
- Refer to the CS coding instructions on the Collaborative Stage website at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC and NPCR. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS Site-Specific Factor 2

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2890	3	01/09, 01/10, 01/11, 01/12	Required

Description
Identifies additional information needed to generate stage or prognostic factors that have an effect on stage or survival.

Rationale
For cases diagnosed from 2004 through 2015, site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Effective for cases diagnosed January 1, 2016 and later, site-specific factors are used to record additional staging information needed to assign AJCC clinical and pathologic stage, to document biomarkers and prognostics factors of clinical significance, and for research purposes. This data is required on a site-specific basis for cases diagnosed January 1, 2016 and later.

Instructions for Coding
- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.
- Refer to the CS coding instructions on the Collaborative Stage website at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC and NPCR. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS Site-Specific Factor 3

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2900	3	01/09, 01/10, 01/11, 01/12	Required

Description
Identifies additional information needed to generate stage or prognostic factors that have an effect on stage or survival.

Rationale
For cases diagnosed from 2004 through 2015, site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Effective for cases diagnosed January 1, 2016 and later, site-specific factors are used to record additional staging information needed to assign AJCC clinical and pathologic stage, to document biomarkers and prognostics factors of clinical significance, and for research purposes. This data is required on a site-specific basis for cases diagnosed January 1, 2016 and later.

Instructions for Coding
- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.
- Refer to the CS coding instructions on the Collaborative Stage website at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC and NPCR. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS Site-Specific Factor 4

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2910	3	01/09, 01/10, 01/11, 01/12	Required

Description
Identifies additional information needed to generate stage or prognostic factors that have an effect on stage or survival.

Rationale
For cases diagnosed from 2004 through 2015, site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Effective for cases diagnosed January 1, 2016 and later, site-specific factors are used to record additional staging information needed to assign AJCC clinical and pathologic stage, to document biomarkers and prognostics factors of clinical significance, and for research purposes. This data is required on a site-specific basis for cases diagnosed January 1, 2016 and later.

Instructions for Coding
- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.
- Refer to the CS coding instructions on the Collaborative Stage website at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC and NPCR. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS Site-Specific Factor 5

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2920	3	01/09, 01/10, 01/11, 01/12	Required

Description
Identifies additional information needed to generate stage or prognostic factors that have an effect on stage or survival.

Rationale
For cases diagnosed from 2004 through 2015, site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Effective for cases diagnosed January 1, 2016 and later, site-specific factors are used to record additional staging information needed to assign AJCC clinical and pathologic stage, to document biomarkers and prognostics factors of clinical significance, and for research purposes. This data is required on a site-specific basis for cases diagnosed January 1, 2016 and later.

Instructions for Coding
- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.
- Refer to the CS coding instructions on the Collaborative Stage website at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC and NPCR. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS Site-Specific Factor 6

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2930	3	01/09, 01/10, 01/11, 01/12	Required

Description
Identifies additional information needed to generate stage or prognostic factors that have an effect on stage or survival.

Rationale
For cases diagnosed from 2004 through 2015, site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Effective for cases diagnosed January 1, 2016 and later, site-specific factors are used to record additional staging information needed to assign AJCC clinical and pathologic stage, to document biomarkers and prognostics factors of clinical significance, and for research purposes. This data is required on a site-specific basis for cases diagnosed January 1, 2016 and later.

Instructions for Coding
- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.
- Refer to the CS coding instructions on the Collaborative Stage website at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC and NPCR. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS Site-Specific Factor 7

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2861	3	New 01/10, 01/11, 01/12	Required

Description
Identifies additional information needed to generate stage or prognostic factors that have an effect on stage or survival.

Rationale
For cases diagnosed from 2004 through 2015, site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Effective for cases diagnosed January 1, 2016 and later, site-specific factors are used to record additional staging information needed to assign AJCC clinical and pathologic stage, to document biomarkers and prognostics factors of clinical significance, and for research purposes. This data is required on a site-specific basis for cases diagnosed January 1, 2016 and later.

Instructions for Coding
- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.
- Refer to the CS coding instructions on the Collaborative Stage website at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC and NPCR. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS Site-Specific Factor 8

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2862	3	New 01/10, 01/11, 01/12	Required

Description
Identifies additional information needed to generate stage or prognostic factors that have an effect on stage or survival.

Rationale
For cases diagnosed from 2004 through 2015, site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Effective for cases diagnosed January 1, 2016 and later, site-specific factors are used to record additional staging information needed to assign AJCC clinical and pathologic stage, to document biomarkers and prognostics factors of clinical significance, and for research purposes. This data is required on a site-specific basis for cases diagnosed January 1, 2016 and later.

Instructions for Coding
- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.
- Refer to the CS coding instructions on the Collaborative Stage website at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC and NPCR. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS Site-Specific Factor 9

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2863	3	New 01/10, 01/11, 01/12	Required

Description
Identifies additional information needed to generate stage or prognostic factors that have an effect on stage or survival.

Rationale
For cases diagnosed from 2004 through 2015, site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Effective for cases diagnosed January 1, 2016 and later, site-specific factors are used to record additional staging information needed to assign AJCC clinical and pathologic stage, to document biomarkers and prognostics factors of clinical significance, and for research purposes. This data is required on a site-specific basis for cases diagnosed January 1, 2016 and later.

Instructions for Coding
- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.
- Refer to the CS coding instructions on the Collaborative Stage website at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC and NPCR. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS Site-Specific Factor 10

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2864	3	New 01/10, 01/11, 01/12	Required

Description
Identifies additional information needed to generate stage or prognostic factors that have an effect on stage or survival.

Rationale
For cases diagnosed from 2004 through 2015, site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Effective for cases diagnosed January 1, 2016 and later, site-specific factors are used to record additional staging information needed to assign AJCC clinical and pathologic stage, to document biomarkers and prognostics factors of clinical significance, and for research purposes. This data is required on a site-specific basis for cases diagnosed January 1, 2016 and later.

Instructions for Coding
- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.
- Refer to the CS coding instructions on the Collaborative Stage website at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC and NPCR. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS Site-Specific Factor 11

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2865	3	New 01/10, 01/11, 01/12	Required

Description
Identifies additional information needed to generate stage or prognostic factors that have an effect on stage or survival.

Rationale
For cases diagnosed from 2004 through 2015, site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Effective for cases diagnosed January 1, 2016 and later, site-specific factors are used to record additional staging information needed to assign AJCC clinical and pathologic stage, to document biomarkers and prognostics factors of clinical significance, and for research purposes. This data is required on a site-specific basis for cases diagnosed January 1, 2016 and later.

Instructions for Coding
- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.
- Refer to the CS coding instructions on the Collaborative Stage website at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC and NPCR. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS Site-Specific Factor 12

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2866	3	New 01/10, 01/11, 01/12	Required

Description
Identifies additional information needed to generate stage or prognostic factors that have an effect on stage or survival.

Rationale
For cases diagnosed from 2004 through 2015, site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Effective for cases diagnosed January 1, 2016 and later, site-specific factors are used to record additional staging information needed to assign AJCC clinical and pathologic stage, to document biomarkers and prognostics factors of clinical significance, and for research purposes. This data is required on a site-specific basis for cases diagnosed January 1, 2016 and later.

Instructions for Coding
- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.
- Refer to the CS coding instructions on the Collaborative Stage website at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC and NPCR. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS Site-Specific Factor 13

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2867	3	New 01/10, 01/11, 01/12	Required

Description
Identifies additional information needed to generate stage or prognostic factors that have an effect on stage or survival.

Rationale
For cases diagnosed from 2004 through 2015, site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Effective for cases diagnosed January 1, 2016 and later, site-specific factors are used to record additional staging information needed to assign AJCC clinical and pathologic stage, to document biomarkers and prognostics factors of clinical significance, and for research purposes. This data is required on a site-specific basis for cases diagnosed January 1, 2016 and later.

Instructions for Coding
- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.
- Refer to the CS coding instructions on the Collaborative Stage website at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC and NPCR. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS Site-Specific Factor 14

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2868	3	New 01/10, 01/11, 01/12	Required

Description
Identifies additional information needed to generate stage or prognostic factors that have an effect on stage or survival.

Rationale
For cases diagnosed from 2004 through 2015, site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Effective for cases diagnosed January 1, 2016 and later, site-specific factors are used to record additional staging information needed to assign AJCC clinical and pathologic stage, to document biomarkers and prognostics factors of clinical significance, and for research purposes. This data is required on a site-specific basis for cases diagnosed January 1, 2016 and later.

Instructions for Coding
- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.
- Refer to the CS coding instructions on the Collaborative Stage website at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC and NPCR. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS Site-Specific Factor 15

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2869	3	New 01/10, 01/11, 01/12	Required

Description
Identifies additional information needed to generate stage or prognostic factors that have an effect on stage or survival.

Rationale
For cases diagnosed from 2004 through 2015, site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Effective for cases diagnosed January 1, 2016 and later, site-specific factors are used to record additional staging information needed to assign AJCC clinical and pathologic stage, to document biomarkers and prognostics factors of clinical significance, and for research purposes. This data is required on a site-specific basis for cases diagnosed January 1, 2016 and later.

Instructions for Coding
- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.
- Refer to the CS coding instructions on the Collaborative Stage website at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC and NPCR. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS Site-Specific Factor 16

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2870	3	New 01/10, 01/11, 01/12	Required

Description
Identifies additional information needed to generate stage or prognostic factors that have an effect on stage or survival.

Rationale
For cases diagnosed from 2004 through 2015, site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Effective for cases diagnosed January 1, 2016 and later, site-specific factors are used to record additional staging information needed to assign AJCC clinical and pathologic stage, to document biomarkers and prognostics factors of clinical significance, and for research purposes. This data is required on a site-specific basis for cases diagnosed January 1, 2016 and later.

Instructions for Coding
- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.
- Refer to the CS coding instructions on the Collaborative Stage website at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC and NPCR. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS Site-Specific Factor 17

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2871	3	New 01/10, 01/11, 01/12	Required

Description
Identifies additional information needed to generate stage or prognostic factors that have an effect on stage or survival.

Rationale
For cases diagnosed from 2004 through 2015, site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Effective for cases diagnosed January 1, 2016 and later, site-specific factors are used to record additional staging information needed to assign AJCC clinical and pathologic stage, to document biomarkers and prognostics factors of clinical significance, and for research purposes. This data is required on a site-specific basis for cases diagnosed January 1, 2016 and later.

Instructions for Coding
- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.
- Refer to the CS coding instructions on the Collaborative Stage website at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC and NPCR. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS Site-Specific Factor 18

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2872	3	New 01/10, 01/11, 01/12	Required

Description
Identifies additional information needed to generate stage or prognostic factors that have an effect on stage or survival.

Rationale
For cases diagnosed from 2004 through 2015, site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Effective for cases diagnosed January 1, 2016 and later, site-specific factors are used to record additional staging information needed to assign AJCC clinical and pathologic stage, to document biomarkers and prognostics factors of clinical significance, and for research purposes. This data is required on a site-specific basis for cases diagnosed January 1, 2016 and later.

Instructions for Coding
- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.
- Refer to the CS coding instructions on the Collaborative Stage website at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC and NPCR. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS Site-Specific Factor 19

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2873	3	New 01/10, 01/11, 01/12	Required

Description
Identifies additional information needed to generate stage or prognostic factors that have an effect on stage or survival.

Rationale
For cases diagnosed from 2004 through 2015, site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Effective for cases diagnosed January 1, 2016 and later, site-specific factors are used to record additional staging information needed to assign AJCC clinical and pathologic stage, to document biomarkers and prognostics factors of clinical significance, and for research purposes. This data is required on a site-specific basis for cases diagnosed January 1, 2016 and later.

Instructions for Coding
- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.
- Refer to the CS coding instructions on the Collaborative Stage website at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC and NPCR. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS Site-Specific Factor 20

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2874	3	New 01/10, 01/11, 01/12	Required

Description
Identifies additional information needed to generate stage or prognostic factors that have an effect on stage or survival.

Rationale
For cases diagnosed from 2004 through 2015, site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Effective for cases diagnosed January 1, 2016 and later, site-specific factors are used to record additional staging information needed to assign AJCC clinical and pathologic stage, to document biomarkers and prognostics factors of clinical significance, and for research purposes. This data is required on a site-specific basis for cases diagnosed January 1, 2016 and later.

Instructions for Coding
- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.
- Refer to the CS coding instructions on the Collaborative Stage website at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC and NPCR. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS Site-Specific Factor 21

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2875	3	New 01/10, 01/11, 01/12	Required

Description
Identifies additional information needed to generate stage or prognostic factors that have an effect on stage or survival.

Rationale
For cases diagnosed from 2004 through 2015, site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Effective for cases diagnosed January 1, 2016 and later, site-specific factors are used to record additional staging information needed to assign AJCC clinical and pathologic stage, to document biomarkers and prognostics factors of clinical significance, and for research purposes. This data is required on a site-specific basis for cases diagnosed January 1, 2016 and later.

Instructions for Coding
- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.
- Refer to the CS coding instructions on the Collaborative Stage website at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC and NPCR. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS Site-Specific Factor 22

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2876	3	New 01/10, 01/11, 01/12	Required

Description
Identifies additional information needed to generate stage or prognostic factors that have an effect on stage or survival.

Rationale
For cases diagnosed from 2004 through 2015, site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Effective for cases diagnosed January 1, 2016 and later, site-specific factors are used to record additional staging information needed to assign AJCC clinical and pathologic stage, to document biomarkers and prognostics factors of clinical significance, and for research purposes. This data is required on a site-specific basis for cases diagnosed January 1, 2016 and later.

Instructions for Coding
- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.
- Refer to the CS coding instructions on the Collaborative Stage website at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC and NPCR. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS Site-Specific Factor 23

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2877	3	New 01/10, 01/11, 01/12	Required

Description
Identifies additional information needed to generate stage or prognostic factors that have an effect on stage or survival.

Rationale
For cases diagnosed from 2004 through 2015, site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Effective for cases diagnosed January 1, 2016 and later, site-specific factors are used to record additional staging information needed to assign AJCC clinical and pathologic stage, to document biomarkers and prognostics factors of clinical significance, and for research purposes. This data is required on a site-specific basis for cases diagnosed January 1, 2016 and later.

Instructions for Coding
- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.
- Refer to the CS coding instructions on the Collaborative Stage website at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC and NPCR. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS Site-Specific Factor 24

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2878	3	New 01/10, 01/11, 01/12	Required

Description
Identifies additional information needed to generate stage or prognostic factors that have an effect on stage or survival.

Rationale
For cases diagnosed from 2004 through 2015, site-specific factors are used to record additional staging information needed by Collaborative Stage to derive TNM and/or SEER Summary Stage codes for particular site-histology schema.

Effective for cases diagnosed January 1, 2016 and later, site-specific factors are used to record additional staging information needed to assign AJCC clinical and pathologic stage, to document biomarkers and prognostics factors of clinical significance, and for research purposes. This data is required on a site-specific basis for cases diagnosed January 1, 2016 and later.

