NEW HAMPSHIRE STATE CANCER REGISTRY

Data Collection Manual

5th Edition - July 2016

NAACCR FORDS

FACILITY ONCOLOGY REGISTRY DATA STANDARDS

and

NEW HAMPSHIRE STATE CANCER REGISTRY

SUPPLEMENT

Effective with cases diagnosed on or after January 1, 2016

Commission on Cancer

NEW HAMPSHIRE STATE CANCER REGISTRY
Data Collection Manual
5th Edition - July 2016
Includes:

FORDS

Facility Oncology Registry Data Standards Revised for 2016

(Incorporates all updates since FORDS was originally published in July 2002)

Includes updates to January 1, 2016

and

NEW HAMPSHIRE STATE CANCER REGISTRY SUPPLEMENT

Effective with cases diagnosed on or after January 1, 2016

Commission on Cancer

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NEW HAMPSHIRE STATE CANCER REGISTRY
DATA COLLECTION MANUAL

In an ongoing effort to facilitate the data collection of cancer cases by reporting facilities, the New Hampshire State Cancer Registry (NHSCR) has developed the *NHSCR Data Collection Manual*. With permission from the American College of Surgeons and the Commission on Cancer, the NHSCR used the *Facility Oncology Registry Data Standards (FORDS): Revised for 2016* manual as the basis for the *NHSCR Data Collection Manual*. Per copyright law, the context of the *FORDS* information itself is not altered in any way. Instead, sections of the *FORDS* are highlighted and notations added that clarify NHSCR-specific requirements. NHSCR has also been granted permission by SEER to reference sections from the *SEER Program Coding and Staging Manual 2016*. Definitions for required data items that are not included in *FORDS* were taken from the *NAACCR Data Standards and Data Dictionary*.

NHSCR thanks the CoC, SEER, and NAACCR for allowing the use of the FORDS[1], SEER[2], and NAACCR[3] coding manuals as a basis for the NHSCR Data Collection Manual.

An electronic version of this manual is available on the NHSCR website:
http://geiselmed.dartmouth.edu/nhscr/registrars/

- NHSCR provides additional pages to provide definitions and coding instructions for data items not included in FORDS. These are listed at the end of the Table of Contents.
- These NHSCR-specific pages are in page number/alpha order and inserted throughout *FORDS* in corresponding sections. For example, page 5A is placed after page 5.
- Some notations begin with an asterisk (*). Because there was insufficient space for a notation to be placed by the section requiring a clarification, the asterisk (*) indicates a cross-reference between a clarification and a notation on the same page.
- For registrars using a paper copy of the *FORDS 2016* manual, we ask that the manual be updated by replacing the original *FORDS* pages with the NHSCR-noted pages and inserting the additional NHSCR pages for non-*FORDS* data items.

References

1. American College of Surgeons. Commission on Cancer. *Facility Oncology Registry Data Standards (FORDS): Revised for 2016.* Available at: https://www.facs.org/quality-programs/cancer/ncdb/registrymanuals/cocmanuals/fordsmanual
2. Adamo M, Dickie, L, Ruhl J. (January 2016). *SEER Program Coding and Staging Manual 2016.* National Cancer Institute, Bethesda, MD 20850-9765. Available at: http://seer.cancer.gov/tools/codingmanuals/
3. Thornton ML, (ed). Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Record Layout Version 16, 20th ed. Springfield, Ill.: North American Association of Central Cancer Registries, September 2015, revised October 2015, revised November 2015. Available at: http://www.naaccr.org/StandardsandRegistryOperations/VolumeII.aspx

Acknowledgement

The NHSCR is supported by the Centers for Disease Control (CDC) and Prevention's National Program of Cancer Registries (NPCR) through cooperative agreement U58/DP003930 awarded to the New Hampshire Department of Health and Human Services, Division of Public Health Services, Bureau of Disease Control and Health Statistics, Health Statistics and Data Management Section. The contents of this manual are solely the responsibility of the NHSCR and do not necessarily represent the official views of the Centers for Disease Control and Prevention. Strict policies and procedures have been developed to maintain confidentiality in disclosure of data.

Table of Contents

NHSCR-specific items NOT listed here are provided on page xii.

The *NSHCR Table of Required Data Items* table is located at the beginning of Section Two.
This table provides a list of NHSCR-required data items.

PATIENT IDENTIFICATION (CONTINUED)

Table of Contents
for NHSCR-specific items NOT included in *FORDS: Revised for 2016*

Preface 2016

For all cases diagnosed on or after January 1, 2016, the Commission on Cancer will require its accredited programs to use Facility Oncology Registry Data Standards (FORDS): Revised for 2016; Collaborative Stage Data Collection System Version 02.05 for the collection of Site-specific Factors only; continued use of 7th Edition of the AJCC Cancer Staging Manual; the most current multiple primary and histology rules; the Hematopoietic rules; and, the SEER*RX systemic therapy application.

Revisions to CoC reporting requirements for 2016 are minimal and are primarily due to the discontinued use of Collaborative Stage to stage cancer cases. Other than the below-specified revisions, CoC data reporting requirements remain the same as for 2015. The CoC's transition away from use of Collaborative Stage includes the requirement of AJCC clinical and pathologic stage (requirement of both now enforced via edits), SEER Summary Stage 2000, and new Tumor Size Summary and Mets at Diagnosis data items. The CoC will continue to use the Collaborative Stage Data Collection System Version 02.05 for cases diagnosed 2004-2015, and only for the collection of Site-specific Factors (SSF) for cases diagnosed 1/1/2016 and forward. The majority of CS input data items are no longer required.

New Data Items

Eight new data items are introduced in **FORDS: Revised for 2016** and required for cases diagnosed January 1, 2016 and later.

- Tumor Size Summary [756]
- Mets at Diagnosis - Distant Lymph Nodes [1114]
- Mets at Diagnosis – Bone [1112]
- Mets at Diagnosis – Brain [1113]
- Mets at Diagnosis – Liver [1115]
- Mets at Diagnosis – Lung [1116]
- Mets at Diagnosis – Other [1117]
- SEER Summary Stage 2000 [759]

Refer to the Table of Required Items in Section Two for NHSCR requirements on these variables.

Discontinued Data Items (No Longer Required)

Beginning with cases diagnosed in 2016, the following Collaborative Stage input data items are no longer required. They must continue to be abstracted for cases diagnosed from 2004 through 2015.

- CS Tumor Size [2800]
- CS Extension [2810]
- CS Tumor Size/Ext Eval [2820]
- CS Lymph Nodes [2830]
- CS Lymph Nodes Eval [2840]
- CS Mets at DX Data Items [2850-2854] (Required 2009-2015)
- CS Mets Eval [2860]
- CS Version Derived [2936]
- Derived AJCC-6 Data Items [2940-3000]
- Derived SS and Flag Data Items [3010-3050]
- Derived AJCC-7 Data Items [3400-3430]

Specific Stage Data Items with Continuing Requirement
The following data items were considered as Collaborative Stage input data items for the purposes of Collaborative Stage, but are now are continued to be required for AJCC staffing and research purposes. They are required for all cases diagnosed in 2004 and later:

- Regional Nodes Positive [820]
- Regional Nodes Examined [830]
- Lymph-vascular Invasion [1182] (Required 2009+)
- CS Site-specific Factors [2861-2880, 2890-2930]
- CS Version Input Original [2935]
- CS Version Input Current [2937]

Note: CoC's requirements for the 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 SSFs.

Implementation of New AJCC T, N, and M Categories:
According to the AJCC manual and trainings, the appropriate T, N, and M categories should be assigned based on clinical and pathologic staging/classification timeframes. This may entail allowing, for example, the pathologic staging M category to be properly assigned as cM1 when existence of distant metastasis is found upon imaging after surgery. However, historically cancer registry abstracting software has been set up to code two separate and mutually exclusive clinical and pathologic strings of T, N, M, and stage categories, with an implied "c" in the clinical TNM string, and an implied "p" in the pathologic TNM string. Upon abstraction, the registrar had no way of recording the appropriate M category for the pathologic stage if it is cM1. This discrepancy between registry software data items and AJCC staging classification rules caused a dilemma for registrars when abstracting the T, N, and M data items and resulted in inconsistent coding practices and data loss.

As a result, this issue will be addressed upon implementation of NAACCR version 16-compliant software with the addition of new AJCC T, N, and M categories for the AJCC T, N, and M data items [940, 950, 960, 880, 890, and 900]. 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. The revisions will be incorporated into software look ups to allow for selection of necessary 'p' values within the clinical codes and selection of necessary 'c' values within the pathologic codes when abstracting. For example, the addition of pTis to the clinical classification T category will enable its use for in situ tumors in accordance with the AJCC rules (serves as a reminder that the in situ diagnosis cannot be made on imaging alone). This implementation will allow registrars to comply with AJCC rules while abstracting, thus reducing stage assignment confusion and increasing registrar confidence in assigning AJCC stage, increasing data integrity, and reducing the time and resources that registrars and standard setters currently spend addressing these issues.

CoC will require CoC-approved Cancer Programs to use the new T, N, and M categories and convert historical data upon upgrading to NAACCR version 16-compliant software (Please see the NAACCR 2016 Implementation Guidelines for complete details). The new category options will be implemented for cases of all diagnosis years abstracted using NAACCR version 16-compliant software. Conversion of historical data for the diagnosis years of 2015 and earlier is being carried out for the purposes of formatting the data

to accommodate consistent viewing, abstraction, and editing of the data across all diagnosis years. Please note that the prefixes included in the new categories are only intended to reflect clinical significance for cases diagnosed January 1, 2016 and later, and should not be analyzed in any fashion for cases diagnosed earlier. Existing T, N, and M values will not be converted for any cases diagnosed in 2016 that are initially abstracted using NAACCR Version 15-compliant software. As a result, the T, N, and M categories will need to be reviewed for these cases upon upgrade to NAACCR Version 16-compliant software. The registrar will have to accurately re-assign the new T, N, and M categories (that include c and p designations).

Clinical and Pathologic AJCC Stage Required
Beginning with cases diagnosed January 1, 2016 and later, both clinical and pathologic AJCC stage will be required for data submission to the NCDB. The requirement will be enforced via edits. Collaborative Stage is no longer required (required historically for cases diagnosed from 2004 – 2015).

No Submission of Derived Stage to the NCDB for Cases Diagnosed 2016 and Later
For cases diagnosed 2016 and later, no software-derived values should be submitted in the directly-assigned AJCC Stage data items [910, 970]. Registrars are encouraged to fully understand how their vendor software functions, and should never manually copy over any derived values into the directly-assigned data items. Algorithms are under development to identify derived values submitted in the directly-assigned data items. Programs will receive a deficiency on CoC Program Standard 5.6 if submission of derived values in the directly-assigned AJCC Stage data items is detected.

Documenting Clinical and Pathologic AJCC Stage
The hospital registrar will be responsible for recording the physician-assigned stage in the registry database.

a) If the stage assigned by the physician is inconsistent with the documentation in the medical record, the registrar should assign the stage and record the registrar-assigned stage in the registry database. The registrar should verify the case information with the physician, as he or she may have additional information that would aid in the assignment of a stage. However, it is outside the realm of the responsibility of the registrar to educate the physician. **The registrar should inform the registry physician advisor and refer identified coding issues to the Cancer Committee for quality improvement activities.**

b) If no physician-assigned stage can be found in the medical record, the registrar should assign the stage and record it in the registry database. **The registrar should inform the registry physician advisor and refer identified documentation issues to the Cancer Committee for quality improvement activities.**

c) CoC Program Standard 1.10, Clinical Educational Activity states that the required cancer-related educational activity offered to physicians, nurses, and other allied health professionals is to be focused on the use of AJCC (or other appropriate) staging. The cancer committee is encouraged to use AJCC-developed materials for this purpose.

Revision of TNM Staged By Data Items
The length of the TNM Path Staged By [930] and TNM Clin Staged By [990] data items has been expanded to 2 digits to accommodate new codes. The historic 1 character codes will be concerted to the new codes upon upgrade to NAACCR Version 16-compliant software.

Non-FORDS Code Modifications

ICD-O-3

The NAACCR Guidelines for ICD-O-3 Update Implementation (published December 2013) included a table of new ICD-O-3 codes and terms effective for 2015; however, the use of the new codes was postponed due to issues with adding these codes to the CSv2 software. For diagnosis year 2016, all standard setters have agreed to postpone these codes once again, and to use the alternate codes published in Table 2 of the Guidelines for ICD-O-3 Update Implementation. It is anticipated that these codes will be implemented in 2017 when the AJCC-TNM 8th Edition goes into effect.

Newly-reportable Conditions/Tumors:

- Non-invasive mucinous cystic neoplasm of the pancreas with high-grade dysplasia replaces mucinous cystadenocarcinoma, non-invasive (8470/2).
- Solid pseudopapillary neoplasm of pancreas (8452/3) is synonymous with solid pseudopapillary carcinoma (C25._).
- Cystic pancreatic endocrine neoplasm (CPEN). Assign 8150/3 unless specified as a neuroendocrine tumor, Grade 1 (8240/3) or neuroendocrine tumor, Grade 2 (8249/3).
- Mature teratoma of the testes in adults is malignant (assign 9080/3), but continues to be non-reportable in prepubescent children (9080/0). Report only if pubescence is explicitly stated in the medical record. **Do not report if there is no mention of pubescence in the medical record**.