Instructions for Coding
- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.
- Refer to the CS coding instructions on the Collaborative Stage website at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC and NPCR. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS Site-Specific Factor 25

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2879	3	New 01/10, 01/11, 01/12	Required

Description
Identifies additional information needed to generate stage or prognostic factors that have an effect on stage or survival.

Rationale
CS Site-Specific Factor 25 is used to discriminate between CS staging schema (for diagnosed from 2004 through 2015 only) or between AJCC chapters for cases where site and histology alone are insufficient to identify the tumor type or location to identify the applicable staging method. Use of this item is limited to specific subsites and histologies.

Instructions for Coding
- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.
- Refer to the CS coding instructions on the Collaborative Stage website at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC and NPCR. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

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.

Instructions for Coding
- 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 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.**

Instructions for Coding
- 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 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**.

Instructions for Coding
- 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) 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**.

Instructions for Coding
- 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:
- 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.

Instructions for Coding
- NAACCR or MCTR-approved abbreviations should be utilized (see website www.cancer.mt.gov for lists).
- 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"

Blank Page

Collaborative Stage

Recorded for cases diagnosed 2004-2015 only

Blank Page

Collaborative Stage Data Collection System

For cases diagnosed beginning January 1, 2016, the Collaborative Stage Data Collection System (CS) has been retired. CS is to be used for staging cases diagnosed on or after January 1, 2004 through December 31, 2015. It is not to be used for cases diagnosed prior to, or after those dates. For cases diagnosed from 2004-2015 all CS items identified in this manual are to be completed. SEE the interactive application at http://seer.cancer.gov/csreqstatus/application.html for the specific Site-Specific Factors required by site and histology.

The following data items were considered as Collaborative Stage input data items for the purposes of Collaborative Stage, but are now continued to be required for AJCC staging and research purposes:

- Regional Nodes Positive
- Regional Nodes Examined
- Lymph-vascular Invasion
- CS Site-Specific Factors
- CS Version Input Original
- CS Version Input Current

The requirements for Site-Specific Factors have not changed from 2015; the data items of CS Version Input Original and Current continue to be required to accommodate continued collection of the SSF's.

Differences between CS Derived Values and Directly-assigned AJCC

Some differences in the ways that the CS algorithm operates and how the AJCC stage assignment rules are made can result in dissimilarities between the derived values for some patients and the direct-coded stages. Because of those differences, the CS Derived AJCC values must never be copied into the equivalent direct-coded AJCC fields. The dissimilarities of most interest to registrars are those that might explain discrepancies between the derived AJCC T, N, M and Stage Group values and the values recorded for the same cases when directly coded using the AJCC instructions, as described in the next paragraph.

As a "best stage" system, CS makes use of the most complete information available to stage the tumor. The *AJCC Cancer Staging Manual* distinguishes between clinical staging, based on information available prior to primary treatment, and pathologic staging, based on information gathered as a product of the treatment process (particularly surgery). It also has specific rules governing how the components gathered at different times in the process may be combined. The CS algorithm derives a clinical (c) or pathologic (p) descriptor for each of the T, N and M stage components based on the source of information used to validate the most extensive spread of the tumor, and uses the components to derive a stage group without reference to the value of the descriptors. Some derived stage groups may involve combinations that are neither clinical nor pathologic according to AJCC rules, so a case that is unstageable for a physician applying AJCC rules may be assigned a Derived AJCC Stage Group value by the CS algorithm. Other cases may involve combinations that do not match either the physician-assigned clinical stage or the pathologic stage.

CS Tumor Size

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2800	3	09/06, 01/09, 01/10, 01/11	Required-H

Description
Records the largest dimension or diameter of the **primary tumor** in millimeters.

Rationale
Tumor size at diagnosis is an independent prognostic indicator for many tumors and it is used by Collaborative Stage to derive some TNM-T codes. Effective for cases diagnosed January 1, 2016 and later, this data item is no longer required.

Instructions for Coding
- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

CS Extension

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2810	3	09/06, 01/09, 01/10, 01/11	Required-H

Description

Identifies contiguous growth (extension) of the primary tumor within the organ of origin or its direct extension into neighboring organs. For certain sites such as ovary, discontinuous metastasis is coded in *CS Extension*.

Rationale

Tumor extension at diagnosis is a prognostic indicator used by Collaborative Stage to derive some TNM-T codes and some SEER Summary Stage codes. Effective for cases diagnosed January 1, 2016 and later, this data item is no longer required.

Instructions for Coding

- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

CS Tumor Size/Ext Eval

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2820	1	09/06, 01/09, 01/10, 01/11	Required-H

Description

Records how the codes for the two items *CS Tumor Size* and *CS Extension* were determined, based on the diagnostic methods employed.

Rationale

This item is used by Collaborative Stage to describe whether the staging basis for the TNM-T code is clinical or pathological and to record applicable prefix and suffix descriptors used with TNM staging. Effective for cases diagnosed January 1, 2016 and later, this data item is no longer required.

Instructions for Coding

- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

CS Lymph Nodes

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2830	3	09/06, 01/09, 01/10, 01/11	Required-H

Description
Identifies the regional lymph nodes involved with cancer at the time of diagnosis.

Rationale
The involvement of specific regional lymph nodes is a prognostic indicator used by Collaborative Stage to derive some TNM-N codes and SEER Summary Stage codes. Effective for cases diagnosed January 1, 2016 and later, this data item is no longer required.

Instructions for Coding
- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

CS Regional Nodes Eval

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2840	1	09/06, 01/09, 01/10, 01/11	Required-H

Description
Records how the code for *CS Lymph Nodes* was determined, based on the diagnostic methods employed.

Rationale
This data item is used by Collaborative Stage to describe whether the staging basis for the TNM-N code is clinical or pathological and to record applicable prefix and suffix descriptors used with TNM staging. Effective for cases diagnosed January 1, 2016 and later, this data item is no longer required.

Instructions for Coding
- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

CS Mets at Diagnosis

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2850	2	09/06, 01/09, 01/10, 01/11	Required-H

Description
Identifies the distant site(s) of metastatic involvement at time of diagnosis.

Rationale
The presence of metastatic disease at diagnosis is an independent prognostic indicator, and it is used by Collaborative Stage to derive TNM-M codes and SEER Summary Stage codes. Effective for cases diagnosed January 1, 2016 and later, this data item is no longer required.

Instructions for Coding
- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

CS Mets Eval

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2860	1	09/06, 01/09, 01/10, 01/11	Required-H

Description
Records how the code for *CS Mets at DX* was determined based on the diagnostic methods employed.

Rationale
This data item is used by Collaborative Stage to describe whether the staging basis for the TNM-M code is clinical or pathological and to record applicable prefix and suffix descriptors used with TNM staging. Effective for cases diagnosed January 1, 2016 and later, this data item is no longer required.

Instructions for Coding
- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

CS Mets at Diagnosis - Bone

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2851	1	New 01/10, 01/11	Required-H

Description
Identifies the presence of distant metastatic involvement of bone at time of diagnosis.

Rationale
The presence of metastatic bone disease at diagnosis is an independent prognostic indicator, and it is used by Collaborative Stage to derive TNM-M codes and SEER Summary Stage codes. Effective for cases diagnosed January 1, 2016 and later, this data item is no longer required.

Instructions for Coding
- Refer to the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

CS Mets at Diagnosis – Brain

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2852	1	New 01/10, 01/11	Required-H

Description
Identifies the presence of distant metastatic involvement of the brain at time of diagnosis.

Rationale
The presence of metastatic brain disease at diagnosis is an independent prognostic indicator, and it is used by Collaborative Stage to derive TNM-M codes and SEER Summary Stage codes. Effective for cases diagnosed January 1, 2016 and later, this data item is no longer required.

Instructions for Coding
- Refer to the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

CS Mets at Diagnosis - Liver

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2853	1	New 01/10, 01/11	Required-H

Description
Identifies the presence of distant metastatic involvement of the liver at time of diagnosis.

Rationale
The presence of metastatic liver disease at diagnosis is an independent prognostic indicator, and it is used by Collaborative Stage to derive TNM-M codes and SEER Summary Stage codes. Effective for cases diagnosed January 1, 2016 and later, this data item is no longer required.

Instructions for Coding
- Refer to the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

CS Mets at Diagnosis - Lung

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2854	1	New 01/10, 01/11	Required-H

Description
Identifies the presence of distant metastatic involvement of the lung at time of diagnosis.

Rationale
The presence of metastatic lung disease at diagnosis is an independent prognostic indicator, and it is used by Collaborative Stage to derive TNM-M codes and SEER Summary Stage codes. Effective for cases diagnosed January 1, 2016 and later, this data item is no longer required.

Instructions for Coding
- Refer to the current *CS Manual* for coding instructions.
- CoC does not require that registrars report information for this item that is not readily available in the facility's records. However, if that information is obtained along with other material from another source, it may be used.

Derived AJCC-6 T

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2940	2	01/09, 01/10	Required-H

Description
This item is the derived AJCC "T" staging element from coded fields using the CS algorithm.

Rationale
Derived AJCC-6 T can be used can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes. Effective for cases diagnosed January 1, 2016 and later, this data item is no longer required.

Instructions for Coding
- This data item is autocoded and is not recorded by registry staff.
- The two-digit storage codes are designed for analytic purposes.
- Refer to the current *CS Manual* for the display equivalent of the storage codes.
- Refer to the *AJCC Cancer Staging Manual, 6th Edition* for site-specific "T" descriptions.

Derived AJCC-6 T Descriptor

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2950	1	09/04, 01/10	Required-H

Description
This item is the derived AJCC "T Descriptor" from coded fields using the CS algorithm.

Rationale
Derived AJCC-6 T Descriptor can be used in analysis to differentiate the timing of staging with respect to the treatment process. Effective for cases diagnosed January 1, 2016 and later, this data item is no longer required.

Instructions for Coding
- This data item is autocoded and is not recorded by registry staff.
- Refer to the *AJCC Cancer Staging Manual, 6th Edition* for prefix definitions for codes c, p, a, and y.
- Refer to the current *CS Manual* for the calculation procedures for all codes.

Code	Description
c	Clinical stage
p	Pathologic stage
a	Autopsy stage
y	Surgical resection performed **after** pre-surgical systemic treatment or radiation; tumor size/extension based on pathologic evidence.
N	Not applicable
0	Not derived

Derived AJCC-6 N

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2960	2	01/10	Required-H

Description
This item is the derived AJCC "N" staging element from coded fields using the CS algorithm.

Rationale
Derived AJCC-6 N can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes. Effective for cases diagnosed January 1, 2016 and later, this data item is no longer required.

Instructions for Coding
- This data item is autocoded and is not recorded by registry staff.
- The two-digit storage codes are designed for analytic purposes.
- Refer to the current *CS Manual* for the display equivalent of the storage codes.
- Refer to the *AJCC Cancer Staging Manual, 6th Edition* for the site-specific "N" descriptions.

Derived AJCC-6 N Descriptor

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2970	1	09/04, 01/10	Required-H

Description
This item is the derived AJCC "N Descriptor" from coded fields using the CS algorithm.

Rationale
Derived AJCC-6 N Descriptor can be used in analysis to differentiate the timing of staging with respect to the treatment process. Effective for cases diagnosed January 1, 2016 and later, this data item is no longer required.

Instructions for Coding
- This data item is autocoded and is not recorded by registry staff.
- Refer to *the AJCC Cancer Staging Manual, 6th Edition* for prefix definitions for codes c, p, a, and y.
- Refer to the current *CS Manual* for the calculation procedures for all codes.

Code	Description
c	Clinical stage
p	Pathologic stage
a	Autopsy stage
y	Lymph nodes removed for examination **after** pre-surgical systemic treatment or radiation and lymph node evaluation based on pathologic evidence.
N	Not applicable
0	Not derived

Derived AJCC-6 M

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2980	2	01/10	Required-H

Description
This item is the derived AJCC "M" staging element from coded fields using the CS algorithm.

Rationale
Derived AJCC-6 M can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes. Effective for cases diagnosed January 1, 2016 and later, this data item is no longer required.

Instructions for Coding
- This data item is autocoded and is not recorded by registry staff.
- The two-digit storage codes are designed for analytic purposes.
- Refer to the current *CS Manual* for the display equivalent of the storage codes.
- Refer to the *AJCC Cancer Staging Manual, 6th Edition* for the site-specific "M" descriptions.

Derived AJCC-6 M Descriptor

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	2990	1	09/04, 01/10	Required-H

Description
This item is the derived AJCC "M Descriptor" from coded fields using the CS algorithm.

Rationale
Derived AJCC-6 M Descriptor can be used in analysis to differentiate the timing of staging with respect to the treatment process. Effective for cases diagnosed January 1, 2016 and later, this data item is no longer required.

Instructions for Coding
- This data item is autocoded and is not recorded by registry staff.
- Refer to *the AJCC Cancer Staging Manual, 6th Edition* for prefix definitions for codes c, p, a, and y.
- Refer to the current *CS Manual* for the calculation procedures for all codes.

Code	Description
c	Clinical stage
p	Pathologic stage
a	Autopsy stage
y	Pathologic examination of metastatic tissue performed **after** pre-surgical systemic treatment or radiation and extension based on pathologic evidence.
N	Not applicable
0	Not derived

Derived AJCC-6 Stage Group

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	3000	2	01/10, 01/11	Required-H

Description
This item is the derived AJCC "Stage Group" from the coded fields using the algorithm.

Rationale
The CS *Derived AJCC-6 Stage Group* can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes. Effective for cases diagnosed January 1, 2016 and later, this data item is no longer required.

Instructions for Coding
- This data item is autocoded and is not recorded by registry staff.
- The two-digit storage codes are designed for analytic purposes.
- Refer to the current *CS Manual* for the display equivalent of the storage codes.
- Refer to the *AJCC Cancer Staging Manual, 6th Edition* for site-specific "Stage Group" descriptions.

Derived AJCC-7 T

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	3400	2	New 01/10	Required-H

Description
This item is the derived AJCC "T" staging element from coded fields using the CS algorithm.

Rationale
Derived AJCC-7 T can be used can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes. Effective for cases diagnosed January 1, 2016 and later, this data item is no longer required.

Instructions for Coding
- This data item is autocoded and is not recorded by registry staff.
- The two-digit storage codes are designed for analytic purposes.
- Refer to the current *CS Manual* for the display equivalent of the storage codes.
- Refer to the *AJCC Cancer Staging Manual, 7th Edition* for site-specific "T" descriptions.

Derived AJCC-7 T Descriptor

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	3402	1	New 01/10	Required-H

Description
This item is the derived AJCC "T Descriptor" from coded fields using the CS algorithm.

Rationale
Derived AJCC-7 T Descriptor can be used in analysis to differentiate the timing of staging with respect to the treatment process. Effective for cases diagnosed January 1, 2016 and later, this data item is no longer required.