Hematopoetic and Lymphoid Database and Manual. An updated version of the Hematopoietic and Lymphoid (Heme) Database was released by NCI SEER in January 2015. There were no updates to Heme Database for 2016. Registrars will continue to use the current posted manual that's on the website, see http://seer.cancer.gov/tools/heme/.

A small number of other modifications to **FORDS: Revised for 2016** were made for clarification. *Appendix C* lists all content changes made in **FORDS: Revised for 2016**. Note that the modifications for this edition resulted in pagination changes, and communications about **FORDS** content should refer to the *Section One* heading or the item definition in which the information is found rather than to page numbers.

Additional Coding References

The following references are required to code some items. Coding instructions for items from these sources are not reproduced in **FORDS: Revised for 2016** in order to avoid redundancy and possible conflict when the primary manuals are updated. For each, use the most current version applicable for the diagnosis year.

Fritz A, Percy C, Jack A, et al (eds). *ICD-O: International Classification of Diseases for Oncology*, 3rd ed. Geneva, World Health Organization: 2000.

Edge S, Byrd D, Compton C, et al (eds): *AJCC Cancer Staging Manual*, 7th ed. American Joint Committee on Cancer, Chicago IL. Springer: 2009. Errata exist and can be downloaded from *www.cancerstaging.org*.

Collaborative Stage Data Collection System, Version 02.05. Available at *www.cancerstaging.org/cstage*. Site-specific factor requirements by schema, diagnosis year and standard-setter (including CoC) are available at http://seer.cancer.gov/csreqstatus/.

Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual and the Hematopoietic and Lymphoid Neoplasms Database (Hematopoietic DB), most current version. Available at *http://seer.cancer.gov/registrars/*.

The 2007 Multiple Primary and Histology Coding Rules, revised 2012. National Cancer Institute, Surveillance, Epidemiology and End Results Program. Bethesda, MD: 2007. Available for download at *http://seer.cancer.gov/tools/mphrules/*.

*SEER*Rx – Interactive Drug Database*. National Cancer Institute, Surveillance, Epidemiology and End Results Program, Bethesda MD. Available for download *at http://seer.cancer.gov/tools/seerrx/*.

The following references also may be useful.

NAACCR Inc. 2016 Implementation Guidelines and Recommendations. North American Association of Central Cancer Registries, Springfield IL: 2015. Available at *http://www.naaccr.org/StandardsandRegistryOperations/ImplementationGuidelines.aspx*

NAACCR, Inc. Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, version 16. North American Association of Central Cancer Registries, Springfield IL: 2015. Available at *http://www.naaccr.org/StandardsandRegistryOperations/VolumeII.aspx*.

SEER Program Coding and Staging Manual (http://seer.cancer.gov/tools/codingmanuals/index.html).

An interactive tool that incorporates many of the references above is provided free by The Centers for Disease Control and Prevention. The *Registry Plus Online Help* application has full copies of the **FORDS**, **Collaborative Stage**, and **Multiple Primary and Histology Coding** manuals as well as the **NAACCR Data Dictionary**, the **SEER Coding Manual**, and the introduction and histology sections of ICD-O-3. It also describes all standard edits with links to the item definitions they use and explanations for interpreting them. *Registry Plus Online Help* is free and available at *http://www.cdc.gov/cancer/npcr*. Select "Registry Plus" under "Software and Tools"; select "Online Help"; then select "Technical Information and Installation." Follow the instructions to download and install.

Preface 2016

NEW HAMPSHIRE STATE CANCER REGISTRY
Data Collection Manual

Introduction
Cancer became a reportable disease in NH in 1985, and since 1986, the New Hampshire State Cancer Registry (NHSCR) has been charged to collect incidence data on all cancer cases seen and/or treated in New Hampshire. As required by NH Administrative Rules (*Appendix F*), the NHSCR currently collects reports from hospital registrars operating in all the large hospitals in NH. Hospitals with relatively smaller caseloads of cancer (fewer than 105 cases per year) generally do not have their own cancer registry and NHSCR staff helps these hospitals with their abstracting duties. NHSCR also receives reports of cases from physician practices, free standing radiation oncology centers, out-of-state pathology laboratories and other sources. In addition, the NHSCR receives reports for cases diagnosed in other states who are NH residents at diagnosis, based on agreements of information exchange with other states.

The NHSCR has an innovative, two-phase reporting system. An initial *rapid* report that provides the most elemental aspects of case identification is reported within 45 days of diagnosis. A *definitive* case report is reported 180 days from the date of diagnosis and includes more specific information, such as treatment and staging information. The timeliness of the receipt of information is essential to the ability of the NHSCR to provide meaningful data.

NHSCR Data Collection Manual and *FORDS: Revised for 2016*
To ensure the integrity of cancer data that are collected and submitted by reporting facilities, the NHSCR has developed the *NHSCR Data Collection Manual*. This manual is a combination of the *Facility Oncology Registry Data Standards (FORDS): Revised for 2016* with additional material pertaining to NHSCR-specific requirements and clarifications. NHSCR has been granted permission by the American College of Surgeons and the Commission on Cancer to use the *FORDS* manual information as the basis for the *NHSCR Data Collection Manual*. Per copyright law, the context of the *FORDS* information itself is not altered in any way. Instead, sections of the *FORDS* are highlighted and notations added that clarify NHSCR-specific requirements. To comply with NHSCR reporting requirements, all reporting facilities are to use the standards set forth in this manual for cases diagnosed **January 1, 2016 forward**.

The main differences between NHSCR requirements and *FORDS 2016* are as follows:

- All cases seen with evidence of cancer or for cancer-directed treatment since the NHSCR reference date of June 1986 are reportable to the NHSCR.
- Non-analytic cases ARE reportable only IF the case has not been reported by the diagnosing or treating facility. (See NHSCR Non-Analytic Tracking Form procedure.) For example, reportable are patients receiving transient care, patients with active cancer admitted for medical conditions other than cancer, and patients with a history of cancer that are now undergoing cancer-directed treatment. NHSCR does not require the reporting of historical cases when they do not have active disease. Place of diagnosis, residence, and class of case are **not** determining factors for reportability.
- All intraepithelial neoplasia, grade III, are reportable, EXCEPT carcinoma in situ of cervix (CIS, CIN III) and of the prostate (PIN III).
- Reportable-by-agreement cases that fall outside the NHSCR's reportable list should not be transmitted to the NHSCR. Only count NHSCR reportable cancers when assigning sequence numbers.
- The use of ambiguous terminology is further defined: There is a difference between ambiguous terms that constitute a diagnosis and ambiguous terms describing tumor spread.
- It is important to accession cases with cytology diagnosis that are positive for malignant cells.

- **Staging**
  - NHSCR requires both AJCC and SEER Summary Stage on all cases diagnosed prior to year 2004, including Class of Case 00 & 30-99.
  - AJCC staging is also required for breast and colorectal cancer diagnosed in years 2011 and forward.
  - Use coding rules from the AJCC manual that was effective for the cancer in question
  - Collaborative Stage is to be used for all cases diagnosed 2004-2015.
  - Effective with diagnosis year 2015, all cases must be manually staged using both AJCC and SEER Summary Stage.
- Effective with cases diagnosed January 1, 2010, the recording of Comorbidities and Complications or Secondary Diagnosis is required by NHSCR.
- The NHSCR is a population-based incidence registry only. NHSCR does not conduct annual follow-up on cases once initial diagnosis and complete first-course treatment has been reported. If a completed definitive case is revised as a result of additional information becoming available, submit a revised abstract to the NHSCR with a notation indicating the revision.
- *Date of Initial RX-CoC* is required by NHSCR. Registries should be careful not to confuse this data item with *Date of Initial RX—SEER* (NAACCR Item #1260).
- Descriptions and coding instructions of additional data items that are not included in *FORDS*, but may be required by NHSCR, are provided (e.g. marital status, text fields). These pages are marked and highlighted with NHSCR-Specific notation.
- As part of the CDC-CER Specialized Registry, reporting facilities are required to collect additional information on all cases and more detailed data on breast, colorectal, and chronic myeloid leukemia (CML) cases diagnosed in year 2011. Please refer to the *Table of Required Items* for these variables. *Appendix G* is the data dictionary for the CER non-standard NAACCR items. It is not required to conduct annual follow-up of cases reported to NHSCR once initial diagnosis and complete first-course treatment information has been reported.
- NHSCR collects follow-up only for breast and colorectal cancers diagnosed in year 2011 for the Patient-Centered Outcomes project (*Appendix H*).

Reportable Cases
Section One: Case Eligibility **and** *Appendix F: NH Rules and Regulations* of this manual provide detailed criteria and definitions of cases that are required by the NHSCR.

Casefinding
To successfully identify reportable cancers, reporting facilities should have casefinding procedures in place to confirm whether a case is required. While there are many sources for the identification of cancer cases, the principle sources are **pathology reports** (histology, cytology, bone marrow, and autopsy) and **medical disease indices**. The list provided in *Appendix I* consists of ICD-10-CM codes used to identify potentially reportable cancer cases. This casefinding list is **not** the same as a reportable list. Some of these codes may contain conditions that are not considered reportable; however, these diagnoses may indicate a reportable condition. Casefinding must include both primary and up to four (4) secondary diagnoses. The patient medical record will need to be reviewed to verify whether or not the case is reportable to the NHSCR. Facilities are urged to maintain a list of non-reportable cases in case the NHSCR requests these as a potentially missed case resulting from a casefinding audit.

Data Collection
Section Two: Coding Instructions of this manual contains the *NHSCR Table of Required Data Items* and provides coding definitions of individual data items. In the case where NHSCR and CoC requirements differ, NHSCR requirements take precedence over the CoC.

NHSCR is participating in CDC's Enhancing Cancer Registries for Comparative Effectiveness Research (CER) project. This project aims to collect more detailed cancer registry data beyond SEER, CoC and NAACCR standards. As part of the new reporting requirements, every facility is required to collect specific additional variables for ALL cases (e.g. co-morbidities) and more detailed treatment information on all breast, colorectal, and chronic myeloid leukemia (CML) cases diagnosed in year 2011. These new data items are listed in the *Table of Required Items* in *Section Two*, and definitions and coding instructions are provided in *Appendix G: CER Data Dictionary*.

Data Transmissions

Reporting facilities should have an agreement with the NHSCR for the submission of both rapid and definitive cancer reports. *Appendix F: NHSCR Rules and Regulations* of this manual specifies the various methods of cancer case reporting.

Cases must be retransmitted to the NHSCR if a change is made *after* the completed cases have already been transmitted. (See page 16A)

SECTION ONE:

Case Eligibility and Overview of Coding Principles

CASE ELIGIBILITY

The American College of Surgeons Commission on Cancer (CoC) requires registries in accredited programs to accession, abstract, and conduct follow-up activities* for required tumors diagnosed and/or initially treated at the abstracting facility. The tumors must meet the criteria for analytic cases** (*Class of Case* 00-22), and pathologically and clinically diagnosed inpatients and outpatients must be included.

*NHSCR does not require follow-up on cases after the diagnosis and initial treatment information has been reported.

**Certain nonanalytic cases are reportable to the NHSCR.

TUMORS REQUIRED BY THE CoC TO BE ACCESSIONED, ABSTRACTED, FOLLOWED AND SUBMITTED TO THE NATIONAL CANCER DATA BASE (NCDB)

Examples of reportable and non-reportable cases are provided on pages 5A - 5D.

Malignancies with an ICD-O-3 behavior code of 2 or 3 are required for all sites.

EXCEPTION 1: Juvenile astrocytoma, listed as 9421/1 in ICD-O-3, *is required* and should be recorded as 9421/3 in the registry.

EXCEPTION 2: 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.

EXCEPTION 3: Malignant primary skin cancers (C44._) with histology codes 8000–8110 *are not required* by the CoC. Skin primaries with those histologies diagnosed prior to January 1, 2003, were required to be accessioned and followed if the AJCC stage group at diagnosis was II, III, or IV. Those cases should remain in the registry data and continue to be followed.

EXCEPTION 4: 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), larynx (LIN III), and squamous intraepithelial neoplasia excluding cervix (SIN III) *are not required* by CoC. SIN III is a specific instance of intraepithelial neoplasia, grade III which is listed in ICD-O-3 as /2

All intraepithelial neoplasia, grade III, are reportable, EXCEPT carcinoma in situ of cervix (CIS, CIN III) and of the prostate (PIN III).

Nonmalignant primary intracranial and central nervous system tumors diagnosed on or after January 1, 2004, with an ICD-O-3* behavior code of 0 or 1 are required for the following sites: meninges (C70._), brain (C71._), spinal cord, cranial nerves, and other parts of central nervous system (C72._), pituitary gland (C75.1), craniopharyngeal duct (C75.2) and pineal gland (C75.3).

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

REPORTABLE-BY-AGREEMENT CASES

Registries may be requested to collect information about tumors that are not required to be abstracted by the CoC for accredited programs. Ordinarily, such requests will come from the facility's cancer committee or the central registry. The CoC does not require that reportable-by-agreement cases be accessioned, abstracted, followed, or submitted, but the requestor may identify the extent of information needed.