Instructions for Coding
- This data item is autocoded and is not recorded by registry staff.
- Refer to the *AJCC Cancer Staging Manual, 7th Edition* for prefix definitions for codes c, p, a, and y.
- Refer to the current *CS Manual* for the calculation procedures for all codes.

Code	Description
c	Clinical stage
p	Pathologic stage
a	Autopsy stage
y	Surgical resection performed **after** pre-surgical systemic treatment or radiation; tumor size/extension based on pathologic evidence.
N	Not applicable
0	Not derived

Derived AJCC-7 N

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	3410	2	New 01/10	Required-H

Description
This item is the derived AJCC "N" staging element from coded fields using the CS algorithm.

Rationale
Derived AJCC-7 N can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes. Effective for cases diagnosed January 1, 2016 and later, this data item is no longer required.

Instructions for Coding
- This data item is autocoded and is not recorded by registry staff.
- The two-digit storage codes are designed for analytic purposes.
- Refer to the current *CS Manual* for the display equivalent of the storage codes.
- Refer to the *AJCC Cancer Staging Manual, 7th Edition* for the site-specific "N" descriptions.

Derived AJCC-7 N Descriptor

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	3412	1	New 01/10	Required-H

Description
This item is the derived AJCC "N Descriptor" from coded fields using the CS algorithm.

Rationale
Derived AJCC-7 N Descriptor can be used in analysis to differentiate the timing of staging with respect to the treatment process. Effective for cases diagnosed January 1, 2016 and later, this data item is no longer required.

Instructions for Coding
- This data item is autocoded and is not recorded by registry staff.
- Refer to *the AJCC Cancer Staging Manual, 7th Edition* for prefix definitions for codes c, p, a, and y.
- Refer to the current *CS Manual* for the calculation procedures for all codes.

Code	Description
c	Clinical stage
p	Pathologic stage
a	Autopsy stage
y	Lymph nodes removed for examination **after** pre-surgical systemic treatment or radiation and lymph node evaluation based on pathologic evidence.
N	Not applicable
0	Not derived

Derived AJCC-7 M

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	3420	2	New 01/10	Required-H

Description
This item is the derived AJCC "M" staging element from coded fields using the CS algorithm.

Rationale
Derived AJCC-7 M can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes. Effective for cases diagnosed January 1, 2016 and later, this data item is no longer required.

Instructions for Coding
- This data item is autocoded and is not recorded by registry staff.
- The two-digit storage codes are designed for analytic purposes.
- Refer to the current *CS Manual* for the display equivalent of the storage codes.
- Refer to the *AJCC Cancer Staging Manual, 7th Edition* for the site-specific "M" descriptions.

Derived AJCC-7 M Descriptor

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	3422	1	New 01/10	Required-H

Description
This item is the derived AJCC "M Descriptor" from coded fields using the CS algorithm.

Rationale
Derived AJCC-7 M Descriptor can be used in analysis to differentiate the timing of staging with respect to the treatment process. Effective for cases diagnosed January 1, 2016 and later, this data item is no longer required.

Instructions for Coding
- This data item is autocoded and is not recorded by registry staff.
- Refer to *the AJCC Cancer Staging Manual, 7th Edition* for prefix definitions for codes c, p, a, and y.
- Refer to the current *CS Manual* for the calculation procedures for all codes.

Code	Description
c	Clinical stage
p	Pathologic stage
a	Autopsy stage
y	Pathologic examination of metastatic tissue performed **after** pre-surgical systemic treatment or radiation and extension based on pathologic evidence.
N	Not applicable
0	Not derived

Derived AJCC-7 Stage Group

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	3430	2	New 01/10, 01/11	Required-H

Description
This item is the derived AJCC "Stage Group" from coded fields using the CS algorithm.

Rationale
The CS *Derived AJCC-7 Stage Group* can be used to evaluate disease spread at diagnosis, plan and track treatment patterns, and analyze outcomes. Effective for cases diagnosed January 1, 2016 and later, this data item is no longer required.

Instructions for Coding
- This data item is autocoded and is not recorded by registry staff.
- The two-digit storage codes are designed for analytic purposes.
- Refer to the current *CS Manual* for the display equivalent of the storage codes.
- Refer to the *AJCC Cancer Staging Manual, 7th Edition* for site-specific "Stage Group" descriptions.

Derived SS1977

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	3010	1	01/09, 01/10	Required-H

Description
This item is the derived "SEER Summary Stage 1977" from the CS algorithm.

Rationale
Derived SS1977 can be used to evaluate patterns of disease spread at diagnosis, track treatment patterns, and analyze outcomes, especially when comparing or combining cases diagnosed prior to 2001 (when an updated version was implemented) with those diagnosed later. Effective for cases diagnosed January 1, 2016 and later, this data item is no longer required.

Instructions for Coding
- Refer to the applicable *SEER Summary Staging Manual, 1977* for site-specific categories.
- Refer to the current *CS Manual* for the calculation procedures for this item.

Code	Description
0	In-situ
1	Localized
2	Regional, direct extension only
3	Regional, regional lymph nodes only
4	Regional, direct extension and regional lymph nodes
5	Regional, NOS
7	Distant metastases/systemic disease
8	Not applicable
9	Unstaged, unknown, or unspecified
(blank)	Not derived

Derived SS2000

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	3020	1	01/09, 01/10	Required-H

Description
This item is the derived "SEER Summary Stage 2000" from the CS algorithm.

Rationale
Derived SS2000 can be used to evaluate patterns of disease spread at diagnosis, track treatment patterns, and analyze outcomes. Effective for cases diagnosed January 1, 2016 and later, this data item is no longer required.

Instructions for Coding
- Refer to the applicable *SEER Summary Staging Manual, 2000* for site-specific categories.
- Refer to the current *CS Manual* for the calculation procedures for this item.

Code	Description
0	In-situ
1	Localized
2	Regional, direct extension only
3	Regional, regional lymph nodes only
4	Regional, direct extension and regional lymph nodes
5	Regional, NOS
7	Distant metastases/systemic disease
8	Not applicable
9	Unstaged, unknown, or unspecified
(blank)	Not derived

Blank Page

Blank Page

Treatment Information

Blank Page

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 instructions for coding 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**.

Instructions for Coding
- 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:
- 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**.

Instructions for Coding
- 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 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**.

Instructions for Coding
- 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 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**.

Instructions for Coding
- 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 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**.

Instructions for Coding
- 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 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**.

Instructions for Coding
- 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 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.

Instructions for Coding
- 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 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**.

Instructions for Coding
- 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 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.

Instructions for Coding
- 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 Hospital/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 Hospital	Helena
477	1417945627	6810360	Kalispell Regional Healthcare	Kalispell
438	1790798387	6810380	Central Montana Medical Center	Lewistown
439	1952312050	6810390	Cabinet Peaks Medical Center	Libby

Number	NPI Number	ACoS Number	Facility Name	City
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 Sprgs
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
Path				
498	1790787935	9999999	Yellowstone Pathology Institute	Billings
493	1669597266	9999999	Northern Plains Pathology	Great Falls
495	1740364017	9999999	Western Montana Clinic	Missoula
491		9999999	St. Patrick Providence Pathology	Missoula
Phys				
200	1760485619	9999999	Tallman Dermatology	Billings
214	1093828378	9999999	Yellowstone Dermatology & Skin Cancer Cln	Billings
218	1720197817	9999999	MT Skin Cancer & Dermatology Center	Bozeman
220	1265477681	9999999	Big Sky Dermatology	Bozeman
202	1003900457	9999999	Advanced Dermatology of Butte	Butte
208	1720073596	9999999	Dermatology Office of Great Falls	Great Falls
210	1003902909	9999999	Helena Dermatology & Laser Clinic	Helena
212	1497896229	9999999	Associated Dermatology of Helena	Helena
204	1114093846	9999999	Dermatology Associates of Kalispell	Kalispell
104	1427034834	9999999	Glacier Oncology	Kalispell
206	1942217484	9999999	CPG Dermatology	Missoula
216	1518045731	9999999	Dermatology Provider of Missoula	Missoula

Blank Page

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.

Instructions for Coding

- 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.

Instructions for Coding

- 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.

Instructions for Coding
- 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.

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date of DX/Stage Procedure* and *Date of DX/Stage Procedure Flag.* ***In the table below, the lowercase letter "b" is used to represent each blank space***.

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: 02182007)	CCYYMMDD (example: 20070218)	bb
Month and year known	MM99CCYY (example: 02992007)	CCYYMMbb (example: 200702bb)	bb
Year only known	9999CCYY (example: 99992007)	CCYYbbbb (example: 2007bbbb)	bb
Unknown if procedure done	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	10
Procedure not done	00000000 (example: 00000000)	bbbbbbbb (example: bbbbbbbb)	11
Date is unknown, procedure done	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12

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.

Instructions for Coding

- Site-specific codes for this data item are founding Appendix B.
- 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 B.
- 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 B for the correct site-specific code for the procedure.
20-80	Site-specific codes; resection	Refer to Appendix B 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 B 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.

Instructions for Coding

- 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.

Instructions for Coding
- 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*.

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date of Surgery* and *Date of Surgery Flag.* ***In the table below, the lowercase letter "b" is used to represent each blank space***.

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: 02182007)	CCYYMMDD (example: 20070218)	bb
Month and year known	MM99CCYY (example: 02992007)	CCYYMMbb (example: 200702bb)	bb
Year only known	9999CCYY (example: 99992007)	CCYYbbbb (example: 2007bbbb)	bb
Unknown if any surgery performed	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	10
No surgery performed	00000000 (example: 00000000)	bbbbbbbb (example: bbbbbbbb)	11
Date is unknown, surgery performed	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12

Date of Surgical Discharge

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Date – Surgical Discharge	3180	8	01/10, 01/11	Optional

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.

Instructions for Coding
- 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	Optional

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.

Instructions for Coding
- 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.

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date of Surgical Discharge* and *Date of Surgical Discharge Flag.* ***In the table below, the lowercase letter "b" is used to represent each blank space***.

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: 02182007)	CCYYMMDD (example: 20070218)	bb
Month and year known	MM99CCYY (example: 02992007)	CCYYMMbb (example: 200702bb)	bb
Year only known	9999CCYY (example: 99992007)	CCYYbbbb (example: 2007bbbb)	bb
Unknown if any surgery performed	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	10
No primary site surgery performed	00000000 (example: 00000000)	bbbbbbbb (example: bbbbbbbb)	11
Date is unknown, primary site surgery performed	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12

Radiation

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
RX Summ – Radiation	1360	1	01/12	Required

Description
Records the type of radiation therapy administered as first course treatment at this and all other facilities. This field is replaced with Radiation Treatment Modality but is available for entry for historical purposes.

In RMCDS, click on the box "First Course Treatment" to enter Radiation.

Rationale
This data item allows for the evaluation of the administration of radiation therapy as part of the first course of therapy. In addition, when evaluating the quality of care, it is useful to know the reason if radiation therapy was not administered.

Instructions for Coding
- Radiation to brain and central nervous system for leukemia and lung cases is coded as radiation in this field.
- Assign **code 0** when:
  - There is no information in the patient's medical record about radiation AND It is known that radiation 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 radiation
  - The treatment plan offered multiple treatment options and the patient selected treatment that did not include radiation
  - Patient elected to pursue no treatment following the discussion of radiation treatment. Discussion does not equal a recommendation
  - Watchful waiting/active surveillance (prostate)
  - Patient diagnosed at autopsy
  - Radiotherapy recommended, but patient died before receiving radiotherapy
- Assign **code 1** for:
  - Beam radiation directed to cancer tissue. The source of the beam radiation is not coded. Sources may include but are not limited to X-ray, cobalt, linear accelerator, neutron beam, betatron, spray radiation, stereotactic radiosurgery such as gamma knife, and proton beam
  - Total body irradiation (TBI) prior to a bone marrow transplant
- Assign **code 2** when the radiation is delivered by interstitial implant, molds, seeds, needles or Intracavitary applicators. The radioactive material used in implants includes, but is not limited to cesium, radium, radon, radioactive gold, and iodine. Example: Brachytherapy with 125 seeds. Assign code 2. Seeds are always low dose therapy because they are left in place and the radioactivity decays over time.
- Assign **code 3** when radioactive isotopes are given orally, Intracavitary or by intravenous injection. Radioactive isotopes include but are not limited to I-131 or P-32.
- Assign **code 3** for 90-Yttrium and for 131-Iodine when given with Rituxan as treatment for lymphoma (code Rituxan as chemotherapy).
- Assign **code 4** when the patient has beam radiation **and** either radioactive implants or radioisotopes.
- Assign **code 8** when:
  - Radiation has been recommended, but there is no confirmation of its activity being delivered
  - The only information available is that the patient was referred to a radiation oncologist. **Note**: Review cases coded 8 periodically for later confirmation of radiation therapy
- Assign **code 9** when there is no documentation that radiation was recommended or performed.

Code	Definition
0	None
1	Beam radiation
2	Radioactive implants
3	Radioisotopes
4	Combination of 1 with 2 or 3
5	Radiation, NOS – method or source not specified
7	Patient refused radiation therapy
8	Recommended, unknown if given
9	Unknown if radiation administered

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.

Instructions for Coding
- 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.

Instructions for Coding
- 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*.

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date Radiation Started* and *Date Radiation Started Flag.* ***In the table below, the lowercase letter "b" is used to represent each blank space***.

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: 02182007)	CCYYMMDD (example: 20070218)	bb
Month and year known	MM99CCYY (example: 02992007)	CCYYMMbb (example: 200702bb)	bb
Year only known	9999CCYY (example: 99992007)	CCYYbbbb (example: 2007bbbb)	bb
Unknown if any radiation given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	10
No radiation given	00000000 (example: 00000000)	bbbbbbbb (example: bbbbbbbb)	11
Date is unknown, radiation given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12
Radiation not started yet	88888888 (example: 88888888)	bbbbbbbb (example: bbbbbbbb)	15

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	Recommended

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.

Instructions for Coding
- 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	Optional

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.

Instructions for Coding
- 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*.

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date Radiation Ended* and *Date Radiation Ended Flag.* ***In the table below, the lowercase letter "b" is used to represent each blank space***.

Description	**<u>Traditional Date</u> Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999**	**<u>Interoperable Date</u> 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: 02182007)	CCYYMMDD (example: 20070218)	bb
Month and year known	MM99CCYY (example: 02992007)	CCYYMMbb (example: 200702bb)	bb
Year only known	9999CCYY (example: 99992007)	CCYYbbbb (example: 2007bbbb)	bb
Unknown if any radiation given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	10
No radiation given	00000000 (example: 00000000)	bbbbbbbb (example: bbbbbbbb)	11
Date is unknown, radiation given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12
Radiation is ongoing	88888888 (example: 88888888)	bbbbbbbb (example: bbbbbbbb)	15

Regional Treatment Modality

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1570	2	09/06, 01/09, 01/11, 01/15	Required

Description
Records the dominant modality of radiation therapy used to deliver the most clinically significant regional dose to the primary volume of interest during the first course of treatment.