NHSCR requires the reporting of certain nonanalytic cases. Reportable-by-agreement cases that fall outside the NHSCR's reportable list should not be transferred to the NHSCR.

Examples of Reportable-by-Agreement Cases:

- The cancer committee requests abstracting and follow-up of *Class of Case* 30 cases.

- The state central registry requests abstracting and reporting of pathology-only cases.

AMBIGUOUS TERMS AT DIAGNOSIS

The use of ambiguous terminology is further defined on 5E - 5F.

As part of the registry case-finding activities, all diagnostic reports should be reviewed to confirm whether a case is required. If the terminology is ambiguous, use the following guidelines to determine whether a particular case should be included. Words or phrases that appear to be synonyms of these terms do not constitute a diagnosis. For example, "likely" alone does not constitute a diagnosis.

Ambiguous Terms that Constitute a Diagnosis*

Apparent(ly)	Presumed
Appears	Probable
Comparable with	Suspect(ed)
Compatible with	Suspicious (for)
Consistent with	Tumor* (beginning with 2004 diagnoses and only for C70.0–C72.9, C75.1–75.3)
Favors	Typical of
Malignant appearing	
Most likely	
Neoplasm* (beginning with 2004 diagnoses and only for C70.0–C72.9, C75.1–75.3)	

*additional terms for nonmalignant primary intracranial and central nervous system tumors only

*There is a difference between ambiguous terms that constitute a diagnosis and ambiguous terms describing tumor spread. Clarification is provided on page 21A.

EXCEPTION: If a cytology is identified only with an ambiguous term, do not interpret it as a diagnosis of cancer. It is important to accession cases with cytology diagnosis that are positive for malignant cells. Abstract the case only if a positive biopsy or a physician's clinical impression of cancer supports the cytology findings.

Examples of Diagnostic Terms:

- The inpatient discharge summary documents a chest X ray *consistent with carcinoma* of the right upper lobe. The patient refused further work-up or treatment. *Consistent with carcinoma* is indicative of cancer.

- The pathology report states *suspicious for malignancy*. *Suspicious for malignancy* is indicative of cancer.

Ambiguous Terms That *Do Not* Constitute a Diagnosis *without additional information*

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

Cases with a final diagnosis using any of the non-diagnostic terms are reportable if cancer-directed treatment is given or if the physician states the final diagnosis is a malignancy.

Examples of Nondiagnostic Terms:

- The inpatient discharge summary documents a chest x-ray *consistent with neoplasm* of the right upper lobe. 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.

- Final diagnosis is reported as *possible carcinoma* of the breast. *Possible* is not a diagnostic term for 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.

CLASS OF CASE

All accessioned cases are assigned a *Class of Case* (NAACCR Item #610) 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 are not required to be staged or followed,* regardless of the year of diagnosis. *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*.

*NHSCR requires the staging of all cases, including *Class of Case* 00.

Nonanalytic Cases

Nonanalytic cases (*Class of Case* 30-99) are not usually included in routine treatment or survival statistics. The CoC does not require registries in accredited programs to accession, abstract, or follow these cases, but the program or central registry may require them.**

**NHSCR requires the reporting of nonanalytic cases.

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 nonanalytic 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. Nonanalytic 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.

DATE OF FIRST CONTACT

The *Date of First Contact* (NAACCR Item #580) 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 case *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 noncancer-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 nonanalytic (for example, consult 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 not required by the Commission on Cancer to be abstracted unless the patient receives first course treatment from the facility. *NHSCR requires the reporting of path-only cases.

- 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* (NAACCR Item #610) 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. *Facilities that have agreements with staff physicians to report these may transmit as physician-only cases.

- 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 nonanalytic cases, the *Date of First Contact* is the date the patient's nonanalytic 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.

NOTE: NHSCR requires NH reporting facilities to accession and abstract all cases seen with evidence of a reportable cancer or for cancer-directed treatment, on or after the NHSCR reference date (June 1986) only IF the case has not been reported by the diagnosing or treating facility. See NHSCR Non-Analytic Tracking Form procedure found at: *http://geiselmed.dartmouth.edu/nhscr/registrars/*

Non-analytic cases include patients receiving transient care, patients with active cancer admitted for medical conditions other than cancer, patients with a history of cancer that are now undergoing cancer-directed treatment, as well as pathology-only, physician-only, and consult-only cases (i.e. class case 30-99). NHSCR does not require the reporting of historical cases when they do not have active disease. Place of diagnosis, residence, and class of case are not determining factors for reportability.

Reportable Examples

Example 1: "Atypical fibroxanthoma (superficial malignant fibrous histiocytoma)." The case is reportable because the information in parentheses provides more detail and confirms a reportable malignancy.

Example 2: "Positive histology from needle biopsy followed by negative resection." This case is reportable based on positive needle biopsy.

Example 3: "Biopsy-proven squamous cell carcinoma of the nipple with a subsequent areolar resection showing foreign body granulomatous reaction to suture material and no evidence of residual malignancy in the nipple epidermis." This case is reportable. The fact that no residual malignancy was found in the later specimen does not disprove the malignancy diagnosed by the biopsy.

Example 4: Final diagnosis from dermatopathologist: ulcerated histologically malignant spindle cell neoplasm, consistent with atypical fibroxanthoma.

Note: An exhaustive immunohistochemical work-up shows no melanocytic, epithelial or vascular differentiation. Atypical fibroxanthoma is a superficial form of a malignant fibrous histiocytoma. This case is reportable. The pathologist has the final say on behavior for a particular case. In this case, the pathologist states that this tumor is malignant.

Example 5: "Aggressive adult granulosa cell tumor with one of two lymph nodes positive for malignant metastatic granulosa cell tumor." This case is reportable because malignant granulosa cell tumor is reportable. The lymph node metastases prove malignancy.

Example 6: "Carcinoid of the appendix found on appendectomy." Carcinoid tumor, NOS is reportable (8240/3).

Example 7: "Ovarian mucinous borderline tumor with foci of intraepithelial carcinoma." This case is reportable because there are foci of intraepithelial carcinoma (carcinoma in situ).

Example 8: "Squamous cell carcinoma of the anus, NOS." Squamous cell carcinoma of the anus (C210) is reportable.

Note: Squamous cell carcinoma of the perianal skin (C445) is not reportable.

Example 9: "Gastrointestinal stromal tumor (GIST) with lymph nodes positive for malignancy." Report the case and code the behavior as malignant (/3).

Example 10: Dermoid cyst of the brain is reportable.

Example 11: Tectal plate lipoma is a reportable brain tumor. It is a benign neoplasm of the mid brain (brain stem).

Example 12: Non-invasive mucinous cystic neoplasm (MCN) of the pancreas with high grade dysplasia is reportable. For neoplasms of the pancreas, the term MCN with high grade dysplasia replaces the term mucinous cystadenocarcinoma, non-invasive (8470/2).

Example 13: Rathke pouch tumor (C751, 9350/1) is a reportable neoplasm for cases diagnosed 2004 and later. Rathke cleft cyst and Rathke pouch tumor are different conditions. Rathke cleft cyst is not reportable.

**Source: Adamo M, Dickie, L, Ruhl J. (January 2016). SEER Program Coding and Staging Manual 2016. National Cancer Institute, Bethesda, MD 20850-9765.*

Example 14: Report mature teratoma of the testis when diagnosed after puberty (malignant) and do not report when diagnosed in a child (benign). Do not report mature teratoma of the testis when it is not known whether the patient is prepubescent or postpubescent. Pubescence can take place over a number of years; review physical history and do not rely only on age. For testis: Mature teratoma in adults is malignant (9080/3); therefore, is a reportable neoplasm.

Example 15: Report as either 8240/3 or 8151/3 when the pathology diagnosis is a neuroendocrine tumor (/3) and the clinical diagnosis is an insulinoma (/0).

Example 16: Hemangioma, NOS (9120/0) and cavernous hemangioma (9121/0) arising in the dura and parenchyma of the brain/CNS are reportable.

Example 17: Cystic pancreatic endocrine neoplasm (CPEN) is reportable. Assign 8150/3 unless specified as a neuroendocrine tumor, Grade 1 (8240/3) or neuroendocrine tumor, Grade 2 (8249/3).

Example 18: Solid pseudopapillary neoplasm of the pancreas is reportable as 8452/3.

Example 19: Report liver cases with an LI-RADS category LR-5 or LR-5V based on the 2014 American College of Radiology definitions, http://nrdr.acr.org/lirads. Use the date of the LR-5 or LR-5V scan as the date of diagnosis when it is the earliest confirmation of the malignancy. Do not report cases based only on an LI-RADS category of LR-4.

Non-Reportable Examples

Example 1: Left thyroid lobectomy shows microfollicular neoplasm with evidence of minimal invasion. Micro portion of path report states "The capsular contour is focally distorted by a finger of the microfollicular nodule which appears to penetrate into the adjacent capsular and thyroid tissue." Do not report this case based on the information provided. There is no definitive statement of malignancy. Search for additional information in the record. Contact the pathologist or the treating physician.

Example 2: Sclerosing hemangioma of the lung with multiple regional lymph nodes involved with sclerosing hemangioma. This case is not reportable. The lymph node involvement is non-malignant. According to the WHO Classification of Lung Tumours, sclerosing hemangioma "behaves in a clinically benign fashion...Reported cases with hilar or mediastinal lymph node involvement do not have a worse prognosis."

Example 3: Carcinoid tumorlets in the lung are not reportable.

Example 4: "AIN II-III," "AIN II/III," "VAIN II-III," "VAIN II/III," "VIN II-III," "VIN II/III," etc. are not reportable. Intraepithelial neoplasia (8077/2 and 8148/2) must be unequivocally stated as Grade III to be reportable.

Example 5: Squamous cell carcinoma of the perianal skin (C445) is not reportable. Squamous cell carcinoma of the anus (C210) is reportable.

Example 6: Breast cases designated "BIRADS 4" or "BIRADS 5" without any additional information are not reportable. The American College of Radiology defines Category 4 as "Suspicious abnormality." This is not

reportable terminology – abnormality is not a reportable term. Category 5 is defined as "Highly suggestive of malignancy." "(Highly) suggestive" is not reportable ambiguous terminology (see Ambiguous Terminology below). Lung: Do not use the ACR Lung Imaging Reporting and Data System (Lung-RADS™) to determine reportability. Look for reportable terminology from the managing physician or other sources.

Example 7: Squamous cell carcinoma of the canthus (C441) is not reportable.

Example 8: Low grade appendiceal mucinous neoplasm (LAMN) is not reportable. The WHO classification designates LAMN as /1 with uncertain malignant potential.

Example 9: Diffuse idiopathic pulmonary neuroendocrine cell hyperplasia (DIPNECH) is not reportable. It is a generalized proliferation of scattered single cells, small nodules (neuroendocrine bodies), or linear proliferation of pulmonary neuroendocrine cells (PNCs), according to the WHO classification of lung tumors.

Example 10: Lentiginous melanocytic lesion is not reportable.

Example 11: Lobular intraepithelial neoplasia grade 1 and grade 2 are not reportable.

Example 12: Intraductal papillary mucinous neoplasms with low or moderate grade dysplasia, also called IPMN adenomas, are not reportable.

Example 13: Non-invasive mucinous cystic neoplasm (MCN) of the pancreas with low or intermediate grade dysplasia is not reportable.

Example 14: Subdural hygroma is not reportable – it is not a neoplasm. Subdural hygroma is a collection of cerebrospinal fluid in the subdural space. It may be related to a head injury.

Example 15: Brain lesions associated with multiple sclerosis are not reportable. These brain lesions are not neoplastic; they are part of the disease process of multiple sclerosis.

Example 16: High grade squamous intraepithelial lesion (HGSIL or HSIL) of the vulva or vagina is not reportable.

Example 17: HGSIL, HSIL, carcinoma in situ (CIS), and AIN III (8077) arising in perianal skin (C445) are not reportable.

Example 18: Do not report mature teratoma of the testis when diagnosed before puberty (benign, 9080/0). Pubescence can take place over a number of years; review history and physical information and do not rely only on age. Do not report mature teratoma when it is not known whether the patient is pre- or post-pubescent.

Example 19: For ovary: Mature teratoma is benign (9080/0); therefore, is not a reportable neoplasm.

Example 20: Venous angiomas (9122/0) are not reportable wherever they arise. The primary site for venous hemangioma arising in the brain is blood vessel (C490). The combination of 9122/0 and C490 is not reportable. This is a venous abnormality. Previously called venous angiomas, these are currently referred to as developmental venous anomalies (DVA).

**Source: Adamo M, Dickie, L, Ruhl J. (January 2016). SEER Program Coding and Staging Manual 2016. National Cancer Institute, Bethesda, MD 20850-9765.*

Example 21: Do not report liver cases based only on an LI-RADS category of LR-4.
Report liver cases with an LI-RADS category LR-5 or LR-5V based on the 2014 American College of Radiology definitions, http://nrdr.acr.org/lirads.