In RMCDS, click on the box "First Course Treatment" to enter Regional Treatment Modality.

Rationale
Radiation treatment is frequently delivered in two or more phases which can be summarized as "regional" and "boost" treatments. To evaluate patterns of radiation oncology care, it is necessary to know which radiation resources were employed in the delivery of therapy. For outcomes analysis, the modalities used for each of these phases can be very important.

Instructions for Coding
- 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 regional and boost and determination of the respective treatment modality may require assistance from the radiation oncologist to ensure consistent coding.
- In the event multiple radiation therapy modalities were employed in the treatment of the patient, record only the dominant modality.
- Note that in some circumstances the boost treatment may precede the regional treatment.
- For purposes of this data item, photons and x-rays are equivalent.
- Code IMRT or conformal 3D whenever either is explicitly mentioned.
- Code radioembolization as brachytherapy.
- Note: do not confuse a radioiodine *scan* with treatment. Only treatment is recorded in this item.

Code	Label	Definition
00	No radiation treatment	Radiation therapy was not administered to the patient. Diagnosed at autopsy.
20	External beam, NOS	The treatment is known to be by external beam, but there is insufficient information to determine the specific modality.
21	Orthovoltage	External beam therapy administered using equipment with a maximum energy of less than one (1) million volts (MV). Orthovoltage energies are typically expressed in units of kilovolts (kV).
22	Cobalt-60, Cesium-137	External beam therapy using a machine containing either a Cobalt-60 or Cesium-137 source. Intracavitary use of these sources is coded either 50 or 51.
23	Photons (2-5 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 2-5 MV.
24	Photons (6-10 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 6-10 MV.
25	Photons (11-19 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 11-19 MV.
26	Photons (>19 MV)	External beam therapy using a photon producing machine with a beam energy of more than 19 MV.
27	Photons (mixed energies)	External beam therapy using more than one energy over the course of treatment.
28	Electrons	Treatment delivered by electron beam.
29	Photons and electrons mixed	Treatment delivered using a combination of photon and electron beams.
30	Neutrons, with or without photons/electrons	Treatment delivered using neutron beam.

Code	Label	Definition
31	IMRT	Intensity modulated radiation therapy, an external beam technique that should be clearly stated in patient record.
32	Conformal or 3-D therapy	An external beam technique using multiple, fixed portals shaped to conform to a defined target volume. Should be clearly described as conformal or 3-D therapy in patient record.
40	Protons	Treatment delivered using proton therapy.
41	Stereotactic radiosurgery, NOS	Treatment delivered using stereotactic radiosurgery, type not specified in patient record.
42	Linac radiosurgery	Treatment categorized as using stereotactic technique delivered with a linear accelerator.
43	Gamma Knife	Treatment categorized as using stereotactic technique delivered using a Gamma Knife machine.
50	Brachytherapy, NOS	Brachytherapy, interstitial implants, molds, seeds, needles, radioembolization, or intracavitary applicators of radioactive materials not otherwise specified.
51	Brachytherapy, Intracavitary, LDR	Intracavitary (no direct insertion into tissues) radio-isotope treatment using low dose rate applicators and isotopes (Cesium-137, Fletcher applicator).
52	Brachytherapy, Intracavitary, HDR	Intracavitary (no direct insertion into tissues) radioisotope treatment using high dose rate after-loading applicators and isotopes.
53	Brachytherapy, Interstitial, LDR	Interstitial (direct insertion into tissues) radioisotope treatment using low dose rate sources.
54	Brachytherapy, Interstitial, HDR	Interstitial (direct insertion into tissues) radioisotope treatment using high dose rate sources.
55	Radium	Infrequently used for low dose rate (LDR) interstitial and intracavitary therapy.
60	Radioisotopes, NOS	Iodine-131, Phosphorus-32, etc.
61	Strontium-89	Treatment primarily by intravenous routes for bone metastases.
62	Strontium-90	
80*	Combination modality, specified*	Combination of external beam radiation and either radioactive implants or radioisotopes.*
85*	Combination modality, NOS*	Combination of radiation treatment modalities not specified in code 80.*
98	Other, NOS	Other radiation, NOS; Radiation therapy is administered, but the treatment modality is not specified or is unknown.
99	Unknown	It is unknown whether radiation therapy was administered.

* ***Note:*** For cases diagnosed prior to January 1, 2003, the codes reported in this data item describe any radiation administered to the patient as part or all of the first course of therapy. Codes 80 and 85 describe specific converted descriptions of radiation therapy coded according to *Vol. II, ROADS*, and *DAM* rules and **should not** be used to record regional radiation for cases diagnosed on or later than January 1, 2003.

Examples:

Code	Reason
00	A patient was treated for melanoma with PUVA (psoralen and long-wave ultraviolet radiation). Code this treatment as *Other Treatment*, code 1.
20	A patient with prostate carcinoma receives pelvic irradiation at the reporting facility, and is then referred to a major medical center for experimental proton therapy boost.
24	A patient treated with breast conserving surgery has an interstitial boost at the time of the excisional biopsy. The implant uses Ir-192 and is left in place for three days. This is followed by 6 MV photon treatment of the entire breast. In this case, the "boost" precedes the regional treatment.
25	In an experimental program, a patient with a Stage III carcinoma of the prostate receives 4,500 cGy to the pelvis using 15 MV photons, and then the prostate receives a 600 cGy boost with neutrons.
25	Patient receives 15 MV external pelvis treatment to 4,500 cGy for cervical carcinoma, and then receives two Fletcher intracavitary implants.
29	A patient with carcinoma of the parotid receives daily treatments of which 60% are delivered by 15 MV photons and 40% of the dose is delivered by 16 MV electrons.
53	A prostate cancer patient is treated with I-125 seeds. I-125 is low dose brachytherapy.
99	A patient with a head and neck cancer was referred from another facility for an HDR Brachytherapy boost. Detailed treatment records from the other facility are not available.

Boost Treatment Modality

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	3200	2	01/04, 01/09, 01/15	Recommended

Description
Records the dominant modality of radiation therapy used to deliver the most clinically significant boost dose to the primary volume of interest during the first course of treatment. This is accomplished with external beam fields of reduced size (relative to the regional treatment fields), implants, stereotactic radiosurgery, conformal therapy, or IMRT. External beam boosts may consist of two or more successive phases with progressively smaller fields generally coded as a single entity.

In RMCDS, click on the button "Radiation Detail" to enter Modality, cGy, Treatment Volume, and Location of Treatment.

Rationale
Radiation treatment is frequently delivered in two or more phases which can be summarized as "regional" and "boost" treatments. To evaluate patterns of radiation oncology care, it is necessary to know which radiation resources were employed in the delivery of therapy. For outcomes analysis, the modalities used for each of these phases can be very important.

Instructions for Coding
- Radiation boost treatment modalities will typically be found in the radiation oncologist's summary letter for the first course of treatment. Segregation of treatment components into regional and boost and determination of the respective treatment modality may require assistance from the radiation oncologist to ensure consistent coding.
- In the event multiple radiation therapy boost modalities were employed in the treatment of the patient, record only the dominant modality.
- Note that in some circumstances the boost treatment may precede the regional treatment.
- For purposes of this data item, photons and x-rays are equivalent.
- Code radioembolization as brachytherapy.

Code	Label	Definition
00	No boost treatment	A boost dose was not administered to the patient. Diagnosed at autopsy.
20	External beam, NOS	The treatment is known to be by external beam, but there is insufficient information to determine the specific modality.
21	Orthovoltage	External beam therapy administered using equipment with a maximum energy of less than one (1) million volts (MV). Orthovoltage energies are typically expressed in units of kilovolts (kV).
22	Cobalt-60, Cesium-137	External beam therapy using a machine containing either a Cobalt-60 or Cesium-137 source. Intracavitary use of these sources is coded either 50 or 51.
23	Photons (2-5 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 2-5 MV.
24	Photons (6-10 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 6-10 MV.
25	Photons (11-19 MV)	External beam therapy using a photon producing machine with a beam energy in the range of 11-19 MV.
26	Photons (>19 MV)	External beam therapy using a photon producing machine with a beam energy of more than 19 MV.
27	Photons (mixed energies)	External beam therapy using more than one energy over the course of treatment.
28	Electrons	Treatment delivered by electron beam.
30	Neutrons, with or without photons/electrons	Treatment delivered using neutron beam.

Code	Label	Definition
31	IMRT	Intensity modulated radiation therapy, an external beam technique that should be clearly stated in patient record.
32	Conformal or 3-D therapy	An external beam technique using multiple, fixed portals shaped to conform to a defined target volume. Should be clearly described as conformal or 3-D therapy in patient record.
40	Protons	Treatment delivered using proton therapy.
41	Stereotactic radiosurgery, NOS	Treatment delivered using stereotactic radiosurgery, type not specified in patient record.
42	Linac radiosurgery	Treatment categorized as using stereotactic technique delivered with a linear accelerator.
43	Gamma Knife	Treatment categorized as using stereotactic technique delivered using a Gamma Knife machine.
50	Brachytherapy, NOS	Brachytherapy, interstitial implants, molds, seeds, needles, radioembolization, or intracavitary applicators of radioactive materials not otherwise specified.
51	Brachytherapy, Intracavitary, LDR	Intracavitary (no direct insertion into tissues) radio-isotope treatment using low dose rate applicators and isotopes (Cesium-137, Fletcher applicator).
52	Brachytherapy, Intracavitary, HDR	Intracavitary (no direct insertion into tissues) radioisotope treatment using high dose rate after-loading applicators and isotopes.
53	Brachytherapy, Interstitial, LDR	Interstitial (direct insertion into tissues) radioisotope treatment using low dose rate sources.
54	Brachytherapy, Interstitial, HDR	Interstitial (direct insertion into tissues) radioisotope treatment using high dose rate sources.
55	Radium	Infrequently used for low dose rate (LDR) interstitial and intracavitary therapy.
60	Radioisotopes, NOS	Iodine-131, Phosphorus-32, etc.
61	Strontium-89	Treatment primarily by intravenous routes for bone metastases.
62	Strontium-90	
98	Other, NOS	Radiation therapy administered, but the treatment modality is not specified or is unknown.
99	Unknown	It is unknown whether radiation therapy was administered. Death certificate only.

Examples:

Code	Reason
29	A patient with carcinoma of the tonsil receives 4,500 cGy to the head and neck region with 6MV photons. The primary site and involved regional lymph nodes are then boosted, i.e., taken to a maximum dose of 7,400 cGy, using a sequence of beam arrangements involving 6 MV photons, 15 MV photons, and 12 MV electrons.
30	In an experimental program, a patient with Stage III carcinoma of the prostate receives 4,500 cGy to the pelvis using 15 MV photons, and then the prostate receives a 600 cGy boost with neutrons.
40	A patient with prostate carcinoma receives pelvic irradiation at the reporting facility and is referred to a major medical center for experimental proton therapy boost.
51	A patient receives external pelvic treatment to 4,500 cGy for cervical carcinoma, then receives two Fletcher intracavitary implants as boost treatment.
55	A patient treated with breast conserving surgery has an interstitial boost at the time of the excisional biopsy. The implant uses Ir-192 and is left in place for three days.
99	A patient with a head and neck cancer was referred to another facility for an HDR Brachytherapy boost. Detailed treatment records from the other facility are not available.

Regional Dose: cGy

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1510	5	01/04, 01/15	Recommended

Description
Records the dominant or most clinically significant total dose of regional radiation therapy delivered to the patient during the first course of treatment. The unit of measure is centiGray (cGy).

In RMCDS, click on the button "Radiation Detail" to enter Modality, cGy, Treatment Volume, and Location of Treatment.

Rationale
To evaluate patterns of radiation oncology care, it is necessary to capture information describing the prescribed regional radiation dose. Outcomes are strongly related to the dose delivered.

Instructions for Coding

- 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 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.
- Regional dose will typically be found in the radiation oncologist's summary letter for the first course treatment. Determination of the total dose of regional radiation therapy may require assistance from the radiation oncologist for consistent coding.
- For proton treatment, dosage is reported in cGe units (Cobalt Gray Equivalent) rather than cGy. Please record 100x cGe for *Regional Dose: cGy* (note that it is necessary to multiply cGe by 100 to code this).
- Do not include the boost dose, if one was administered.
- Code 88888 when Brachytherapy or radioisotopes – codes 50-62 for Regional Treatment Modality – were administered to the patient.
- Note that dose is still occasionally specified in "rads". One rad is equivalent to one centiGray (cGy).

Code	Definition
(fill spaces)	Record the actual regional dose delivered.
00000	Radiation therapy was not administered. Diagnosed at autopsy.
88888	Not applicable, brachytherapy or radioisotopes administered to the patient.
99999	Regional radiation therapy was administered, but the dose is unknown; it is unknown whether radiation therapy was administered. Death certificate only.

Examples:

Code	Reason
05000	A patient with Stage III prostate carcinoma received pelvic irradiation to 5,000 cGy followed by a prostate boost to 7,000 cGy. Record the regional dose as 5,000 cGy.
06000	A patient with a left supraclavicular metastasis from a gastric carcinoma received 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. Record the regional dose reflecting the prescribed dose of 6,000 cGy.
05500	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 lymph nodes are treated 4,500 cGy, calculated to a depth of 3 cm, and an interstitial boost in the primary tumor bed delivers an additional 2,500 cGy to a small volume in the breast. Record the primary target of the breast as 5,500 cGy.

Boost Dose: cGy

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	3210	5	09/04, 06/05, 01/15	Recommended

Description
Records the additional dose delivered to that part of the treatment volume encompassed by the boost fields or devices. The unit of measure is centiGray (cGy).

In RMCDS, click on the button "Radiation Detail" to enter Modality, cGy, Treatment Volume, and Location of Treatment.

Rationale
To evaluate patterns of radiation oncology care, it is necessary to capture information describing the prescribed regional radiation dose. Outcomes are strongly related to the dose delivered.

Instructions for Coding
- 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 dose as indicated in the summary chart. Consult the radiation oncologist for the exact dose, if necessary.
- Radiation boost treatment dose will typically be found in the radiation oncologist's summary letter for the first course treatment. Determination of the additional boost dose of radiation therapy may require assistance from the radiation oncologist for consistent coding.
- For photon treatment, dosage is reported in cGe units (Cobalt Gray Equivalent) rather than cGy. Please record 100x cGe for *Regional Dose: cGy* (note that it is necessary to multiply cGe by 100 to code this).
- Do not include the regional dose. In general, the boost dose will be calculated as the difference between the maximum prescribed dose and the regional dose. Many patients will not have a boost.
- Code 88888 when brachytherapy or radioisotopes – codes 50-62 for *Boost Treatment Modality* – were administered to the patient.
- Note that dose is still occasionally specified in "rads". One rad is equivalent to one centiGray (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	Definition
(fill spaces)	Record the actual boost dose delivered.
00000	Boost dose therapy was not administered. Diagnosed at autopsy.
88888	Not applicable, brachytherapy or radioisotopes administered to the patient.
99999	Boost radiation therapy was administered, but the dose is unknown. Death certificate only.

Examples:

Code	Reason
02000	A patient with Stage III prostate carcinoma received pelvic irradiation to 5,000 cGy followed by a conformal prostate boost to 7,000 cGy. Record the prescribed (and delivered) boost dose, 2,000 cGy (7,000 cGy minus 5,000 cGy).
00000	A patient with a left supraclavicular metastasis from a gastric carcinoma received 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 boost doses. In this case, there is no planned boost. Record the boost dose as 00000 cGy.
88888	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 5,040 cGy. The supraclavicular lymph nodes are treated 4,500 cGy, calculated to a depth of 3 cm, and an interstitial boost in the primary tumor bed is delivered to a small volume in the breast. Record the boost dost as 88888. Note that standards for describing an interstitial or intracavitary treatment with a single number are somewhat variable.

Number of Treatments to this Volume

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1520	3	01/10, 01/11, 01/12, 01/15	Recommended

Description
Records the total number of treatment sessions (fractions) 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 is used to evaluate patterns of radiation therapy and the treatment schedules

Instructions for Coding

- The number of treatments or fractions 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.
- Although a 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.
- The total number of treatment sessions (fractions) is the sum of the number of fractions of regional treatment and the number of fractions of boost treatment.
- Count each separate administration of brachytherapy or implants as a single treatment or fraction.

Code	Label	Definition
000	None	Radiation therapy was not administered to the patient. Diagnosed at autopsy.
001-998	Number of Treatments	Total number of treatment sessions administered to the patient.
999	Unknown	Radiation therapy was administered, but the number of treatments is unknown; it is unknown whether radiation therapy was administered. Death certificate only.

Examples:

Code	Reason
025	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 treatment portals. Twenty-five treatment sessions were given. Record 25 treatments.
035	A patient with Stage IIIB bronchogenic carcinoma received 25 treatments to the left hilum and mediastinum, given 25 daily treatments over five weeks. A left hilar boost was then given in 10 additional treatments. Record 35 treatments.
050	A patient with advanced 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. Record 50 treatments.
010	The patient was given Mammosite brachytherapy, repeated in 10 separate sessions. Record 10 treatments.
001	Prostate cancer patient treated with a single administration of seeds. Code a 1 treatment.

Radiation Treatment Volume

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1540	2	01/04, 01/11, 01/12, 01/15	Recommended

Description
Identifies the volume or anatomic target of the most clinically significant radiation therapy delivered to the patient 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 describing the anatomical structures targeted by the regional radiation therapy 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 (local analysis of physician practices) and on a regional or national basis.

Instructions for Coding
- 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.
- If two discrete volumes are treated and one of those includes the primary site, record the treatment to the primary site.

Code	Label	Definition
00	No radiation treatment	Radiation therapy was not administered to the patient. Diagnosed at autopsy.
01	Eye/orbit	The radiation therapy target volume is limited to the eye and/or orbit.
02	Pituitary	The target volume is restricted to the pituitary gland and all adjacent volumes are irradiated incidentally.
03	Brain (NOS)	Treatment is directed at tumors lying within the substance of the brain, or its meninges.
04	Brain (limited)	The treatment volume encompasses less than the total brain, or less than all of the meninges.
05	Head and neck (NOS)	The treatment volume is directed at a primary tumor of the oropharyngeal complex, usually encompassing regional lymph nodes.
06	Head and neck (limited)	Limited volume treatment of a head and neck primary with the exception of glottis (code 7), sinuses (code 8), or parotid (code 9).
07	Glottis	Treatment is limited to a volume in the immediate neighborhood of the vocal cords.
08	Sinuses	The primary target is one or both of the maxillary sinuses, the ethmoidal, and/or the frontal sinuses. In some cases, the adjacent lymph node regions may be irradiated.
09	Parotid	The primary target is one of the parotid glands. There may be secondary regional lymph node irradiation as well.
10	Chest/lung (NOS)	Radiation therapy is directed to some combination of hilar, mediastinal, and/or supraclavicular lymph nodes, and/or peripheral lung structures.
11	Lung (limited)	Radiation therapy is directed at one region of the lung without nodal irradiation.
12	Esophagus	The primary target is some portion of the esophagus. Regional lymph nodes may or may not be included in the treatment. Include tumors of the gastroesophageal junction.
13	Stomach	The primary malignancy is in the stomach. Radiation is directed to the stomach and possibly adjacent lymph nodes.

Code	Label	Definition
14	Liver	The primary target is all or a portion of the liver, for either primary or metastatic disease.
15	Pancreas	The primary tumor is in the pancreas. The treatment field encompasses the pancreas and possibly adjacent lymph node regions.
16	Kidney	The target is primary or metastatic disease in the kidney or the kidney bed after resection of a primary kidney tumor. Adjacent lymph node regions may be included in the field.
17	Abdomen (NOS)	Include all treatment of abdominal contents that do not fig codes 12-16.
18	Breast	The primary target is the intact breast and no attempt has been made to irradiate the regional lymph nodes. Intact breast includes breast tissue that either was not surgically treated or received a lumpectomy or partial mastectomy (C50.0-C50.9, Surgical Procedure of Primary Site codes 0-24).
19	Breast/lymph nodes	A deliberate attempt has been made to include regional lymph nodes in the treatment of an intact breast. See definition of intact breast above.
20	Chest wall	Treatment encompasses the chest wall (following mastectomy).
21	Chest wall/lymph nodes	Treatment encompasses the chest wall (following mastectomy) plus fields directed at regional lymph nodes.
22	Mantle, Mini-mantle	Treatment consists of a large radiation field designed to encompass all of the regional lymph nodes above the diaphragm, including cervical, supraclavicular, axillary, mediastinal, and hilar nodes (mantle), or most of them (mini-mantle). This code is used exclusively for patients with Hodgkin's or non-Hodgkin's lymphoma.
23	Lower extended field	The target zone includes lymph nodes below the diaphragm along the paraaortic chain. It may include extension to one side of the pelvis. This code includes the "hockey stick" field utilized to treat seminomas.
24	Spine	The primary target relates to the bones of the spine, including the sacrum. Spinal cord malignancies could be coded 40 (spinal cord).
25	Skull	Treatment is directed at the bones of the skull. Any brain irradiation is a secondary consequence.
26	Ribs	Treatment is directed toward metastatic disease in one or more ribs. Fields may be tangential or direct.
27	Hip	The target includes the proximal femur for metastatic disease. In many cases there may be acetabular disease as well.
28	Pelvic bones	The target includes structures of the bones of the pelvis other than the hip or sacrum.
29	Pelvis (NOS)	Irradiation is directed at soft tissues within the pelvic region and codes 34-36 do not apply.
30	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 31 (Soft tissue).
31	Soft tissue	All treatment of primary or metastatic soft tissue malignancies not fitting other categories.
32	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.
33	Whole body	Entire body included in a single treatment.
34	Bladder and pelvis	The primary malignancy originated in the bladder, all or most of the pelvis

Code	Label	Definition
		is treated as part of the plan, typically with a boost to the bladder.
35	Prostate and pelvis	The primary malignancy originated in the prostate, all or most of the pelvis is treated as part of the plan, typically with a boost to the prostate.
36	Uterus and cervix	Treatment is confined to the uterus and cervix or vaginal cuff, usually by intracavitary or interstitial technique.
37	Shoulder	Treatment is directed to the proximal humerus, scapula, clavicle, or other components of the shoulder complex. This is usually administered for control of symptoms for metastases.
38	Extremity bone, NOS	Bones of the arms or legs. This excludes the proximal femur, code 27 (Hip). This excludes the proximal humerus, code 37 (Shoulder).
39	Inverted Y	Treatment has been given to a field that encompasses the paraaortic and bilateral inguinal or inguinofemoral lymph nodes in a single port.
40	Spinal cord	Treatment is directed at the spinal cord or its meninges.
41	Prostate	Treatment is directed at the prostate with or without the seminal vesicles, without regional lymph node treatment.
50	Thyroid	Treatment is directed at the thyroid gland.
60	Lymph node region, NOS	The target is a group of lymph nodes not listed above. Examples include isolated treatment of a cervical, supraclavicular, or inguinofemoral region.
98	Other	Radiation therapy administered, treatment volume other than those previously categorized.
99	Unknown	Radiation therapy administered, treatment volume unknown or not stated in patient record; it is unknown whether radiation therapy was administered. Death certificate only.

Examples:

Code	Reason
01	Lymphoma of the orbit treated with 4 cm x 4 cm portals.
02	Pituitary adenomas receiving small opposed field or rotational treatment.
03	The entire brain is treated for metastatic disease.
04	Limited field irradiation of an oligodendroglioma or glioblastoma.
05	Carcinoma of the left tonsil treated with opposed lateral fields to the neck and an anterior supraclavicular field.
06	Interstitial implant utilized to treat a small carcinoma of the lateral tongue.
07	Small lateral fields utilized to treat a T1 or T2 glottic tumor.
11	Small portal treatment is delivered to the right bronchial/hilar region to stop hemoptysis.
17	Irradiation for hypersplenism due to lymphoma.
19	Tangential fields deliberately arranged in a manner that will encompass internal mammary lymph nodes in a patient with medial primary; breast tangential fields plus supraclavicular and/or axillary field in a patient with five positive lymph nodes.
20	Following mastectomy, a patient has prophylactic chest wall irradiation to prevent local recurrence; a thoracotomy scar is irradiated because of known contamination with tumor.
24	An inverted “T” field is utilized to treat painful metastases in the lumbar vertebrae and sacrum in a patient with prostate cancer.
25	Patient with myeloma receives total skull irradiation for numerous “punched out” lesions that are causing discomfort.
33	Patient with chronic lymphocytic leukemia receives five whole-body treatments of 10 cGy each to reduce adenopathy or lymphocyte count.
33	TBI (total body irradiation) is administered prior to a bone marrow transplant. Both the radiation and the chemotherapy that also is given with bone marrow transplants act to destroy cancer cells, and both are recorded as treatment.
36	Patient receives intracavitary therapy alone for a high-grade Stage IA carcinoma of the endometrium.
38	The distal forearm is treated for a metastatic lesion involving the radius.
39	Stage IA Hodgkin’s disease presenting in an inguinal lymph node.
40	A portion of the spinal cord is treated for a primary ependymoma.
60	Ovarian carcinoma presenting with left supraclavicular lymphadenopathy as the only documented site of metastatic disease. The supraclavicular region is treated to prevent neurologic complications.
98	Anterior neck is treated for a primary thyroid lymphoma.

Location of Radiation Treatment

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1550	1	01/04, 01/12	Recommended

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.

Instructions for 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"; it does not refer to "regional" as used to identify stage or disease spread.

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; it is unknown whether radiation therapy was administered. 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.

Instructions for Coding
- 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.

Instructions for Coding

- 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.

Instructions for Coding
- 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.

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date of Chemotherapy* and *Date of Chemotherapy Flag.* ***In the table below, the lowercase letter "b" is used to represent each blank space***.

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: 02182007)	CCYYMMDD (example: 20070218)	bb
Month and year known	MM99CCYY (example: 02992007)	CCYYMMbb (example: 200702bb)	bb
Year only known	9999CCYY (example: 99992007)	CCYYbbbb (example: 2007bbbb)	bb
Unknown if any chemotherapy given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	10
No chemotherapy given	00000000 (example: 00000000)	bbbbbbbb (example: bbbbbbbb)	11
Date is unknown, chemotherapy given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12
Chemotherapy is planned, not yet begun	88888888 (example: 88888888)	bbbbbbbb (example: bbbbbbbb)	15

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.

Instructions for Coding

- 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 know 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.

Instructions for Coding

- 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.

Instructions for Coding
- 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.

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date of Hormone Therapy* and *Date of Hormone Flag*. ***In the table below, the lowercase letter "b" is used to represent each blank space***.

Description	**<u>Traditional Date</u> Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999**	**<u>Interoperable Date</u> 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: 02182007)	CCYYMMDD (example: 20070218)	bb
Month and year known	MM99CCYY (example: 02992007)	CCYYMMbb (example: 200702bb)	bb
Year only known	9999CCYY (example: 99992007)	CCYYbbbb (example: 2007bbbb)	bb
Unknown if any hormone therapy given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	10
No hormone therapy given	00000000 (example: 00000000)	bbbbbbbb (example: bbbbbbbb)	11
Date is unknown, hornone therapy given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12
Hormone therapy is planned, not yet begun	88888888 (example: 88888888)	bbbbbbbb (example: bbbbbbbb)	15

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.

Instructions for Coding
- 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.

Instructions for Coding

- 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.

Instructions for Coding
- 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.

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date of BRM/Immunotherapy* and *Date of BRM Flag.* ***In the table below, the lowercase letter "b" is used to represent each blank space***.

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: 02182007)	CCYYMMDD (example: 20070218)	bb
Month and year known	MM99CCYY (example: 02992007)	CCYYMMbb (example: 200702bb)	bb
Year only known	9999CCYY (example: 99992007)	CCYYbbbb (example: 2007bbbb)	bb
Unknown if any immunotherapy given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	10
No immunetherapy given	00000000 (example: 00000000)	bbbbbbbb (example: bbbbbbbb)	11
Date is unknown, immunotherapy given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12
Immunotherapy is planned, not yet begun	88888888 (example: 88888888)	bbbbbbbb (example: bbbbbbbb)	15

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.

Instructions for Coding

- 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 instructions for coding 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.

Instructions for Coding

- 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.

Instructions for Coding
- 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*.

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date of Other Treatment* and *Date of Other Treatment Flag.* ***In the table below, the lowercase letter "b" is used to represent each blank space***.

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: 02182007)	CCYYMMDD (example: 20070218)	bb
Month and year known	MM99CCYY (example: 02992007)	CCYYMMbb (example: 200702bb)	bb
Year only known	9999CCYY (example: 99992007)	CCYYbbbb (example: 2007bbbb)	bb
Unknown if other treatment given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	10
No other treatment given	00000000 (example: 00000000)	bbbbbbbb (example: bbbbbbbb)	11
Date is unknown, other treatment given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12
Other treatment is planned, not yet begun	88888888 (example: 88888888)	bbbbbbbb (example: bbbbbbbb)	15

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.

Instructions for Coding
- 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 know 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 know 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.

Instructions for Coding

- 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.

Instructions for Coding
- 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*.

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date of Transplant/Endocrine* and *Date of Transplant/Endocrine Flag.* ***In the table below, the lowercase letter "b" is used to represent each blank space***.

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: 02182007)	CCYYMMDD (example: 20070218)	bb
Month and year known	MM99CCYY (example: 02992007)	CCYYMMbb (example: 200702bb)	bb
Year only known	9999CCYY (example: 99992007)	CCYYbbbb (example: 2007bbbb)	bb
Unknown if transplant/ endocrine given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	10
No transplant/endocrine given	00000000 (example: 00000000)	bbbbbbbb (example: bbbbbbbb)	11
Date is unk, transplant/ endocrine given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12

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

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.