Example 22: The terms "high grade dysplasia" (HGD) and "severe dysplasia" are not reportable. For the purposes of cancer registry reporting, they are not synonymous with in situ for tumors in the gastrointestinal tract (such as colon, stomach, esophagus). These cases are only reportable when the pathologist documents carcinoma in situ, or intraepithelial neoplasia grade III, or when the registry includes in their policies and procedures the pathologist's statement that HGD is equivalent to carcinoma in situ.

How to Use Ambiguous Terminology for Case Ascertainment

1. In Situ and Invasive (Behavior codes /2 and /3)

a. If any of the reportable **ambiguous terms precede** a word that is **synonymous** with an in situ or invasive tumor (e.g., cancer, carcinoma, malignant neoplasm, etc.), accession the case.

Example: The pathology report says: Prostate biopsy with markedly abnormal cells that are typical of adenocarcinoma. Accession the case.

Negative Example: The final diagnosis on the outpatient report reads: Rule out pancreatic cancer. Do not accession the case.

b. Discrepancies

i. Accession the case based on the reportable ambiguous term when there are reportable and non-reportable ambiguous terms in the medical record.

1) Do **not** accession a case when the original source document used a **non-reportable** ambiguous term and subsequent documents refer to history of cancer.

***Example*:** Report from the dermatologist is "possible melanoma." Patient admitted later for unrelated procedure and physician listed history of melanoma. Give priority to the information from the dermatologist and do not report this case. "Possible" is **not** a reportable ambiguous term. The later information is less reliable in this case.

ii. Accept the reportable term and accession the case when there is a single report in which both reportable and non-reportable terms are used.

***Example**:* Abdominal CT reveals a 1 cm liver lesion. "The lesion is consistent with hepatocellular carcinoma" appears in the discussion section of the report. The final diagnosis is "1 cm liver lesion, possibly hepatocellular carcinoma." Accession the case. "Consistent with" is a reportable ambiguous term. Accept "consistent with" over the non-reportable term "possibly."

Exception: Do **not** accession a case based ONLY on **suspicious** cytology.

Note: "Suspicious cytology" means any cytology report diagnosis that uses an ambiguous term, including ambiguous terms that are listed as reportable on the preceding page.

Follow back on cytology diagnoses using ambiguous terminology is strongly recommended.

Cytology refers to the microscopic examination of cells in body fluids obtained from aspirations, washings, scrapings, and smears; usually a function of the pathology department.

Important: Accession cases with cytology diagnoses that are positive for malignant cells.

c. Use the reportable ambiguous terms when **screening** diagnoses on pathology reports, operative reports, scans, mammograms, and other diagnostic testing with the exception of tumor markers.

i. Do not accession a case when resection, excision, biopsy, cytology, or physician's statement proves the ambiguous diagnosis is not reportable.

Example 1: Mammogram shows calcifications suspicious for intraductal carcinoma. The biopsy of the area surrounding the calcifications is negative for malignancy. Do not accession the case.

**Source: Adamo M, Dickie, L, Ruhl J. (January 2016). SEER Program Coding and Staging Manual 2016. National Cancer Institute, Bethesda, MD 20850-9765.*

Example 2: CT report states "mass in the right kidney, highly suspicious for renal cell carcinoma." CT-guided needle biopsy with final diagnosis "Neoplasm suggestive of oncocytoma. A malignant neoplasm cannot be excluded." Discharged back to the nursing home and no other information is available. Do not accession the case. The suspicious CT finding was biopsied and not proven to be malignant. "Suggestive of" is not a reportable ambiguous term.

Example 3: Stereotactic biopsy of the left breast is "focally suspicious for DCIS" and is followed by a negative needle localization excisional biopsy. Do not accession the case. The needle localization excisional biopsy was performed to further evaluate the suspicious stereotactic biopsy finding. The suspicious diagnosis was proven to be false.

Example 4: Esophageal biopsy with diagnosis of "focal areas suspicious for adenocarcinoma in situ." Diagnosis on partial esophagectomy specimen "with foci of high grade dysplasia; no invasive carcinoma identified." Do not accession the case. The esophagectomy proved that the suspicious biopsy result was false.

2. Benign and **borderline** primary **intracranial** and **CNS** tumors

a. Use the "Ambiguous terms that are reportable" list above to identify benign and borderline primary intracranial and CNS tumors that are reportable

b. If any of the reportable **ambiguous terms precede** either the word "**tumor**" or the word "**neoplasm**," accession the case

c. **Neoplasm** and **tumor** are **reportable** terms for brain and CNS because they are listed in ICD-O-3 with behavior codes of /0 and /1

d. **Mass and lesion are not reportable terms for brain and CNS because they are not listed in ICD-O-3 with behavior codes of /0 or /1**

Example: The mass on the CT scan is consistent with pituitary tumor. Accession the case.

e. **Discrepancies**

i. Accession the case based on the reportable ambiguous term when there are reportable and non-reportable ambiguous terms in the medical record

1. Do not accession a case when subsequent documents refer to history of tumor and the original source document used a **non-reportable** ambiguous term

2. Accept the reportable term and accession the case when there is a single report and one section of a report uses a reportable term such as "apparently" and another section of the same report uses a term that is not on the reportable list

Exception: Do not accession a case based ONLY on ambiguous **cytology** (the reportable term is preceded by an ambiguous term such as apparently, appears, compatible with, etc.).

f. Use these terms when **screening** diagnoses on pathology reports, scans, ultrasounds, and other diagnostic testing other than tumor markers

i. Do not accession the case when resection, excision, biopsy, cytology or physician's statement proves the ambiguous diagnosis is not reportable

**Source: Adamo M, Dickie, L, Ruhl J. (January 2016). SEER Program Coding and Staging Manual 2016. National Cancer Institute, Bethesda, MD 20850-9765.*

OVERVIEW OF CODING PRINCIPLES

UNIQUE PATIENT IDENTIFIER CODES

Accession Number (NAACCR Item #550) and *Sequence Number* (NAACCR Item #560) 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.
- Once cases are submitted to RQRS or the NCDB, accession numbers are not to be changed for any reason. Even if there is a clerical error, of if cases are found in an out-of-order fashion when case finding (i.e., find an old case after abstraction of a newer one), the accession number serves as a permanent identifier for a patient at your facility. NCDB does not accommodate any requests for accession number changes for cases already submitted.
- The sequence number is the sequence of all tumors over the lifetime of a patient and is counted throughout the patient's lifetime.
- Only tumors that would have been reportable at the time of diagnosis for CoC 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 was not cared for by the program or was not otherwise required to be accessioned. Because of differences in requirements, it is 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.

*When assigning sequence numbers, only count cases that are reportable to NHSCR. If your facility collects non-reportable cancers (e.g. CIS, PIN, etc.), assign the sequence pertinent to your facility *after* the case has been transmitted.

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 Section Two of this volume should be consulted for specific coding instructions.

The NPI data items are:

NPI–Archive FIN	*(NAACCR Item #3105)*
NPI–Following Physician	*(NAACCR Item #2475)*
NPI–Following Registry	*(NAACCR Item #2445)*
NPI–Institution Referred From	*(NAACCR Item #2415)*
NPI–Institution Referred To	*(NAACCR Item #2425)*
NPI–Managing Physician	*(NAACCR Item #2465)*
NPI–Physician #3	*(NAACCR Item #2495)*
NPI–Physician #4	*(NAACCR Item #2505)*
NPI–Primary Surgeon	*(NAACCR Item #2485)*
NPI–Reporting Facility	*(NAACCR Item #545)*

NHSCR requires the collection and transmission of the *National Provider Identifier --Reporting Facility* and *National Provider Identifier -- Managing Physician* when available.

CODING DATES

Beginning in 2010, the way dates are transmitted between facility registries and central registries or the National Cancer Data Base (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 a 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 of Most Definitive Surgical Resection of the Primary Site	Interoperable Date of Most Definitive Surgical Resection of the Primary Site	Rx Date Mst Defn Srg Flag
	Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999	Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown or not applicable.	
Full date known	MMDDCCYY (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

CANCER IDENTIFICATION

The following instructions apply to *Primary Site* (NAACCR Item #400), *Laterality* (NAACCR Item #410), *Histology* (NAACCR Item #522), *Behavior Code* (NAACCR Item #523),and *Grade/Differentiation* (NAACCR Item #440).

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 pp. 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 and lymphoid 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.

*Apply the Multiple Primary Rules in the SEER Hematopoietic and Lymphoid Neoplasm Coding Manual and Database at http://seer.cancer.gov/tools/heme/ .

Kaposi Sarcoma

- Code Kaposi sarcoma to the site in which it arises.
- Code to Skin, NOS (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 (eg, "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 chondrosarcoma 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

Laterality

Laterality (NAACCR Item #410) 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 can not develop midline tumors. For example, skin of the trunk can have a midline tumor, but the breasts can not.

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 (excluding diagnoses prior to 2004)
C71.0	Cerebrum (excluding diagnoses prior to 2004)
C71.1	Frontal lobe (excluding diagnoses prior to 2004)
C71.2	Temporal lobe (excluding diagnoses prior to 2004)
C71.3	Parietal lobe (excluding diagnoses prior to 2004)
C71.4	Occipital lobe (excluding diagnoses prior to 2004)
C72.2	Olfactory nerve (excluding diagnoses prior to 2004)
C72.3	Optic nerve (excluding diagnoses prior to 2004)
C72.4	Acoustic nerve (excluding diagnoses prior to 2004)
C72.5	Cranial nerve, NOS (excluding diagnoses prior to 2004)
C74.0–C74.9	Adrenal gland
C75.4	Carotid body

Morphology: Histology Code

The instructions for coding histology and behavior of solid tumors are found in the "Morphology" section of the **ICD-O-3** "Coding Guidelines for Topography and Morphology" (ICD-O-3 pp. 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 lymphatic histologies.

Morphology: Grade

The word "grade" is used to indicate several distinct continua of cellular variability in cancer. Cancer registries have collected *Grade/Differentiation* (NAACCR Item #440) for many years, and in recent years registrars have become familiar with other grade systems. These are coding instructions for **cases diagnosed 1/1/2014** and forward. For diagnoses prior to that date, consult the applicable **FORDS** edition based on the diagnosis date of the cancer.

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.

Coding Grade for Hematopoietic and Lymphoid Neoplasms

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

   [http://seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules/].
2. **Determine the Cell Indicator by applying the "Grade of Tumor Rules" within the current Hematopoietic and Lymphoid Neoplasm Manual [http://seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules/] 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 (8020/34)
Carcinoma, anaplastic (8021/34)
Follicular adenocarcinoma, well differentiated (8331/31)
Thymic carcinoma, well differentiated (8585/31)
Sertoli-Leydig cell tumor, poorly differentiated (8631/33)
Sertoli-Leydig cell tumor, poorly differentiated with heterologous elements (8634/33)
Undifferentiated sarcoma (8805/34)
Liposarcoma, well differentiated (8851/31)
Seminoma, anaplastic (9062/34)
Malignant teratoma, undifferentiated (9082/34)
Malignant teratoma, intermediate type (9083/32)
Intraosseous osteosarcoma, well differentiated (9187/31)
Astrocytoma, anaplastic (9401/34)
Oligodendroglioma, anaplastic (9451/34)
Retinoblastoma, differentiated (9511/31)
Retinoblastoma, undifferentiated (9512/34)

***SEER Note:** Code grade from the time of the initial diagnosis. Do not code grade from recurrence or progression.

Example: Prostate carcinoma Gleason score 2+3 per biopsies. Watchful waiting for one year. One year later, score of 4+3 per second biopsies. Surgery performed and the Gleason score is 7. Code the grade based on the original Gleason score of 2+3.

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 the 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 & 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) 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. 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.

Historic Perspective

Gleason score	Description					
	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**

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.

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 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* of ***FORDS Revised for 2011*** 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. 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*

*If a completed definitive case is revised as a result of additional information becoming available, submit a revised abstract to the NHSCR with a notation referencing the revision. Additional instructions are provided on page 16A.

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 or histology 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.

Example 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),

Changing Information on the Abstract*

The information originally collected on the abstract should be changed or modified under the following circumstances.

1. To correct coding or abstracting errors (for example, errors found during quality control activities)

2. When clarifications or rule changes retroactively affect data item code.
   Example: SEER adds codes to a data item and asks the registries to review a set of cases and update using the new codes.

3. When better information is available later
   Example 1: Consults from specialty labs, pathology report addendums or comments or other information have been added to the chart. Reports done during the diagnostic workup and placed on the chart after the registrar abstracted the information may contain valuable information. Whenever these later reports give better information about the histology, grade of tumor, primary site, etc., change the codes to reflect the better information.

   Example 2: The primary site was recorded as unknown at the time of diagnosis. At a later date, the physician determines that the cancer is primary to the testis. Change the primary site from unknown to testis.

   Example 3: The original diagnosis was in situ. Metastases are diagnosed at a later date. Change the behavior code for the original diagnosis from in situ to invasive when no new primary has been diagnosed in the interim.

   Example 4: Patient seen in Hospital A. The pathologic diagnosis was negative for malignancy. Patient goes to Hospital B and the slides from Hospital A are re-read. The diagnosis at Hospital B is reportable. Hospital B sends their slide report back to Hospital A. Hospital A reports the case based on the info from Hospital B. Enter supporting documentation in a text field.