Instructions for Coding

- 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

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.

Instructions for Coding
- 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*.

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date of Systemic Treatment* and *Date of Systemic Treatment Flag.* ***In the table below, the lowercase letter "b" is used to represent each blank space***.

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: 02182007)	CCYYMMDD (example: 20070218)	bb
Month and year known	MM99CCYY (example: 02992007)	CCYYMMbb (example: 200702bb)	bb
Year only known	9999CCYY (example: 99992007)	CCYYbbbb (example: 2007bbbb)	bb
Unknown if any systemic therapy given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	10
No systemic therapy given	00000000 (example: 00000000)	bbbbbbbb (example: bbbbbbbb)	11
Date is unknown, systemic therapy given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12
Systemic therapy not started yet	88888888 (example: 88888888)	bbbbbbbb (example: bbbbbbbb)	15

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.

Instructions for Coding
- 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

Code	Label	General Instructions Applying to All Sites	Additional Notes Specific to Breast (C50.x)
			in the data items *Regional Lymph Nodes Examined* and *Regional Lymph Nodes Positive*.
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.	
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.	• 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.

Code	Label	General Instructions Applying to All Sites	Additional Notes Specific to Breast (C50.x)
		• 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.	
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.

Instructions for Coding
- 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	Optional

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.

Instructions for Coding
- 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	Recommended

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.

Instructions for Coding
- 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.

Instructions for Coding
- 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	Optional

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.

Instructions for Coding
- 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-9-CM "E" code and record it, space allowing, as an additional *Comorbidities and Complications*.
- 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	Recommended

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.

Instructions for Coding

- 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.

Instructions for Coding
- 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.

Instructions for Coding
- 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*.

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date of First Course of Treatment* and *Date 1st Course RX Flag.* ***In the table below, the lowercase letter "b" is used to represent each blank space***.

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: 02182007)	CCYYMMDD (example: 20070218)	bb
Month and year known	MM99CCYY (example: 02992007)	CCYYMMbb (example: 200702bb)	bb
Year only known	9999CCYY (example: 99992007)	CCYYbbbb (example: 2007bbbb)	bb
Unknown if any treatment given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	10
Diagnosis at autopsy only	00000000 (example: 00000000)	bbbbbbbb (example: bbbbbbbb)	11
Date is unknown, treatment given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12

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.

Instructions for Coding

- 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.

Instructions for Coding
- 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.

Instructions for Coding
- 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.

Instructions for Coding
- *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.

Blank Page

Blank Page

Outcomes

Blank Page

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.

Instructions for Coding

- 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.

Instructions for Coding
- 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*.

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date of Last Contact or Death* and *Date of Last Contact Flag.* ***In the table below, the lowercase letter "b" is used to represent each blank space***.

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: 02182007)	CCYYMMDD (example: 20070218)	bb
Month and year known	MM99CCYY (example: 02992007)	CCYYMMbb (example: 200702bb)	bb
Year only known	9999CCYY (example: 99992007)	CCYYbbbb (example: 2007bbbb)	bb
Date is unknown	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12

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.

Instructions for Coding
- 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	Required

Description
Records the presence or absence of clinical evidence of the patient's malignant or non-malignant tumor as the *Date of Last Contact or Death*.

Rationale
This information is used for patient follow-up and outcomes studies.

Instructions for Coding

- 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.

Instructions for Coding
- 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.

Instructions for Coding
- 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.

Instructions for Coding

- See Appendix C 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.

Instructions for Coding

- See Appendix C 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.

Instructions for Coding

- 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
7797	State death certificate available but underlying cause of death is not coded (for central registries only)

Autopsy

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1930	1		Required

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.

Instructions for Coding

- 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.

Instructions for Coding
- 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.

Instructions for Coding
- 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.

Instructions for Coding
- 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.

Instructions for Coding
- 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.

Instructions for Coding
- 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.

Instructions for Coding
- 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.

Instructions for Coding
- 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.

Instructions for Coding
- 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.

Instructions for Coding
- 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.

Instructions for Coding
- 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.

Instructions for Coding

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	Optional

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.

Instructions for Coding
- 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.

Instructions for Coding

- 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.

Instructions for Coding
- 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*.

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Recurrence Date – 1st* and *Recurrence Date – 1st Flag.* ***In the table below, the lowercase letter "b" is used to represent each blank space***.

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: 02182007)	CCYYMMDD (example: 20070218)	bb
Month and year known	MM99CCYY (example: 02992007)	CCYYMMbb (example: 200702bb)	bb
Year only known	9999CCYY (example: 99992007)	CCYYbbbb (example: 2007bbbb)	bb
Unknown if patient had recurrence	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	10
No recurrence; never disease-free	00000000 (example: 00000000)	bbbbbbbb (example: bbbbbbbb)	11
Date is unknown, but patient had a recurrence	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12

Recurrence Type - 1st

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	1880	2	06/05, 01/10, 01/11, 01/15	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.

Instructions for Coding

- 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* 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. This 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. Nor 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 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.

Definitions:

Local recurrence: recurs in initial primary organ

Trocar recurrence: organ removed, recurs in scar tissue from removal

Regional recurrence: recurs in adjacent organ or lymph nodes draining the organ

Distant recurrence: recurs in a location beyond regional

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.

Instructions for Coding

- 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.

Instructions for Coding
- 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.

Instructions for Coding
- 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.

Instructions for Coding
- 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.

Instructions for Coding
- 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.

Instructions for Coding
- 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 is normally limited to periods (i.e., 39.2 RD), slashes for fractional addresses (i.e., 101 ½ MAIN ST), and hyphens when a hyphen carries meaning (i.e., 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 (i.e., 425 FLOWER BLVD # 72).
- See "Residency Rules" on page 52 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	Optional

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.

Instructions for Coding

- 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 52 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.

Instructions for Coding
- Record the name of the city or town used in the contact person's mailing address.
- See "Residency Rules" in on page 52 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.

Instructions for Coding
- 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.

Instructions for Coding
- 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 52 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.

Instructions for Coding
- 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.

Instructions for Coding
- Record who the phone number belongs to.

Type:

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	Optional

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.

Instructions for Coding

- This item corresponds to *Follow-up Contact - Country*.
- See Appendix C 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.

Instructions for Coding
- 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	Optional

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.

Instructions for Coding

- 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	Optional

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.

Instructions for Coding

- 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	Optional

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.

Instructions for Coding

- 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	Optional

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.

Instructions for Coding

- 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 instructions for coding AJCC items and leave *Override Site/TNM-Stage Group* blank.

Instructions for Coding
- 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.

Instructions for Coding
- 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 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.

Instructions for Coding
- 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.

Instructions for Coding

- 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.

Instructions for Coding

- 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.

Instructions for Coding

- 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.

Instructions for Coding

- 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*.

Instructions for Coding

- 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 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.

Instructions for Coding
- 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.

Instructions for Coding
- 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.

Instructions for Coding
- 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.

Instructions for Coding
- 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.

Override CS 1-19

Alternate Name	NAACCR Item #	Length	Revision Date	Required Status
	3750-3768	1	New 1/13	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 date in a record have been reviewed and, while quite 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 override flag is used to skip the edit in the future.

Instructions for Coding
- Instructions will be provided as edits that use these items are implemented.

Code	Definition
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed and confirmed as reported.

Blank Page

Blank Page

Appendix A

Subsequent Primaries Hematologic Malignancies 2001-2009

Blank Page

CRITERIA FOR DETERMINING MULTIPLE PRIMARIES OF LYMPHATIC AND HEMATOPOIETIC DISEASES

Use the table in this Appendix only for hematologic malignancies diagnosed prior to January 1, 2010. Beginning with diagnoses on January 1, 2010, use Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and the Hematopoietic and Lymphoid Neoplasm Database (Hematopoietic DB).

The following rules are to be used as a guide for identifying lymphomas and leukemias with second primaries. Note that the rules refer to general headings followed by the ICD-O morphology codes included in each heading. For specific terms such as "histiocytic," "diffuse," "nodular" and "granulocytic," check the ICD-O Alphabetic Index to determine into which general category a specific term falls. Complete instructions for determining subsequent primaries in lymphatic and hematopoietic diseases are available in both the SEER Program Code Manual 2004 and the FORDS.

***Note*:** *Different histologic terms are sometimes used to describe progressive stages or phases of the same disease process.*

Lymphoma Codes: Lymphomas present some unique coding difficulties because of the complexity of the classification and the variety of terminologies in use. The following rules will be helpful in choosing the correct ICD-O-3 code for the histologic type:

1. The current preferred terminology is the World Health Organization Classification of Tumors of the Hematopoietic and Lymphoid Tissues.
2. If this terminology is not what is stated in the diagnosis, the following guidelines from older classifications apply:
    a. When the terms "diffuse" and "nodular" (follicular) are both mentioned in a diagnosis, ignore the term "diffuse" in coding, because most nodular tumors progress to diffuse or have some diffuse aspects.
    b. If neither diffuse nor nodular (follicular) is mentioned, presume the lymphoma is diffuse.
    c. The terms lymphoma, malignant lymphoma, and non-Hodgkin's lymphoma may be used interchangeably.
    d. Avoid using non-specific or unclassified lymphoma terms if there are specific diagnoses that can be coded.
    e. Some terms have equivalent meanings, for example:
        i. Centroblastic = non-cleaved
        ii. Centrocytic = cleaved
        iii. Follicular = nodular
        iv. Histiocytic = large (cell)
        v. Lymphocytic = small (cell)
        vi. Mixed lymphocytic and histiocytic = mixed small and large (cell)
    f. When the term "mixed cellularity" is used with non-Hodgkin's lymphoma, it means mixed lymphocytic-histiocytic lymphoma.

DEFINITIONS OF SINGLE AND SUBSEQUENT PRIMARIES FOR HEMATOLOGIC MALIGNANCIES BASED ON ICD-O-3 REPORTABLE MALIGNANCIES, EFFECTIVE WITH DIAGNOSES 01/01/2001 – 12/31/2009

Cancer registrars are often faced with multiple pathology reports in patients with hematologic malignancies, and the diagnoses reported may require different morphology codes. This is due in part to the fact that more intensive diagnostic study may yield a more specific diagnosis, and in part due to the natural histories of hematopoietic diseases, which may progress from one disease into another.

The following chart was prepared by Seer Program, NCI, and provided to aid the registrar in determining single versus subsequent primary.

The following guidelines are employed:

1. "Lymphoma" is a general term for hematopoietic solid malignancies of the lymphoid series. "Leukemia" is a general term for liquid malignancies of either the lymphoid or the myeloid series. While it is recognized that some malignancies occur predominantly (or even exclusively) in liquid or solid form, because so many malignancies can potentially arise as either leukemias or lymphomas (or both), all hematopoietic malignancies are assumed to have this potential.
2. Malignancies of the lymphoid series are considered to be different from those of the myeloid series. Therefore, a lymphoid malignancy arising after diagnosis of a myeloid malignancy (or Myelodysplastic or myeloproliferative disorder) would be considered a subsequent primary; however, a myeloid malignancy diagnosed after a previous myeloid malignancy would not count as a subsequent primary. Histiocytic malignancies are considered different from both lymphoid and myeloid malignancies.
3. Hodgkin lymphoma is considered to be different from non-Hodgkin lymphoma (NHL). Among the NHLs, B-cell malignancies are considered different from T-cell/NK cell malignancies. Therefore, a B-cell malignancy arising later in the course of a patient previously diagnosed with a T-cell malignancy would be considered a subsequent primary; however, a T-cell malignancy diagnosed later in the same patient would not be considered a subsequent primary.
4. The sequence of diagnoses affects whether a diagnosis represents a subsequent primary. In some cases, the order of occurrence of the two diagnoses being compared is a factor in the decision whether the second diagnosis is a new primary.

To use the table, assign the ICD-O-3 code to the first diagnosis and find the row containing that code. Assign the ICD-O-3 code for the second diagnosis and find the column containing that code. In the cell at the intersection of the first diagnosis row and the second diagnosis column, a **"**S" symbol indicates that the two diagnoses are most likely the **same** disease process (prepare/update a single abstract), and a **"**D" indicates that they are most likely **different** disease processes (prepare more than one abstract).

Note: *If one of the two diagnoses is an NOS (not otherwise specified) term and the other is more specific and determined to be the same disease process, code the more specific diagnosis regardless of the sequence. For example, if a diagnosis of non-Hodgkin lymphoma, NOS is followed by a diagnosis of follicular lymphoma, assign the morphology code for the follicular lymphoma*.

Note: *The table "Single versus Subsequent Primaries of Lymphatic and Hematopoietic Diseases" and the "Complete Diagnostic Terms for Table (based on ICD-O-3)" display only the ICD-O-3 primary (boldfaced) term associated with the code. Refer to the International Classification of Diseases, Third Edition (ICD-O-3) for a complete list of related terms and synonyms.*

Source: SEER Program, NCI

Complete Diagnostic Terms for Table (Based on ICD-O-3):

1.	9590	Malignant lymphoma, NOS
2.	9591	Malignant lymphoma, non-Hodgkin, NOS
3.	9596	Composite Hodgkin and non-Hodgkin lymphoma
4.	9650-9667	Hodgkin lymphoma (all subtypes)
5.	9670-9671	Malignant lymphoma, small B lymphocytic
6.	9673	Mantle cell lymphoma
7.	9675-9684	Malignant lymphoma, diffuse large B-cell
8.	9687	Burkitt lymphoma
9.	9689, 9699	Marginal zone B-cell lymphoma
10.	9690-9698	Follicular lymphoma
11.	9700-9701	Mycosis fungoides and Sezary syndrome
12.	9702-9719	T/NK-cell non-Hodgkin lymphoma
13.	9727	Precursor cell lymphoblastic lymphoma, NOS
14.	9728	Precursor B-cell lymphoblastic lymphoma
15.	9729	Precursor T-cell lymphoblastic lymphoma
16.	9731-9734	Plasma cell tumors
17.	9740-9742	Mast cell tumors
18.	9750-9756	Histiocytosis/Langerhans cell histiocytosis
19.	9757-9758	Dendritic cell sarcoma
20.	9760	Immunoproliferative disease, NOS
21.	9761	Waldenstrom macroglobulinemia
22.	9762	Heavy chain disease, NOS
23.	9764	Immunoproliferative small intestinal disease
24.	9800-9801	Leukemia, NOS/Acute leukemia, NOS
25.	9805	Acute biphenotypic leukemia
26.	9820	Lymphoid leukemia, NOS
27.	9823	B-cell chronic lymphocytic leukemia/small lymphocytic lymphoma
28.	9826	Burkitt cell leukemia
29.	9827	Adult T-cell leukemia/lymphoma (HTLV-1 positive)
30.	9832	Prolymphocytic leukemia, NOS
31.	9833	Prolymphocytic leukemia, B-cell type
32.	9834	Prolymphocytic leukemia, T-cell type
33.	9835	Precursor cell lymphoblastic leukemia, NOS
34.	9836	Precursor B-cell lymphoblastic leukemia
35.	9837	Precursor T-cell lymphoblastic leukemia
36.	9840-9910	Myeloid leukemias
37.	9920	Therapy related acute myelogenous leukemia
38.	9930	Myeloid sarcoma
39.	9931	Acute panmyelosis with myelofibrosis
40.	9940	Hairy cell leukemia
41.	9945	Chronic myelomonocytic leukemia, NOS
42.	9946	Juvenile myelomonocytic leukemia
43.	9948	Aggressive NK-cell leukemia
44.	9950	Polycythemia vera
45.	9960	Chronic myeloproliferative disease, NOS
46.	9961	Myelosclerosis with myeloid metaplasia
47.	9962	Essential thrombocythemia
48.	9963	Chronic neutrophilic leukemia
49.	9964	Hypereosinophilic syndrome
50.	9980-9986	Refractory anemias
51.	9987	Therapy related myelodysplastic syndrome, NOS
52.	9989	Myelodysplastic syndrome, NOS