4. When the date of diagnosis is confirmed in retrospect to be earlier than the original date abstracted
   Example: Patient has surgery for a benign argentaffin carcinoid (8240/1) of the sigmoid colon in May 2015. In January 2016 the patient is admitted with widespread metastasis consistent with malignant argentaffin carcinoid. The registrar accessions the malignant argentaffin carcinoid as a 2016 diagnosis. Two months later, the pathologist reviews the slides from the May 2015 surgery and concludes that the carcinoid diagnosed in 2015 was malignant. Change the date of diagnosis to May 2015 and histology to 8241 and the behavior code to malignant (/3).

Cases must be retransmitted to the NHSCR if a change is made *after* the completed cases have already been transmitted.

**Source: Adamo M, Dickie, L, Ruhl J. (January 2016). SEER Program Coding and Staging Manual 2016. National Cancer Institute, Bethesda, MD 20850-9765.*

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.

Example 2
A physician decides 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 registry 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 database. Adjust the sequence number(s) of any other primaries the patient may have. If the deleted case is the patient's only primary, do not reuse the accession number.

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.
Current Address is not required by NHSCR.

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." State Vital Statistics rules may differ from Census rules. Do not record residence from the death certificate. Review each case carefully.

Collect the street address of usual residence as stated by the patient. When PO Box is the only address available, record UNKNOWN for address at diagnosis, and record the PO Box address in the address supplemental data field.

Rules for Persons with Ambiguous Residences

Persons with More than One Residence (summer and winter homes): Use the address the patient specifies if a usual residence is not apparent.

Persons with No Usual Residence (transients, homeless): Use the address of the place the patient was staying when the cancer was diagnosed. This location may 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 classification 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.

Coding Country and State

Beginning in 2013, "country" fields accompany "state" fields in addresses. The following state and country address data items are found in **FORDS**:

State at Diagnosis (not changed)
Addr at Diagnosis--Country (new item, associated with *State at Diagnosis*)
State—Current (not changed)
Address Current – Country (new item, associated *with State—Current*)
Place of Birth (discontinued, replaced by *Birthplace—State* and *Birthplace—Country*)
Birthplace—State (new item, coded similarly to the other two "state" fields)
Birthplace—Country (new item, associated with *Birthplace—State*)

Appendix E has a list of all country codes and corresponding state codes. State codes for all U.S. states and possessions and all Canadian provinces are included in Appendix E. State codes for the United States and its possessions are those used by the United States Postal Service. Canadian province or territory codes are from Canada Post sources. Country codes are based on the International Standards Organization (IS) 3166-1 Country Three Character Codes. State and country codes also include some custom codes, which are included in Appendix E.

The list in Appendix E is divided into three parts.

- The first part is the preferred codes to use when sufficient detail is known to identify the U.S. state, Canadian province, or other country to assign precise codes.
- The second part consists of codes for more general regions for use when a precise code can not be assigned (for example, "Near East"). If there is no indication at all of location in the patient record, the country is coded ZZU and the state will be ZZ.
- The third section is a list of obsolete codes that may have been assigned when the registry data were upgraded from former codes. This information is provided to assist registries in interpreting their historic data, but the obsolete codes must not be assigned for current abstracting.

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 rule to the date the baby was born. The exact date may be used for cases diagnosed prior to 2009. Diagnoses made in utero are reportable only when the pregnancy results in a live birth. In the absence of documentation of stillbirth, abortion, or fetal death, assume there was a live birth and report the case.

COMORBIDITIES AND COMPLICATIONS / SECONDARY DIAGNOSES*

The CoC requires that the registry record include 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 or Tenth Revision, Clinical Modification (ICD-9-CM or ICD-10-CM)** code form, typically on the patient's discharge abstract or face sheet of the billing record. Most hospitals in the United States are expected to implement use of ICD-10-CM in 2015. Separate data item series are used to record the two series. ICD-10-CM codes can have up to 7 characters, whereas ICD-9-CM codes only have 5 characters or fewer. Both the specific codes and the rules for recording them differ. The underlying meanings of the codes are similar. That is, the concepts originally described as "comorbidities and complications" are also known as "secondary diagnoses"; in this instance, the separate names are given to distinguish the separate registry data items.

The items describing patient comorbid conditions and complications ICD-9-CM codes are:

Comorbidities and Complications #1 (NAACCR Item #3110)
Comorbidities and Complications #2 (NAACCR Item #3120)

*Effective with cases diagnosed January 1, 2010, the recording of *Comorbidities and Complications* or *Secondary Diagnosis* is required by NHSCR.

Comorbidities and Complications #3 (NAACCR Item #3130)
Comorbidities and Complications #4 (NAACCR Item #3140)
Comorbidities and Complications #5 (NAACCR Item #3150)
*Comorbidities and Complications #6 (*NAACCR Item #3160)
*Comorbidities and Complications #7 (*NAACCR Item #3161)
*Comorbidities and Complications #8 (*NAACCR Item #3162)
*Comorbidities and Complications #9 (*NAACCR Item #3163)
Comorbidities and Complications #10 (NAACCR Item #3164)

The items describing patient comorbid secondary diagnoses ICD-10-CM codes are:

Secondary Diagnosis #1 (NAACCR Item #3780)
Secondary Diagnosis #2 (NAACCR Item #3782)
Secondary Diagnosis #3 (NAACCR Item #3784)
Secondary Diagnosis #4 (NAACCR Item #3786)
Secondary Diagnosis #5 (NAACCR Item #3788)
Secondary Diagnosis #6 (NAACCR Item #3790)
Secondary Diagnosis #7 (NAACCR Item #3792)
Secondary Diagnosis #8 (NAACCR Item #3794)
Secondary Diagnosis #9 (NAACCR Item #3796)
Secondary Diagnosis #10(NAACCR Item #3798)

*Effective with cases diagnosed January 1, 2010, the recording of *Comorbidities and Complications* or *Secondary Diagnosis* is required by NHSCR.

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 postmenopausal 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.

STAGE OF DISEASE AT INITIAL DIAGNOSIS

Surgical Diagnostic and Staging Procedures

Surgical Diagnostic and Staging Procedure (NAACCR Item #1350) and *Surgical Diagnostic and Staging Procedure at This Facility* (NAACCR Item #740) refer solely to surgical procedures performed specifically for diagnosis or staging of the tumor and do not apply to surgical treatment. *Date of Surgical Diagnostic and Staging Procedure* (NAACCR Item #1280) 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 *Surgical Diagnostic and Staging Procedure* (NAACCR Item #1350). Use the data item *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292) 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 Surgical*

Diagnostic and Staging Procedure (NAACCR Item #1280). Record the date of this surgical procedure in the data item *Date of First Course of Treatment* (NAACCR Item #1270) and/or *Date of First Surgical Procedure* (NAACCR Item #1200), as appropriate.

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. 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.

- NHSCR requires both AJCC and SEER Summary Stage on all cases diagnosed prior to year 2004.
- Use coding rules from the AJCC manual that was effective for the specific diagnosis year.
- Collaborative Stage should be used for all cases diagnosed 2004 - 2015.
- AJCC Staging is also required for breast and colorectal cancers diagnosed in year 2011 forward.
- Effective with diagnosis year 2015, all cases must be manually staged using both AJCC and SEER Summary Stage.

The AJCC items that must be coded for Class of Case 10–22 are:

Clinical T (NAACCR Item #940)
Clinical N (NAACCR Item #950)
Clinical M (NAACCR Item #960)
Clinical Stage Group (NAACCR Item #970)
Clinical Stage (Prefix/Suffix) Descriptor (NAACCR Item #980)
Staged By (Clinical Stage) (NAACCR Item #990)
Pathologic T (NAACCR Item #880)
Pathologic N (NAACCR Item #890)
Pathologic M (NAACCR Item #900)
Pathologic Stage Group (NAACCR Item #910)
Pathologic Stage (Prefix/Suffix) Descriptor (NAACCR Item #920)
Staged By (Pathologic Stage) (NAACCR Item #930)

- 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 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 and will be expanded with the implementation of the AJCC 8th Edition Manual. For example, the new category of cN0 for the TNM Path N [890] data item is limited to in situ tumors only in 2016.

Ambiguous Terminology *

*There is a difference between ambiguous terms that constitute a diagnosis and ambiguous terms describing tumor spread. Clarification is provided on page 21A.

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

Ambiguous Terms Describing Tumor Spread

Terms that Constitute Tumor Involvement or Extension		Terms that *Do Not* Constitute Tumor Involvement or Extension
Adherent	Into	Approaching
Apparent	Onto	Equivocal
Compatible with	Out onto	Possible
Consistent with	Probable	Questionable
Encroaching upon	Suspect	Suggests
Fixation, fixed	Suspicious	Very close to
Induration	To	

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 FORDS are required to be completed for *Class of Case* 00-22. See the interactive application at http://seer.cancer.gov/csreqstatus/application.html for the specific Site-Specific Factors required by CoC 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 are continued to be required for AJCC staffing and research purposes. They are required for all cases diagnosed in 2004 and later:

- Regional Nodes Positive [820]
- Regional Nodes Examined [830]
- Lymph-vascular Invasion [1182]
- CS Site-specific Factors [2861-2880, 2890-2930]
- CS Version Input Original [2935]
- CS Version Input Current [2937]

Note: CoC's requirements for the 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 SSFs.

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 directly-assigned AJCC data items. 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

NAACCR Member ListServ <NAACCR-LSERV@LISTSERV.NAACCR.ORG> on behalf of Kathleen Thoburn <kthoburn@FACS.ORG>

Thu 4/28/2016 2:35 PM

To:NAACCR-LSERV@LISTSERV.NAACCR.ORG <NAACCR-LSERV@LISTSERV.NAACCR.ORG>;

Ambiguous Terminology Lists: References of Last Resort

The purpose of this communication is to clarify the use of Ambiguous Terminology as listed in *FORDS: Revised for 2016* for case reportability and staging in Commission on Cancer (CoC)-accredited programs. When abstracting, registrars are to use the "Ambiguous Terms at Diagnosis" list with respect to case reportability, and the "Ambiguous Terms Describing Tumor Spread" list with respect to tumor spread for staging purposes. However, these lists need to be used correctly.

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

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

Sincerely,

Kathleen K. Thoburn, CTR
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For information on the NCDB Call for Data:
https://www.facs.org/quality-programs/cancer/ncdb/datasub/registrars

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.

FIRST COURSE OF 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 *RX Summ–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 clinic 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-accredited hospital 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* (NAACCR Item #1270) is the earliest of *Date of First Surgical Procedure* (NAACCR Item #1200), *Date Radiation Started* (NAACCR Item #1210), *Date Systemic Therapy Started* (NAACCR Item #3230), or *Date Other Treatment Started* (NAACCR Item #1250).

- 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 the patient died before treatment could be given.
- 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, *RX Summ–Treatment Status* (NAACCR Item #1285), 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.

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.

Individual item descriptions in Section Two of this manual should be consulted for specific coding instructions. The paragraphs below describe how the surgery items fit together.

The following summary items apply to all surgical procedures performed at this facility and at other facilities:

Surgical Procedure of Primary Site (NAACCR Item #1290)
Radiation/Surgery Sequence (NAACCR Item #1380)
Scope of Regional Lymph Node Surgery (NAACCR Item #1292)
Surgical Procedure/Other Site (NAACCR Item #1294)
Surgical Margins of the Primary Site (NAACCR Item #1320)
Reason for No Surgery of Primary Site (NAACCR Item #1340)
Date of First Surgical Procedure (NAACCR Item #1200)
RX Date–Surgery Flag (NAACCR Item #1201)
Date of Most Definitive Surgical Resection of the Primary Site (NAACCR Item #3170)
RX Date Mst Defn Srg Flag (NAACCR Item #3171)
Date of Surgical Discharge (NAACCR Item #3180)
RX Date Surg Disch Flag (NAACCR Item #3181)
Readmission to the Same Hospital Within 30 Days of Surgical Discharge (NAACCR Item #3190)

NHSCR collects ALL surgical procedures of a primary site. Registries with software allowing for multiple treatments to be coded, code ALL surgical procedures performed.

The following items apply to surgical procedures performed at this facility:

Surgical Procedure of Primary Site at This Facility (NAACCR Item #670)
RX Hosp–Surg App 2010 (NAACCR Item #668)
Scope of Regional Lymph Node Surgery at This Facility (NAACCR Item #672)
Surgical Procedure/Other Site at This Facility (NAACCR Item #674)

Relationships among Surgical Items

Date of First Surgical Procedure is the date that the first *Surgical Procedure of Primary Site*, *Scope of Regional Lymph Node Surgery*, or *Surgical Procedure/Other Site* is 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 First Surgical Procedure* 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.

Surgical Procedure 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.

- *Surgical Procedure 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 as well as removal of nodes for treatment of the disease.

- *Surgical Procedure/Other Site* describes first course resection of distant lymph node(s) and/or regional or distant tissue or organs beyond the *Surgical Procedure of the 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 site-specific *Surgical Procedure 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 nonprimary site. *Surgical Procedure of Primary Site* 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.

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 surgical 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.