Blank Page

February 28, 2001 PAGE 1 SECOND DX ACROSS FIRST DX DOWN		1. 9590 Malig lymphoma, NOS	2. 9591 NHL, NOS	3. 9596 Compos HD/NHL	4. 9650-9667 Hodgkin lymphoma	5. 9670-9671 ML, small B lymph	6. 9673 Mantle cell lymph	7. 9675-9684 ML, diff large B-cell	8. 9687 Burkitt lymphoma	9. 9689,9699 Marg zn, B-cl lym	10. 9690-9698 Follicular lymphoma
1. Malignant lymphoma, NOS	9590	**S**	S	S	S	S	S	S	S	S	S
2. NHL, NOS	9591	S	**S**	D	D	S	S	S	S	S	S
3. Composite HD/NHL	9596	S	S	**S**	S	S	S	S	S	S	S
4. Hodgkin lymphoma	9650-9667	S	D	D	**S**	D	D	D	D	D	D
5. ML, small B lymphocytic	9670-9671	S	S	D	D	**S**	D	S	D	D	D
6. Mantle cell lymphoma	9673	S	S	D	D	D	**S**	D	D	D	D
7. ML, diffuse, large B-cell	9675-9684	S	S	D	D	S	D	**S**	S	D	S
8. Burkitt lymphoma	9687	S	S	D	D	D	D	D	**S**	D	D
9. Marg zone, B-cell lymphoma	9689, 9699	S	S	D	D	D	D	D	D	**S**	D
10. Follicular lymphoma	9690-9698	S	S	D	D	D	D	S	D	D	**S**
11. Mycos fung, Sezary disease	9700-9701	S	S	D	D	D	D	D	D	D	D
12. T/NK-cell NHL	9702-9719	S	S	D	D	D	D	D	D	D	D
13. Precurs lym'blas lymph NOS	9727	S	S	D	D	D	D	D	D	D	D
14. Precurs lym'blas lymph B-cell	9728	S	S	D	D	D	D	D	D	D	D
15. Precurs lym'blas lymph T-cell	9729	S	S	D	D	D	D	D	D	D	D
16. Plasma cell tumors	9731-9734	D	D	D	D	D	D	D	D	D	D
17. Mast cell tumors	9740-9742	D	D	D	D	D	D	D	D	D	D
18. Histiocytos/Langerhans cell	9750-9756	D	D	D	D	D	D	D	D	D	D
19. Dendritic cell sarcoma	9757-9758	S	S	D	D	D	D	D	D	D	D
20. Immunoprolif disease, NOS	9760	S	S	D	D	S	D	S	D	D	D
21. Waldenstrom macroglob	9761	S	S	D	D	S	D	S	D	D	D
22. Heavy chain disease, NOS	9762	S	S	D	D	D	D	D	D	D	D
23. Immun sm intest disease	9764	S	S	D	D	D	D	D	D	D	D
24. Leuk/Acute leuk, NOS	9800-9801	S	S	D	D	D	D	D	S	D	D
25. Acute biphenotypic leukem	9805	S	S	D	D	S	S	S	S	S	S
26. Lymphocytic leukem, NOS	9820	S	S	D	D	D	D	D	S	D	S
27. BCLL/SLL	9823	S	S	D	D	S	D	S	D	D	D
28. Burkitt cell leukemia	9826	S	S	D	D	D	D	D	S	D	D
29. Adult T-cell leuk/lymph	9827	S	S	D	D	D	D	D	D	D	D
30. Prolym'cyt leuk, NOS	9832	D	D	D	D	S	D	D	D	D	D
31. Prolym'cyt leuk, B-cell	9833	D	D	D	D	S	D	D	D	D	D
32. Prolym'cyt leuk, T-cell	9834	D	D	D	D	D	D	D	D	D	D
33. Precurs lym'cyt leuk, NOS	9835	S	S	D	D	D	D	D	D	D	D
34. Precurs B-cell leuk	9836	S	S	D	D	D	D	D	D	D	D
35. Precurs T-cell leuk	9837	S	S	D	D	D	D	D	D	D	D
36. Myeloid leukemias	9840-9910	D	D	D	D	D	D	D	D	D	D
37. Therapy related AML	9920	D	D	D	D	D	D	D	D	D	D
38. Myeloid sarcoma	9930	D	D	D	D	D	D	D	D	D	D
39. Acute panmyelosis	9931	D	D	D	D	D	D	D	D	D	D
40. Hairy cell leukemia	9940	D	D	D	D	D	D	D	D	D	D
41. Chron myelomonocyt leuk	9945	D	D	D	D	D	D	D	D	D	D
42. Juvenile myelomonocy leuk	9946	D	D	D	D	D	D	D	D	D	D
43. NK-cell leukemia	9948	S	S	D	D	D	D	D	D	D	D
44. Polycythemia vera	9950	D	D	D	D	D	D	D	D	D	D
45. Chron myeloprolif disease	9960	D	D	D	D	D	D	D	D	D	D
46. Myelosclerosis	9961	D	D	D	D	D	D	D	D	D	D
47. Essen thrombocythem	9962	D	D	D	D	D	D	D	D	D	D
48. Chron neutrophilic leukemia	9963	D	D	D	D	D	D	D	D	D	D
49. Hypereosinophilic syndrome	9964	D	D	D	D	D	D	D	D	D	D
50. Refractory anemias	9980-9986	D	D	D	D	D	D	D	D	D	D
51. Therapy related MDS	9987	D	D	D	D	D	D	D	D	D	D
52. Myelodysplastic syndr, NOS	9989	D	D	D	D	D	D	D	D	D	D

Codes: S--one primary only; D--presumably a subsequent primary SEER Program, NCI. E-mail: seerweb@ims.nci.nih.gov

February 2001 PAGE 2 SECOND DX ACROSS FIRST DX DOWN		11. 9700-9701 MF, Sezary disease	12. 9702-9719 T/NK-cell lymphoma	13. 9727 Precurs lym'blas lymph NOS	14. 9728 Precurs lym'blas lymph B-cl	15. 9729 Precurs lym'blas lymph T-cl	16. 9731-9734 Plasma cell tumors	17. 9740-9742 Mast cell tumors	18. 9750-9756 Histiocytos; LCH	19. 9757-9758 Dendritic cell sarc	20. 9760 Immunoprolif dis
1. Malignant lymphoma, NOS	9590	S	S	S	S	S	S	S	S	S	S
2. NHL, NOS	9591	S	S	S	S	S	D	D	D	S	S
3. Composite HD/NHL	9596	S	S	S	S	S	D	D	D	D	S
4. Hodgkin lymphoma	9650-9667	D	D	D	D	D	D	D	D	D	D
5. ML, small B lymphocytic	9670-9671	D	D	D	D	D	D	D	D	D	D
6. Mantle cell lymphoma	9673	D	D	D	D	D	D	D	D	D	D
7. ML, diffuse, large B-cell	9675-9684	D	D	D	D	D	D	D	D	D	S
8. Burkitt lymphoma	9687	D	D	D	D	D	D	D	D	D	D
9. Marg zone, B-cell lymphoma	9689, 9699	D	D	D	D	D	D	D	D	D	D
10. Follicular lymphoma	9690-9698	D	D	D	D	D	D	D	D	D	D
11. Mycos fung, Sezary disease	9700-9701	**S**	D	D	D	D	D	D	D	D	D
12. T/NK-cell NHL	9702-9719	D	**S**	D	D	D	D	D	D	D	S
13. Precurs lym'blas lymph NOS	9727	D	D	**S**	S	S	D	D	D	D	D
14. Precurs lym'blas lymph B-cell	9728	D	D	S	**S**	D	D	D	D	D	D
15. Precurs lym'blas lymph T-cell	9729	D	D	S	D	**S**	D	D	D	D	D
16. Plasma cell tumors	9731-9734	D	D	D	D	D	**S**	D	D	D	D
17. Mast cell tumors	9740-9742	D	D	D	D	D	D	**S**	D	D	D
18. Histiocytos/Langerhans cell	9750-9756	D	D	D	D	D	D	D	**S**	D	D
19. Dendritic cell sarcoma	9757-9758	D	D	D	D	D	D	D	D	**S**	D
20. Immunoprolif disease, NOS	9760	D	D	D	D	D	S	D	D	D	**S**
21. Waldenstrom macroglob	9761	D	D	D	D	D	D	D	D	D	S
22. Heavy chain disease, NOS	9762	D	D	D	D	D	D	D	D	D	S
23. Immun sm intest disease	9764	D	D	D	D	D	S	D	D	D	S
24. Leuk/Acute leuk, NOS	9800-9801	D	S	S	S	S	D	D	D	D	D
25. Acute biphenotypic leukem	9805	S	S	S	S	S	D	D	D	D	D
26. Lymphocytic leukem, NOS	9820	S	S	S	S	S	D	D	D	D	S
27. BCLL/SLL	9823	D	D	D	D	D	D	D	D	D	S
28. Burkitt cell leukemia	9826	D	D	D	D	D	D	D	D	D	D
29. Adult T-cell leuk/lymph	9827	D	D	D	D	D	D	D	D	D	D
30. Prolym'cyt leuk, NOS	9832	D	D	D	D	D	D	D	D	D	D
31. Prolym'cyt leuk, B-cell	9833	D	D	D	D	D	D	D	D	D	D
32. Prolym'cyt leuk, T-cell	9834	D	D	D	D	D	D	D	D	D	D
33. Precurs lym'cyt leuk, NOS	9835	D	D	S	S	S	D	D	D	D	D
34. Precurs B-cell leuk	9836	D	D	S	S	D	D	D	D	D	D
35. Precurs T-cell leuk	9837	D	D	S	D	S	D	D	D	D	D
36. Myeloid leukemias	9840-9910	D	D	D	D	D	D	D	D	D	D
37. Therapy related AML	9920	D	D	D	D	D	D	D	D	D	D
38. Myeloid sarcoma	9930	D	D	D	D	D	D	D	D	D	D
39. Acute panmyelosis	9931	D	D	D	D	D	D	D	D	D	D
40. Hairy cell leukemia	9940	D	D	D	D	D	D	D	D	D	D
41. Chron myelomonocyt leuk	9945	D	D	D	D	D	D	D	D	D	D
42. Juvenile myelomonocy leuk	9946	D	D	D	D	D	D	D	D	D	D
43. NK-cell leukemia	9948	D	S	D	D	D	D	D	D	D	D
44. Polycythemia vera	9950	D	D	D	D	D	D	D	D	D	D
45. Chron myeloprolif disease	9960	D	D	D	D	D	D	D	D	D	D
46. Myelosclerosis	9961	D	D	D	D	D	D	D	D	D	D
47. Essen thrombocythem	9962	D	D	D	D	D	D	D	D	D	D
48. Chron neutrophilic leukemia	9963	D	D	D	D	D	D	D	D	D	D
49. Hypereosinophilic syndrome	9964	D	D	D	D	D	D	D	D	D	D
50. Refractory anemias	9980-9986	D	D	D	D	D	D	D	D	D	D
51. Therapy related MDS	9987	D	D	D	D	D	D	D	D	D	D
52. Myelodysplastic syndr, NOS	9989	D	D	D	D	D	D	D	D	D	D

Codes: S--one primary only; D--presumably a subsequent primary SEER Program, NCI. E-mail: seerweb@ims.nci.nih.gov