Surgical Procedure of Primary Site at This Facility, Scope of Regional Lymph Node Surgery at This Facility, and *Surgical Procedure/Other Site at This Facility* are identical to *Surgical Procedure of Primary Site, Scope of Regional Lymph Node Surgery,* and *Surgical Procedure/Other Site*, respectively, except they each refer solely to surgery provided by the respective facility.
NHSCR collects ALL surgical procedures. Registries are to code procedures done both at their facility and elsewhere.
Six surgery items augment the information recorded in *Surgical Procedure of Primary Site.* The items *Date of Most Definitive Surgical Resection of the Primary Site, Surgical Margins of the Primary Site, Date of Surgical Discharge,* and *Readmission to the Same Hospital Within 30 Days of Surgical Discharge* apply to the most definitive (most invasive) first course primary site surgery performed, that is, to the event recorded under *Surgical Procedure of Primary Site*. When no surgical procedure of the primary site is performed, the reason is recorded in the item *Reason for No Surgery of Primary Site*.

- *Date of Most Definitive Surgical Resection* is the date on which the specific procedure recorded in *Surgical Procedure 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*.

- *Surgical Margins of the Primary Site* 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 *Surgical Procedure of Primary Site*.

- *RX Hosp–Surg App 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.

- *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*.

- *Readmission to the Same Hospital Within 30 Days of Surgical Discharge* distinguishes a 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.

The following summary items apply to all radiation therapy administered at this facility and at other facilities:

Date Radiation Started (NAACCR Item #1210)
RX Date–Radiation Flag (NAACCR Item #1211)
Location of Radiation Treatment (NAACCR Item #1550)
Radiation Treatment Volume (NAACCR Item #1540)
Regional Treatment Modality (NAACCR Item #1570)
Regional Dose: cGy (NAACCR Item #1510)
Boost Treatment Modality (NAACCR Item #3200)
Boost Dose: cGy (NAACCR Item #3210)
Number of Treatments to This Volume (NAACCR Item #1520)
Radiation/Surgery Sequence (NAACCR Item #1380)
Date Radiation Ended (NAACCR Item #3220)
RX Date Rad Ended Flag (NAACCR Item #3221)
Reason for No Radiation (NAACCR Item #1430)

Refer to the *NHSCR Table of Required Data Items* in *Section Two* for a list of required data items.

Relationships among Radiation Items

Date Radiation Started is the date that the first radiation therapy was delivered to the patient as part of all of 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 Radiation Started* 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 be followed by brachytherapy to provide the boost dose.

- Not all patients who receive radiation therapy receive a boost dose radiation. For these cases, boost 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 in ***FORDS*** separate the administration of systemic agents or drugs from medical procedures which affect the hormonal or immunologic balance of the patient.

The following summary items apply to all systemic therapy administered at this facility and at other facilities:

Date Systemic Therapy Started (NAACCR Item #3230)
RX Date Systemic Flag (NAACCR Item #3231)
Date Chemotherapy Started (NAACCR Item #1220)
RX Date–Chemo Flag (NAACCR Item #1221)
Date Hormone Therapy Started (NAACCR Item #1230)
RX Date–Hormone Flag (NAACCR Item #1231)
Date Immunotherapy Started (NAACCR Item #1240)
RX Date BRM Flag (NAACCR Item #1241)
Systemic/Surgery Sequence (NAACCR Item #1639)
Chemotherapy (NAACCR Item #1390)
Hormone Therapy (NAACCR Item #1400)

Refer to the *NHSCR Table of Required Data Items* in *Section Two* for a list of required data items.

Immunotherapy (NAACCR Item #1410)
Hematologic Transplant and Endocrine Procedures (NAACCR Item #3250)

The following items describe systemic therapy performed at this facility:

Chemotherapy at This Facility (NAACCR Item #700)
Hormone Therapy at This Facility (NAACCR Item #710)
Immunotherapy at This Facility (NAACCR Item #720)

Clarification of Systemic Therapy Terms	
Term	**Definition**
Chemotherapy	Cancer therapy that achieves its antitumor 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 antitumor effect through changes in hormonal balance. This type of therapy includes the administration of hormones, agents acting via hormonal mechanisms, antihormones, and steroids.
Immunotherapy	Cancer therapy that achieves its antitumor effect by altering the immune system or changing the host's response to the tumor cells.
Endocrine therapy	Cancer therapy that achieves its antitumor effect through the use of radiation or surgical procedures that suppress the naturally occurring hormonal activity of the patient (when the cancer occurs at another site) 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 and hormone therapy 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 (for example, 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 Started* 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 *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.

Hematologic Transplant and Endocrine Procedures 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 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.

The following items apply to all Other Treatment provided at this facility and at other facilities:

Date Other Treatment Started (NAACCR Item #1250)
RX Date–Other Flag (NAACCR Item #1251)
Other Treatment (NAACCR Item #1420)
Other Treatment at This Facility (NAACCR Item #730)

Refer to the *NHSCR Table of Required Data Items* in *Section Two* for a list of required data items.

Palliative Care

Palliative care is provided to prolong the patient's life by controlling symptoms, to alleviate persistent pain, or to make the patient 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.

The following items apply to all palliative care provided at this facility and at other facilities:

Palliative Care (NAACCR #3270)
Palliative Care at This Facility (NAACCR Item #3280)

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 of 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.*

*Example: A patient with stage IV prostate cancer has painful bone metastases. Radiation is given to shrink the bone tumor and relieve the pain. The radiation is palliative, but also is first course treatment because it destroys proliferating cancer tissue.

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. *NOTE: If radiation also shrinks the tumor, it is coded in both Palliative Care data items and radiation treatment fields.

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 procedure permits a higher concentration of drug to be in contact with the tumor for a longer period of time. Code chemoembolization as *Chemotherapy* when the 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/registrars/)* 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 Therapy*.

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 Therapy* (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 presurgical embolization of hypervascular tumors with particles, coils or alcohol. These presurgical embolizations are typically performed to make the resection of the primary tumor easier. Examples where presurgical embolization is used include meningiomas, hemangioblastomas, paragangliomas, and renal cell metastases in the brain.

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 Class of Case 10-22 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 item descriptions in Section Two of this manual 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:

*NHSCR requires follow-up only for breast and colorectal cancers diagnosed in year 2011 regardless of class of case. All other cancer no longer need to be followed after initial diagnosis and first course treatment has been reported.

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 *Surgical Procedure of Primary Site* (NAACCR Item #1290) is delayed six months or more following the *Date of First Contact* (NAACCR Item #580).

- *Readmission to the Same Hospital Within 30 Days of Surgical Discharge* (NAACCR Item #3190) 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.

- The CoC does not require Class 00 cases to be followed.

*If a completed definitive case is revised as a result of additional information becoming available, submit a revised abstract to the NHSCR with a notation referencing the revision. Additional instructions are provided on page 16A.

- 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* (NAACCR Item #1880) 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 the 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.

- Definition

  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

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:

Patient Address–Current (NAACCR Item #2350)
City/Town–Current (NAACCR Item #1810)
State–Current (NAACCR Item #1820)
Postal Code–Current (NAACCR Item #1830)
Telephone (NAACCR Item #2360)
Date of Last Contact (NAACCR Item #1750)
Follow-Up Source, (NAACCR Item #1790)
Next Follow-Up Source (NAACCR Item #1800).

Refer to the *NHSCR Table of Required Data Items* in *Section Two* for a list of required data items.

Follow-up for *Vital Status* (NAACCR Item #1760) and *Cancer Status* (NAACCR Item #1770) should be conducted annually for all analytic cases in the cancer program's registry. *Class of Case* 00 patients that are not followed will have the most recent information as of the *Date of Last Contact*.

Once the patient's death has been recorded and all care given prior to death is 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 facility analysis.

Administrative Tracking

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

Abstracted By (NAACCR Item #570) *
Facility Identification Number (*FIN)* (NAACCR Item #540)
NPI-Reporting Facility (NAACCR Item #545)
Archive FIN (NAACCR Item #3100)
*NPI-Archive FIN (*NAACCR Item #3105)

Abstracted By, Facility Identification Number (FIN), and *NPI-Reporting Facility* identify the individual and facility responsible for compiling the record. *Archive FIN* and *NPI-Archive FIN* store the identification numbers assigned to the original abstracting facility and are used to convey the original identity assigned to a facility that has since merged with another. In a registry with more than one abstractor or serving more than one facility, it will ordinarily be necessary to enter these three numbers only when they change. All of these items should be autocoded by the registry software.

*In a registry with more than one abstractor, *Abstracted By* should reflect the abstractor who completed the case.

Note: A complete list of FINs is available on the American College of Surgeons Web site 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://nppes.cms.hhs.gov/NPPES/Welcome.do.

EDITS Overrides

Some of the CoC 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, do not make an override entry. 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 for 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.

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

Override Acsn/Class/Seq (NAACCR Item #1985)
Override Age/Site/Morph (NAACCR Item #1990)
Override CoC– Site/Type (NAACCR Item #1987)
Override Site/Type (NAACCR Item #2030)
Override Histology (NAACCR Item #2040)
Override Leuk/Lymphoma (NAACCR Item #2070)
Override Site/Behavior (NAACCR Item #2071)
Override Site/Lat/Morph (NAACCR Item #2074)
Override HospSeq/DxConf (NAACCR Item #1986)
Override HospSeq/Site (NAACCR Item #1988)

The NHSCR highly recommends that registries put their data through edits before submission. The use of override depends on how and whether the standard NAACCR edits and/or the EDITS software have been integrated into the registry software.

Override Site/TNM-StgGrp (NAACCR Item #1989)
Override Surg/DxConf (NAACCR Item #2020)
Over-ride CS 1-19 (NAACCR Items #3750-3768)

Code Versions Used

Fifteen items describe the version of codes applied to record information in the registry record. Because registries cover many years of cases, registry data will be recorded according to many different coding systems. These items are necessary for the analysis of registry data and for further conversions, so it is important that they be maintained accurately.

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

CoC Coding System–Current (NAACCR Item #2140)
CoC Coding System–Original (NAACCR Item #2150)
Race Coding System–Current (NAACCR Item #170)
Race Coding System–Original (NAACCR Item #180)
Site Coding System–Current (NAACCR Item #450)
Site Coding System–Original (NAACCR Item #460)
Morphology Coding System–Current (NAACCR Item #470)
Morphology Coding System–Original (NAACCR Item #480)
ICD-O-2 Conversion Flag (NAACCR Item #1980)
ICD-O-3 Conversion Flag (NAACCR Item #2116)
TNM Edition Number (NAACCR Item #1060)
RX Coding System–Current (NAACCR Item #1460)
CS Version Input Original (NAACCCR Item #2935)
CS Version Input Current (NAACCR Item #2937)
CS Version Derived (NAACCR Item # 2936; for cases diagnosed 2004 through 2015)

All of these items are capable of being autocoded. Registry software operations differ, but typically the registrar will need to update the version of CoC codes, race coding system, site coding system, and morphology coding system whenever it changes.

For newly abstracted cases, code version information will be applied both as the current and original code versions. When registry data are converted to an updated version for a coding system, the code for the current version should be updated automatically by the conversion.

It is not possible to convert from one version of AJCC TNM to another. The registrar should ascertain that the correct version number is recorded for autocoding.

RX Coding System–Current identifies whether the treatment information was recorded using CoC rules or SEER rules and the version of each applied. The CoC requires that the *FORDS* manual be followed for all cases diagnosed January 1, 2003, or later (*RX Coding System–Current* = 06).

The *ICD-O-3 Conversion Flag* identifies how conversion from ICD-O-2 to ICD-O-3 was accomplished, and the *ICD-O-2 Conversion Flag* identifies how conversion from ICD-O-1 to ICD-O-2 was accomplished. Both should be autocoded at the time of conversion. If the results of either conversion were verified by review for some cases, the conversion flag will need to be updated to indicate that the case was reviewed.

SECTION TWO:
Instructions for Coding

At a minimum, reporting facilities must collect the NHSCR required data items.

New Hampshire State Cancer Registry
Table of Required Data Items

Code Description

R = Required
R* = Required, when available
R# = Required, SEER or CoC
RH = Historically collected and currently transmittec
RH* = Historically collected & transmitted when available
RS = Required, site-specific
RC = Collected by SEER from CoC-approved hospitals
S = Supplemental/recommended
D = Derived
DH = Historically derived and currently transmittec

Revised data items highlighted in blue.

Required data items are in accordance with RSA 141B and part He-P 304.0 of the New Hampshire Administrative Rules.

Source: Thornton ML, (ed). Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Record Layout Version 16, 20th ed. Springfield, Ill.: North American Association of Central Cancer Registries, September 2015, revised October 2015, revised November 2015.