February 28, 2001 PAGE 3 SECOND DX ACROSS FIRST DX DOWN		21. 9761 Waldenstrom	22. 9762 Heavy chain dis	23. 9764 Imm sm intest dis	24. 9800-9801 Leuk/Acu leuk NOS	25. 9805 Acute biphenotypic leuk	26. 9820 Lym'cyt leuk, NOS	27. 9823 BCLL/SLL	28. 9826 Burkitt leukemia	29. 9827 Adult T-cell leuk/lym	30. 9832 Prolym leuk, NOS
1. Malignant lymphoma, NOS	9590	S	S	S	S	S	S	S	S	S	S
2. NHL, NOS	9591	S	S	S	S	S	S	S	S	S	D
3. Composite HD/NHL	9596	S	S	S	S	D	S	S	S	S	D
4. Hodgkin lymphoma	9650-9667	D	D	D	D	D	D	D	D	D	D
5. ML, small B lymphocytic	9670-9671	S	D	D	D	S	S	S	D	D	S
6. Mantle cell lymphoma	9673	D	D	D	D	S	D	D	D	D	D
7. ML, diffuse, large B-cell	9675-9684	S	S	S	D	S	S	S	D	D	S
8. Burkitt lymphoma	9687	D	D	D	S	S	S	D	S	D	D
9. Marg zone, B-cell lymphoma	9689, 9699	D	D	D	D	S	D	D	D	D	D
10. Follicular lymphoma	9690-9698	D	D	D	D	S	D	D	D	D	D
11. Mycos fung, Sezary disease	9700-9701	D	D	D	D	S	S	D	D	D	D
12. T/NK-cell NHL	9702-9719	D	D	D	D	S	S	D	D	D	D
13. Precurs lym'blas lymph NOS	9727	D	D	D	S	S	S	D	D	D	D
14. Precurs lym'blas lymph B-cell	9728	D	D	D	S	S	S	D	D	D	D
15. Precurs lym'blas lymph T-cell	9729	D	D	D	S	S	S	D	D	D	D
16. Plasma cell tumors	9731-9734	D	D	D	D	D	D	D	D	D	D
17. Mast cell tumors	9740-9742	D	D	D	D	D	D	D	D	D	D
18. Histiocytos/Langerhans cell	9750-9756	D	D	D	D	D	D	D	D	D	D
19. Dendritic cell sarcoma	9757-9758	D	D	D	D	D	D	D	D	D	D
20. Immunoprolif disease, NOS	9760	S	S	S	D	D	D	D	D	D	D
21. Waldenstrom macroglob	9761	**S**	D	D	D	D	S	S	D	D	D
22. Heavy chain disease, NOS	9762	D	**S**	S	D	D	S	S	D	D	D
23. Immun sm intest disease	9764	D	S	**S**	D	D	D	D	D	D	D
24. Leuk/Acute leuk, NOS	9800-9801	D	D	D	**S**	S	S	D	S	S	D
25. Acute biphenotypic leukem	9805	D	D	D	S	**S**	S	S	S	S	S
26. Lymphocytic leukem, NOS	9820	S	S	D	S	S	**S**	S	S	S	S
27. BCLL/SLL	9823	D	D	D	D	S	S	**S**	D	D	S
28. Burkitt cell leukemia	9826	D	D	D	S	S	S	D	**S**	D	D
29. Adult T-cell leuk/lymph	9827	D	D	D	D	S	S	D	D	**S**	D
30. Prolym'cyt leuk, NOS	9832	D	D	D	D	S	S	S	D	D	**S**
31. Prolym'cyt leuk, B-cell	9833	D	D	D	D	S	S	S	D	D	S
32. Prolym'cyt leuk, T-cell	9834	D	D	D	D	S	S	D	D	S	S
33. Precurs lym'cyt leuk, NOS	9835	D	D	D	S	S	S	D	D	D	D
34. Precurs B-cell leuk	9836	D	D	D	S	S	S	D	D	D	D
35. Precurs T-cell leuk	9837	D	D	D	S	S	S	D	D	D	D
36. Myeloid leukemias	9840-9910	D	D	D	S	S	D	D	D	D	D
37. Therapy related AML	9920	D	D	D	S	S	D	D	D	D	D
38. Myeloid sarcoma	9930	D	D	D	S	S	D	D	D	D	D
39. Acute panmyelosis	9931	D	D	D	S	S	D	D	D	D	D
40. Hairy cell leukemia	9940	D	D	D	S	S	D	D	D	D	D
41. Chron myelomonocyt leuk	9945	D	D	D	S	S	D	D	D	D	D
42. Juvenile myelomonocy leuk	9946	D	D	D	S	S	D	D	D	D	D
43. NK-cell leukemia	9948	D	D	D	S	S	S	D	D	D	D
44. Polycythemia vera	9950	D	D	D	S	D	D	D	D	D	D
45. Chron myeloprolif disease	9960	D	D	D	S	S	D	D	D	D	D
46. Myelosclerosis	9961	D	D	D	S	S	D	D	D	D	D
47. Essen thrombocythem	9962	D	D	D	S	D	D	D	D	D	D
48. Chron neutrophilic leukemia	9963	D	D	D	S	D	D	D	D	D	D
49. Hypereosinophilic syndrome	9964	D	D	D	S	D	D	D	D	D	D
50. Refractory anemias	9980-9986	D	D	D	S	S	D	D	D	D	D
51. Therapy related MDS	9987	D	D	D	S	S	D	D	D	D	D
52. Myelodysplastic syndr, NOS	9989	D	D	D	S	S	D	D	D	D	D

Codes: S--one primary only; D--presumably a subsequent primary SEER Program, NCI. E-mail: seerweb@ims.nci.nih.gov

February 2001 PAGE 4 SECOND DX ACROSS FIRST DX DOWN		31. 9833 Prolym leuk, B-cell	32. 9834 Prolym leuk, T-cell	33. 9835 Precurs leuk, NOS	34. 9836 Precurs leuk, B-cell	35. 9837 Precurs leuk, T-cell	36. 9840-9910 Myeloid leukemias	37. 9920 Therapy rel AML	38. 9930 Myeloid sarcoma	39. 9931 Acute panmyelosis	40. 9940 Hairy cell leukemia	41. 9945 Chr myelomono leu
1. Malignant lymphoma, NOS	9590	S	S	S	S	S	S	S	S	S	S	S
2. NHL, NOS	9591	D	D	S	S	S	D	D	D	D	D	D
3. Composite HD/NHL	9596	D	D	S	S	S	D	D	D	D	D	D
4. Hodgkin lymphoma	9650-9667	D	D	D	D	D	D	D	D	D	D	D
5. ML, small B lymphocytic	9670-9671	S	D	D	D	D	D	D	D	D	D	D
6. Mantle cell lymphoma	9673	D	D	D	D	D	D	D	D	D	D	D
7. ML, diffuse, large B-cell	9675-9684	S	D	D	D	D	D	D	D	D	D	D
8. Burkitt lymphoma	9687	D	D	D	D	D	D	D	D	D	D	D
9. Marg zone, B-cell lymphoma	9689, 9699	D	D	D	D	D	D	D	D	D	D	D
10. Follicular lymphoma	9690-9698	D	D	D	D	D	D	D	D	D	D	D
11. Mycos fung, Sezary disease	9700-9701	D	D	D	D	D	D	D	D	D	D	D
12. T/NK-cell NHL	9702-9719	D	D	D	D	D	D	D	D	D	D	D
13. Precurs lym'blas lymph NOS	9727	D	D	S	S	S	D	D	D	D	D	D
14. Precurs lym'blas lymph B-cell	9728	D	D	S	S	D	D	D	D	D	D	D
15. Precurs lym'blas lymph T-cell	9729	D	D	S	D	S	D	D	D	D	D	D
16. Plasma cell tumors	9731-9734	D	D	D	D	D	D	D	D	D	D	D
17. Mast cell tumors	9740-9742	D	D	D	D	D	D	D	D	D	D	D
18. Histiocytos/Langerhans cell	9750-9756	D	D	D	D	D	D	D	D	D	D	D
19. Dendritic cell sarcoma	9757-9758	D	D	D	D	D	D	D	D	D	D	D
20. Immunoprolif disease, NOS	9760	D	D	D	D	D	D	D	D	D	D	D
21. Waldenstrom macroglob	9761	D	D	D	D	D	D	D	D	D	D	D
22. Heavy chain disease, NOS	9762	D	D	D	D	D	D	D	D	D	D	D
23. Immun sm intest disease	9764	D	D	D	D	D	D	D	D	D	D	D
24. Leuk/Acute leuk, NOS	9800-9801	D	D	S	S	S	S	S	S	D	D	S
25. Acute biphenotypic leukem	9805	S	S	S	S	S	S	S	S	S	S	S
26. Lymphocytic leukem, NOS	9820	S	S	S	S	S	D	D	D	D	S	D
27. BCLL/SLL	9823	S	D	D	D	D	D	D	D	D	D	D
28. Burkitt cell leukemia	9826	D	D	D	D	D	D	D	D	D	D	D
29. Adult T-cell leuk/lymph	9827	D	D	D	D	D	D	D	D	D	D	D
30. Prolym'cyt leuk, NOS	9832	S	S	D	D	D	D	D	D	D	D	D
31. Prolym'cyt leuk, B-cell	9833	**S**	D	D	D	D	D	D	D	D	D	D
32. Prolym'cyt leuk, T-cell	9834	D	**S**	D	D	D	D	D	D	D	D	D
33. Precurs lym'cyt leuk, NOS	9835	D	D	**S**	S	S	D	D	D	D	D	D
34. Precurs B-cell leuk	9836	D	D	S	**S**	D	D	D	D	D	D	D
35. Precurs T-cell leuk	9837	D	D	S	D	**S**	D	D	D	D	D	D
36. Myeloid leukemias	9840-9910	D	D	D	D	D	**S**	S	S	S	D	S
37. Therapy related AML	9920	D	D	D	D	D	S	**S**	S	S	D	S
38. Myeloid sarcoma	9930	D	D	D	D	D	S	S	**S**	S	D	S
39. Acute panmyelosis	9931	D	D	D	D	D	S	S	S	**S**	D	S
40. Hairy cell leukemia	9940	D	D	D	D	D	D	D	D	D	**S**	D
41. Chron myelomonocyt leuk	9945	D	D	D	D	D	S	S	S	S	D	**S**
42. Juvenile myelomonocy leuk	9946	D	D	D	D	D	S	S	S	S	D	S
43. NK-cell leukemia	9948	D	D	D	D	D	D	D	D	D	D	D
44. Polycythemia vera	9950	D	D	D	D	D	D	D	D	D	D	D
45. Chron myeloprolif disease	9960	D	D	D	D	D	S	S	S	S	D	S
46. Myelosclerosis	9961	D	D	D	D	D	S	S	S	S	D	S
47. Essen thrombocythem	9962	D	D	D	D	D	S	S	S	S	D	S
48. Chron neutrophilic leukemia	9963	D	D	D	D	D	S	S	S	S	D	S
49. Hypereosinophilic syndrome	9964	D	D	D	D	D	S	S	S	S	D	S
50. Refractory anemias	9980-9986	D	D	D	D	D	S	S	S	S	D	S
51. Therapy related MDS	9987	D	D	D	D	D	S	S	S	S	D	S
52. Myelodysplastic syndr, NOS	9989	D	D	D	D	D	S	S	S	S	D	S

Codes: S--one primary only; D--presumably a subsequent primary SEER Program, NCI. E-mail: seerweb@ims.nci.nih.gov

February 28, 2001 PAGE 5 SECOND DX ACROSS FIRST DX DOWN		42. 9946 Juv myelomono leu	43. 9948 NK-cell leukemia	44. 9950 Polycythemia vera	45. 9960 Chr myeloprolif dis	46. 9961 Myelosclerosis	47. 9962 Ess thrombocythem	48. 9963 Chr neutrophil leu	49. 9964 Hypereosin syndr	50. 9980-9986 Refract anemias	51. 9987 Therapy rel MDS	52. 9989 Myelodys syn NOS
1. Malignant lymphoma, NOS	9590	S	S	D	D	D	D	D	D	D	D	D
2. NHL, NOS	9591	D	D	D	D	D	D	D	D	D	D	D
3. Composite HD/NHL	9596	D	D	D	D	D	D	D	D	D	D	D
4. Hodgkin lymphoma	9650-9667	D	D	D	D	D	D	D	D	D	D	D
5. ML, small B lymphocytic	9670-9671	D	D	D	D	D	D	D	D	D	D	D
6. Mantle cell lymphoma	9673	D	D	D	D	D	D	D	D	D	D	D
7. ML, diffuse, large B-cell	9675-9684	D	D	D	D	D	D	D	D	D	D	D
8. Burkitt lymphoma	9687	D	D	D	D	D	D	D	D	D	D	D
9. Marg zone, B-cell lymphoma	9689, 9699	D	D	D	D	D	D	D	D	D	D	D
10. Follicular lymphoma	9690-9698	D	D	D	D	D	D	D	D	D	D	D
11. Mycos fung, Sezary disease	9700-9701	D	D	D	D	D	D	D	D	D	D	D
12. T/NK-cell NHL	9702-9719	D	D	D	D	D	D	D	D	D	D	D
13. Precurs lym'blas lymph NOS	9727	D	D	D	D	D	D	D	D	D	D	D
14. Precurs lym'blas lymph B-cell	9728	D	D	D	D	D	D	D	D	D	D	D
15. Precurs lym'blas lymph T-cell	9729	D	D	D	D	D	D	D	D	D	D	D
16. Plasma cell tumors	9731-9734	D	D	D	D	D	D	D	D	D	D	D
17. Mast cell tumors	9740-9742	D	D	D	D	D	D	D	D	D	D	D
18. Histiocytos/Langerhans cell	9750-9756	D	D	D	D	D	D	D	D	D	D	D
19. Dendritic cell sarcoma	9757-9758	D	D	D	D	D	D	D	D	D	D	D
20. Immunoprolif disease, NOS	9760	D	D	D	D	D	D	D	D	D	D	D
21. Waldenstrom macroglob	9761	D	D	D	D	D	D	D	D	D	D	D
22. Heavy chain disease, NOS	9762	D	D	D	D	D	D	D	D	D	D	D
23. Immun sm intest disease	9764	D	D	D	D	D	D	D	D	D	D	D
24. Leuk/Acute leuk, NOS	9800-9801	S	D	D	S	S	D	S	S	D	S	S
25. Acute biphenotypic leukem	9805	S	S	D	S	S	D	D	D	S	S	S
26. Lymphocytic leukem, NOS	9820	D	S	D	D	D	D	D	D	D	D	D
27. BCLL/SLL	9823	D	D	D	D	D	D	D	D	D	D	D
28. Burkitt cell leukemia	9826	D	D	D	D	D	D	D	D	D	D	D
29. Adult T-cell leuk/lymph	9827	D	D	D	D	D	D	D	D	D	D	D
30. Prolym'cyt leuk, NOS	9832	D	D	D	D	D	D	D	D	D	D	D
31. Prolym'cyt leuk, B-cell	9833	D	D	D	D	D	D	D	D	D	D	D
32. Prolym'cyt leuk, T-cell	9834	D	D	D	D	D	D	D	D	D	D	D
33. Precurs lym'cyt leuk, NOS	9835	D	D	D	D	D	D	D	D	D	D	D
34. Precurs B-cell leuk	9836	D	D	D	D	D	D	D	D	D	D	D
35. Precurs T-cell leuk	9837	D	D	D	D	D	D	D	D	D	D	D
36. Myeloid leukemias	9840-9910	S	D	D	S	S	S	S	S	D	S	S
37. Therapy related AML	9920	S	D	D	D	S	D	D	D	D	S	S
38. Myeloid sarcoma	9930	S	D	D	S	S	S	S	D	D	S	S
39. Acute panmyelosis	9931	S	D	D	D	S	D	D	D	D	S	S
40. Hairy cell leukemia	9940	D	D	D	D	D	D	D	D	D	D	D
41. Chron myelomonocyt leuk	9945	S	D	D	S	S	D	S	D	D	S	S
42. Juvenile myelomonocy leuk	9946	**S**	D	D	D	S	D	D	D	D	S	S
43. NK-cell leukemia	9948	D	**S**	D	D	D	D	D	D	D	D	D
44. Polycythemia vera	9950	D	D	**S**	S	S	D	D	D	D	D	D
45. Chron myeloprolif disease	9960	D	D	D	**S**	S	S	S	D	D	D	D
46. Myelosclerosis	9961	S	D	D	S	**S**	S	S	D	D	S	S
47. Essen thrombocythem	9962	D	D	D	S	S	**S**	S	D	D	D	D
48. Chron neutrophilic leukemia	9963	D	D	D	S	S	S	**S**	D	D	D	D
49. Hypereosinophilic syndrome	9964	S	D	D	S	S	D	D	**S**	D	D	D
50. Refractory anemias	9980-9986	S	D	D	S	S	D	D	D	**S**	S	S
51. Therapy related MDS	9987	S	D	D	S	S	D	D	D	S	**S**	S
52. Myelodysplastic syndr, NOS	9989	S	D	D	S	S	D	D	D	S	S	**S**

Codes: S--one primary only; D--presumably a subsequent primary SEER Program, NCI. E-mail: seerweb@ims.nci.nih.gov

Blank Page

Appendix B

Surgery Codes

Blank Page

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 but are <u>not</u> 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*.

Blank Page

Blank Page

Appendix C

Countries and States

Blank Page

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

Blank Page

Blank Page

Index

Blank Page