Item #	Item Name	NHSCR	NPCR	COC	SEER	Source of Standard	Section Name	Notes
10	Record Type	R	R	R	R	NAACCR	Record ID	Auto-coded by software
20	Patient ID Number	R	R	.	R	Reporting	Record ID	Auto-coded by software
21	Patient System ID-Hosp	.	.	.	.	NAACCR	Record ID	
30	Registry Type	.	.	.	.	NAACCR	Record ID	
37	Reserved 00						Record ID	
40	Registry ID	R	R	.	R	NAACCR	Record ID	Auto-coded by software
45	NPI--Registry ID	R	.	.	R*	CMS	Record ID	Auto-coded by software
50	NAACCR Record Version	R	R	R	R	NAACCR	Record ID	Auto-coded by software
60	Tumor Record Number	S	.	.	S	NAACCR	Record ID	Central registry use only
70	Addr at DX--City	R	R	R	R	CoC	Demographic	
80	Addr at DX--State	R	R	R	R	CoC	Demographic	
90	County at DX	R	R	R	R	FIPS/SEER	Demographic	
94	County at DX Geocode1990	D	D	.	R	NAACCR	Demographic	New; Central registry use only
95	County at DX Geocode2000	D	D	.	R	NAACCR	Demographic	New; Central registry use only
96	County at DX Geocode2010	D	D	.	R	NAACCR	Demographic	New; Central registry use only
97	County at DX Geocode2020	D	.	.	R	NAACCR	Demographic	New; Central registry use only
100	Addr at DX--Postal Code	R	R	R	R	CoC	Demographic	
102	Addr at DX--Country	R	.	R	R	NAACCR	Demographic	
110	Census Tract 1970/80/90	RH	RH*	.	RH	SEER	Demographic	Central registry use only
120	Census Cod Sys 1970/80/90	RH	RH*	.	RH	SEER	Demographic	Central registry use only
130	Census Tract 2000	RH	RH	.	RH	NAACCR	Demographic	Central registry use only
135	Census Tract 2010	R	R	.	R	NAACCR	Demographic	Central registry use only; New; For cases diagnosed 2011+
145	Census Tr Poverty Indictr	R	R	.	R	NAACCR	Demographic	
150	Marital Status at DX	R	.	.	R	SEER	Demographic	
160	Race 1	R	R	R	R	SEER/CoC	Demographic	
161	Race 2	R	R	R	R	SEER/CoC	Demographic	May be auto-coded by software
162	Race 3	R	R	R	R	SEER/CoC	Demographic	May be auto-coded by software

Item #	Item Name	NHSCR	NPCR	COC	SEER	Source of Standard	Section Name	Notes
163	Race 4	R	R	R	R	SEER/CoC	Demographic	May be auto-coded by software
164	Race 5	R	R	R	R	SEER/CoC	Demographic	May be auto-coded by software
170	Race Coding Sys--Current	R	.	R	.	NAACCR	Demographic	May be auto-coded by software
180	Race Coding Sys--Original	R	.	R	.	NAACCR	Demographic	May be auto-coded by software
190	Spanish/Hispanic Origin	R	R	R	R	SEER/CoC	Demographic	
191	NHIA Derived Hisp Origin	D	D	.	R	NAACCR	Demographic	Central registry use only
192	IHS Link	R	R*	.	R	NPCR	Demographic	Central registry use only
193	Race--NAPIIA(derived API)	R	R	.	R	NAACCR	Demographic	Central registry use only
200	Computed Ethnicity	R	R	.	R	SEER	Demographic	Central registry use only
210	Computed Ethnicity Source	R	R	.	R	SEER	Demographic	Central registry use only
220	Sex	R	R	R	R	SEER/CoC	Demographic	
230	Age at Diagnosis	R	R	R	R	SEER/CoC	Demographic	
240	Date of Birth	R	R	R	R	SEER/CoC	Demographic	
241	Date of Birth Flag	R	R	R	R	NAACCR	Demographic	
250	Birthplace	RH*	RH*	.	.	SEER/CoC	Demographic	
252	Birthplace--State	R	R*	R	R	NAACCR	Demographic	
254	Birthplace--Country	R	R*	R	R	NAACCR	Demographic	
270	Census Occ Code 1970-2000	R*	R*	.	.	Census/NPCR	Demographic	Central registry use only
272	Census Ind Code 2010 CDC	R*	R*	.	.	Census/NPCR	Demographic	Revised; Central registry use only
280	Census Ind Code 1970-2000	R*	R*	.	.	Census/NPCR	Demographic	Central registry use only
282	Census Occ Code 2010 CDC	R*	R*	.	.	Census/NPCR	Demographic	Revised; Central registry use only
290	Occupation Source	R*	R*	.	.	NPCR	Demographic	Central registry use only
300	Industry Source	R*	R*	.	.	NPCR	Demographic	Central registry use only
310	Text--Usual Occupation	R	R*	.	.	NPCR	Demographic	
320	Text--Usual Industry	R	R*	.	.	NPCR	Demographic	
330	Census Occ/Ind Sys 70-00	R*	R*	.	.	NPCR	Demographic	Central registry use only
362	Census Block Group 2000	S	.	.	S	Census	Demographic	Central registry use only
363	Census Block Group 2010	R	.	.	R	Census	Demographic	Central registry use only
364	Census Tr Cert 1970/80/90	RH	RH*	.	RH	SEER	Demographic	Central registry use only
365	Census Tr Certainty 2000	RH	RH	.	RH	NAACCR	Demographic	Central registry use only
366	GIS Coordinate Quality	R	R*	.	S	NAACCR	Demographic	Central registry use only
367	Census Tr Certainty 2010	R	R	.	R	NAACCR	Demographic	Central registry use only
368	Census Block Grp 1970-90	S	.	.	S	Census	Demographic	Central registry use only
370	Reserved 01						Record ID	
380	Sequence Number--Central	R	R	.	R	SEER	Cancer Identification	Central registry use only
390	Date of Diagnosis	R	R	R	R	SEER/CoC	Cancer Identification	
391	Date of Diagnosis Flag	R	R	.	R	NAACCR	Cancer Identification	
400	Primary Site	R	R	R	R	SEER/CoC	Cancer Identification	
410	Laterality	R	R	R	R	SEER/CoC	Cancer Identification	
419	Morph--Type&Behav ICD-O-2	.	.	.	.		Cancer Identification	
420	Histology (92-00) ICD-O-2	RH	RH	RH	RH	SEER/CoC	Cancer Identification	For cases diagnosed 1992-2000
430	Behavior (92-00) ICD-O-2	RH	RH	RH	RH	SEER/CoC	Cancer Identification	For cases diagnosed 1992-2000
439	Date of Mult Tumors Flag	RH	.	RH	RH	NAACCR	Cancer Identification	
440	Grade	R	R	R	R	SEER/CoC	Cancer Identification	

Item #	Item Name	NHSCR	NPCR	COC	SEER	Source of Standard	Section Name	Notes
441	Grade Path Value	RH	RH*	RH	RH	AJCC	Cancer Identification	Revised
442	Ambiguous Terminology DX	RH	.	RH	RH	SEER	Cancer Identification	For cases diagnosed 2007-2012
443	Date Conclusive DX	RH	.	RH	RH	SEER	Cancer Identification	For cases diagnosed 2007-2012
444	Mult Tum Rpt as One Prim	RH	.	RH	RH	SEER	Cancer Identification	For cases diagnosed 2007-2012
445	Date of Mult Tumors	RH	.	RH	RH	SEER	Cancer Identification	For cases diagnosed 2007-2012
446	Multiplicity Counter	RH	.	RH	RH	SEER	Cancer Identification	For cases diagnosed 2007-2012
448	Date Conclusive DX Flag	RH	.	RH	RH	NAACCR	Cancer Identification	For cases diagnosed 2007-2012
449	Grade Path System	RH	RH*	RH	RH	AJCC	Cancer Identification	Revised
450	Site Coding Sys--Current	R	R	R	.	NAACCR	Cancer Identification	Auto-coded by software
460	Site Coding Sys--Original	R	.	R	.	NAACCR	Cancer Identification	Auto-coded by software
470	Morph Coding Sys--Current	R	R	R	.	NAACCR	Cancer Identification	Auto-coded by software
480	Morph Coding Sys--Originl	R	.	R	.	NAACCR	Cancer Identification	Auto-coded by software
490	Diagnostic Confirmation	R	R	R	R	SEER/CoC	Cancer Identification	
500	Type of Reporting Source	R	R	.	R	SEER	Cancer Identification	
501	Casefinding Source	R	R*	.	.	NAACCR	Cancer Identification	For cases diagnosed 2006+
521	Morph--Type&Behav ICD-O-3	.	.	.	.		Cancer Identification	
522	Histologic Type ICD-O-3	R	R	R	R	SEER/CoC	Cancer Identification	For cases diagnosed 2001+
523	Behavior Code ICD-O-3	R	R	R	R	SEER/CoC	Cancer Identification	For cases diagnosed 2001+
530	Reserved 02						Demographic	
540	Reporting Facility	R	R	R	R	CoC	Hospital-Specific	Auto-coded by software
545	NPI--Reporting Facility	R	R*	R	R*	CMS	Hospital-Specific	Auto-coded by software
550	Accession Number--Hosp	R	.	R	R	CoC	Hospital-Specific	
560	Sequence Number--Hospital	R	.	R	R	CoC	Hospital-Specific	
570	Abstracted By	R	.	R	R	CoC	Hospital-Specific	
580	Date of 1st Contact	R	R	R	.	CoC	Hospital-Specific	
581	Date of 1st Contact Flag	R	R	R	.	NAACCR	Hospital-Specific	
590	Date of Inpt Adm	.	.	.	.	NAACCR	Hospital-Specific	
591	Date of Inpt Adm Flag	.	.	.	.	NAACCR	Hospital-Specific	
600	Date of Inpt Disch	.	.	.	.	NAACCR	Hospital-Specific	
601	Date of Inpt Disch Flag	.	.	.	.	NAACCR	Hospital-Specific	
605	Inpatient Status	.	.	.	.	NAACCR	Hospital-Specific	
610	Class of Case	R	R	R	RC	CoC	Hospital-Specific	
630	Primary Payer at DX	R	R*	R	R	CoC	Hospital-Specific	
668	RX Hosp--Surg App 2010	R	.	R	.	CoC	Hospital-Specific	
670	RX Hosp--Surg Prim Site	R	.	R	R	CoC	Hospital-Specific	
672	RX Hosp--Scope Reg LN Sur	R	.	R	R	CoC	Hospital-Specific	
674	RX Hosp--Surg Oth Reg/Dis	R	.	R	R	CoC	Hospital-Specific	
676	RX Hosp--Reg LN Removed	RH	.	RH	.	CoC	Hospital-Specific	Revised
680	Reserved 03						Cancer Identification	
690	RX Hosp--Radiation	RH	.	.	RH	SEER	Hospital-Specific	
700	RX Hosp--Chemo	R	.	R	R	CoC	Hospital-Specific	
710	RX Hosp--Hormone	R	.	R	R	CoC	Hospital-Specific	
720	RX Hosp--BRM	R	.	R	R	CoC	Hospital-Specific	
730	RX Hosp--Other	R	.	R	R	CoC	Hospital-Specific	

Item #	Item Name	NHSCR	NPCR	COC	SEER	Source of Standard	Section Name	Notes
740	RX Hosp--DX/Stg Proc	R	.	R	.	CoC	Hospital-Specific	
746	RX Hosp--Surg Site 98-02	RH	.	RH	RH	CoC	Hospital-Specific	For cases diagnosed 1998-2002
747	RX Hosp--Scope Reg 98-02	RH	.	RH	RH	CoC	Hospital-Specific	For cases diagnosed 1998-2002
748	RX Hosp--Surg Oth 98-02	RH	.	RH	RH	CoC	Hospital-Specific	For cases diagnosed 1998-2002
750	Reserved 04						Hospital-Specific	
752	Tumor Size Clinical	R	.	.	R	SEER	Stage/Prognostic Factors	New
754	Tumor Size Pathologic	R	.	.	R	SEER	Stage/Prognostic Factors	New
756	Tumor Size Summary	R	R	R	S	NPCR/CoC	Stage/Prognostic Factors	New
759	SEER Summary Stage 2000	R	R	R	R+	SEER	Stage/Prognostic Factors	Revised; For cases diagnosed 2001-2003 & 2015+
760	SEER Summary Stage 1977	RH	RH	RH	S	SEER	Stage/Prognostic Factors	For cases diagnosed <2001
762	Derived SS2017	.	.	.	.	SEER	Stage/Prognostic Factors	New
764	Directly Assigned SS2017	.	.	.	.	SEER	Stage/Prognostic Factors	New
772	SEER Primary Tumor	.	.	.	.	SEER	Stage/Prognostic Factors	New
774	SEER Regional Nodes	.	.	.	.	SEER	Stage/Prognostic Factors	New
776	SEER Mets	.	.	.	.	SEER	Stage/Prognostic Factors	New
779	Extent of Disease 10-Dig	.	.	.	.		Stage/Prognostic Factors	
780	EOD--Tumor Size	RH	.	RH	RH	SEER/CoC	Stage/Prognostic Factors	For cases diagnosed < 2004
790	EOD--Extension	.	.	.	RH	SEER	Stage/Prognostic Factors	
800	EOD--Extension Prost Path	.	.	.	RH	SEER	Stage/Prognostic Factors	
810	EOD--Lymph Node Involv	.	.	.	RH	SEER	Stage/Prognostic Factors	
820	Regional Nodes Positive	R	R	R	R	SEER/CoC	Stage/Prognostic Factors	
830	Regional Nodes Examined	R	R	R	R	SEER/CoC	Stage/Prognostic Factors	
840	EOD--Old 13 Digit	.	.	.	RH	SEER	Stage/Prognostic Factors	
850	EOD--Old 2 Digit	.	.	.	RH	SEER	Stage/Prognostic Factors	
860	EOD--Old 4 Digit	.	.	.	RH	SEER	Stage/Prognostic Factors	
870	Coding System for EOD	.	.	.	RH	SEER	Stage/Prognostic Factors	
880	TNM Path T	R	R	R	R	AJCC	Stage/Prognostic Factors	Revised; For cases diagnosed <2004 & 2015+
890	TNM Path N	R	R	R	R	AJCC	Stage/Prognostic Factors	Revised; For cases diagnosed <2004 & 2015+
900	TNM Path M	R	R	R	R	AJCC	Stage/Prognostic Factors	Revised; For cases diagnosed <2004 & 2015+
910	TNM Path Stage Group	R	R	R	S	AJCC	Stage/Prognostic Factors	Revised; For cases diagnosed <2004 & 2015+
920	TNM Path Descriptor	R	R	R	R	CoC	Stage/Prognostic Factors	Revised; For cases diagnosed <2004 & 2015+
930	TNM Path Staged By	R	.	R	R	CoC	Stage/Prognostic Factors	Revised; For cases diagnosed <2004 & 2015+
940	TNM Clin T	R	R	R	R	AJCC	Stage/Prognostic Factors	Revised; For cases diagnosed <2004 & 2015+; Breast & Rectum 2004+
950	TNM Clin N	R	R	R	R	AJCC	Stage/Prognostic Factors	Revised; For cases diagnosed <2004 & 2015+; Breast & Rectum 2004+
960	TNM Clin M	R	R	R	R	AJCC	Stage/Prognostic Factors	Revised; For cases diagnosed <2004 & 2015+; Breast & Rectum 2004+
970	TNM Clin Stage Group	R	R	R	S	AJCC	Stage/Prognostic Factors	Revised; For cases diagnosed <2004 & 2015+; Breast & Rectum 2004+
980	TNM Clin Descriptor	R	R	R	R	CoC	Stage/Prognostic Factors	Revised; For cases diagnosed <2004 & 2015+; Breast & Rectum 2004+
990	TNM Clin Staged By	R	.	R	R	CoC	Stage/Prognostic Factors	Revised; For cases diagnosed <2004 & 2015+; Breast & Rectum 2004+
1060	TNM Edition Number	R	R	R	R	CoC	Stage/Prognostic Factors	Auto-coded by software
1112	Mets at DX-Bone	R	.	R	R	SEER	Stage/Prognostic Factors	New
1113	Mets at DX-Brain	R	.	R	R	SEER	Stage/Prognostic Factors	New
1114	Mets at Dx-Distant LN	R	.	R	R	SEER	Stage/Prognostic Factors	New
1115	Mets at DX-Liver	R	.	R	R	SEER	Stage/Prognostic Factors	New
1116	Mets at DX-Lung	R	.	R	R	SEER	Stage/Prognostic Factors	New

Item #	Item Name	NHSCR	NPCR	COC	SEER	Source of Standard	Section Name	Notes
1117	Mets at DX-Other	R	.	R	R	SEER	Stage/Prognostic Factors	New
1120	Pediatric Stage	.	.	.	.	CoC	Stage/Prognostic Factors	
1130	Pediatric Staging System	.	.	.	.	CoC	Stage/Prognostic Factors	
1140	Pediatric Staged By	.	.	.	.	CoC	Stage/Prognostic Factors	
1150	Tumor Marker 1	RH	.	RH	RH	SEER	Stage/Prognostic Factors	For cases diagnosed < 2004; Site-specific
1160	Tumor Marker 2	RH	.	RH	RH	SEER	Stage/Prognostic Factors	For cases diagnosed < 2004; Site-specific
1170	Tumor Marker 3	RH	.	RH	RH	SEER	Stage/Prognostic Factors	For cases diagnosed < 2004; Site-specific
1180	Reserved 05						Stage/Prognostic Factors	
1182	Lymph-vascular Invasion	R	R*	R	RS	AJCC	Stage/Prognostic Factors	Revised
1190	Reserved 06						Treatment-1st Course	
1200	RX Date Surgery	R	R	R	RC	CoC	Treatment-1st Course	
1201	RX Date Surgery Flag	R	R	R	RC	NAACCR	Treatment-1st Course	
1210	RX Date Radiation	R	R	R	RC	CoC	Treatment-1st Course	
1211	RX Date Radiation Flag	R	R	R	RC	NAACCR	Treatment-1st Course	
1220	RX Date Chemo	R	R	R	RC	CoC	Treatment-1st Course	
1221	RX Date Chemo Flag	R	R	R	RC	NAACCR	Treatment-1st Course	
1230	RX Date Hormone	R	R	R	RC	CoC	Treatment-1st Course	
1231	RX Date Hormone Flag	R	R	R	RC	NAACCR	Treatment-1st Course	
1240	RX Date BRM	R	R	R	RC	CoC	Treatment-1st Course	
1241	RX Date BRM Flag	R	R	R	RC	NAACCR	Treatment-1st Course	
1250	RX Date Other	R	R	R	RC	CoC	Treatment-1st Course	
1251	RX Date Other Flag	R	R	R	RC	NAACCR	Treatment-1st Course	
1260	Date Initial RX SEER	S	R#	.	R	SEER	Treatment-1st Course	
1261	Date Initial RX SEER Flag	S	R#	.	R	NAACCR	Treatment-1st Course	
1270	Date 1st Crs RX CoC	R	R#	R	.	CoC	Treatment-1st Course	
1271	Date 1st Crs RX CoC Flag	R	R#	R	.	NAACCR	Treatment-1st Course	
1280	RX Date DX/Stg Proc	R	.	R	.	CoC	Treatment-1st Course	
1281	RX Date DX/Stg Proc Flag	R	.	R	.	NAACCR	Treatment-1st Course	
1285	RX Summ--Treatment Status	R	R#	R	R	SEER/CoC	Treatment-1st Course	
1290	RX Summ--Surg Prim Site	R	R	R	R	SEER/CoC	Treatment-1st Course	
1292	RX Summ--Scope Reg LN Sur	R	R	R	R	SEER/CoC	Treatment-1st Course	
1294	RX Summ--Surg Oth Reg/Dis	R	R	R	R	SEER/CoC	Treatment-1st Course	
1296	RX Summ--Reg LN Examined	RH	.	RH	RH	SEER/CoC	Treatment-1st Course	For cases diagnosed 1998-2002
1300	Reserved 07						Treatment-Subsequent &	
1310	RX Summ--Surgical Approch	RH	.	RH	.	CoC	Treatment-1st Course	For cases diagnosed 1998-2002
1320	RX Summ--Surgical Margins	R	.	R	R*	CoC	Treatment-1st Course	Revised
1330	RX Summ--Reconstruct 1st	RH	.	RH	RH	SEER	Treatment-1st Course	For cases diagnosed 1998-2002
1340	Reason for No Surgery	R	R	R	R	SEER/CoC	Treatment-1st Course	
1350	RX Summ--DX/Stg Proc	D	.	R	.	CoC	Treatment-1st Course	
1360	RX Summ--Radiation	D	RH	.	R	SEER	Treatment-1st Course	For cases diagnosed <2003
1370	RX Summ--Rad to CNS	RH	.	.	RH	SEER/CoC	Treatment-1st Course	For cases diagnosed <1998
1380	RX Summ--Surg/Rad Seq	R	R	R	R	SEER/CoC	Treatment-1st Course	Revised
1390	RX Summ--Chemo	R	R	R	R	SEER/CoC	Treatment-1st Course	
1400	RX Summ--Hormone	R	R	R	R	SEER/CoC	Treatment-1st Course	

Item #	Item Name	NHSCR	NPCR	COC	SEER	Source of Standard	Section Name	Notes
1410	RX Summ--BRM	R	R	R	R	SEER/CoC	Treatment-1st Course	
1420	RX Summ--Other	R	R	R	R	SEER/CoC	Treatment-1st Course	
1430	Reason for No Radiation	R	R	R	.	CoC	Treatment-1st Course	
1460	RX Coding System--Current	R	R	R	RH	NAACCR	Treatment-1st Course	May be auto-coded by software
1510	Rad--Regional Dose: cGy	R	.	R	.	CoC	Treatment-1st Course	
1520	Rad--No of Treatment Vol	R	.	R	.	CoC	Treatment-1st Course	
1540	Rad--Treatment Volume	R	.	R	.	CoC	Treatment-1st Course	
1550	Rad--Location of RX	R	.	R	.	CoC	Treatment-1st Course	
1570	Rad--Regional RX Modality	R	R	R	RC	CoC	Treatment-1st Course	
1639	RX Summ--Systemic/Sur Seq	R	R	R	R	CoC	Treatment-1st Course	Revised; For cases diagnosed ≥ 2006
1640	RX Summ--Surgery Type	RH	.	.	RH	SEER	Treatment-1st Course	For cases diagnosed <1996; Derived
1646	RX Summ--Surg Site 98-02	RH	.	RH	RH	SEER/CoC	Treatment-1st Course	For cases diagnosed 1998-2002
1647	RX Summ--Scope Reg 98-02	RH	.	RH	RH	SEER/CoC	Treatment-1st Course	For cases diagnosed 1998-2002
1648	RX Summ--Surg Oth 98-02	RH	.	RH	RH	SEER/CoC	Treatment-1st Course	For cases diagnosed 1998-2002
1650	Reserved 08						Edit Overrides/Convrsn	
1660	Subsq RX 2nd Course Date	RS*	.	.	.	CoC	Treatment-Subsq & Other	For Breast, Colorectal, CML cases diagnosed 2011+
1661	Subsq RX 2ndCrs Date Flag	.	.	.	.	NAACCR	Treatment-Subsq & Other	
1670	Subsq RX 2nd Course Codes	.	.	.	.		Treatment-Subsq & Other	
1671	Subsq RX 2nd Course Surg	.	.	.	.	CoC	Treatment-Subsq & Other	
1672	Subsq RX 2nd Course Rad	.	.	.	.	CoC	Treatment-Subsq & Other	
1673	Subsq RX 2nd Course Chemo	.	.	.	.	CoC	Treatment-Subsq & Other	
1674	Subsq RX 2nd Course Horm	.	.	.	.	CoC	Treatment-Subsq & Other	
1675	Subsq RX 2nd Course BRM	.	.	.	.	CoC	Treatment-Subsq & Other	
1676	Subsq RX 2nd Course Oth	.	.	.	.	CoC	Treatment-Subsq & Other	
1677	Subsq RX 2nd--Scope LN SU	.	.	.	.	CoC	Treatment-Subsq & Other	
1678	Subsq RX 2nd--Surg Oth	.	.	.	.	CoC	Treatment-Subsq & Other	
1679	Subsq RX 2nd--Reg LN Rem	.	.	.	.	CoC	Treatment-Subsq & Other	
1680	Subsq RX 3rd Course Date	.	.	.	.	CoC	Treatment-Subsq & Other	
1681	Subsq RX 3rdCrs Date Flag	.	.	.	.	NAACCR	Treatment-Subsq & Other	
1690	Subsq RX 3rd Course Codes	.	.	.	.		Treatment-Subsq & Other	
1691	Subsq RX 3rd Course Surg	.	.	.	.	CoC	Treatment-Subsq & Other	
1692	Subsq RX 3rd Course Rad	.	.	.	.	CoC	Treatment-Subsq & Other	
1693	Subsq RX 3rd Course Chemo	.	.	.	.	CoC	Treatment-Subsq & Other	
1694	Subsq RX 3rd Course Horm	.	.	.	.	CoC	Treatment-Subsq & Other	
1695	Subsq RX 3rd Course BRM	.	.	.	.	CoC	Treatment-Subsq & Other	
1696	Subsq RX 3rd Course Oth	.	.	.	.	CoC	Treatment-Subsq & Other	
1697	Subsq RX 3rd--Scope LN Su	.	.	.	.	CoC	Treatment-Subsq & Other	
1698	Subsq RX 3rd--Surg Oth	.	.	.	.	CoC	Treatment-Subsq & Other	
1699	Subsq RX 3rd--Reg LN Rem	.	.	.	.	CoC	Treatment-Subsq & Other	
1700	Subsq RX 4th Course Date	.	.	.	.	CoC	Treatment-Subsq & Other	
1701	Subsq RX 4thCrs Date Flag	.	.	.	.	NAACCR	Treatment-Subsq & Other	
1710	Subsq RX 4th Course Codes	.	.	.	.		Treatment-Subsq & Other	
1711	Subsq RX 4th Course Surg	.	.	.	.	CoC	Treatment-Subsq & Other	
1712	Subsq RX 4th Course Rad	.	.	.	.	CoC	Treatment-Subsq & Other	

Item #	Item Name	NHSCR	NPCR	COC	SEER	Source of Standard	Section Name	Notes
1713	Subsq RX 4th Course Chemo	.	.	.	.	CoC	Treatment-Subsq & Other	
1714	Subsq RX 4th Course Horm	.	.	.	.	CoC	Treatment-Subsq & Other	
1715	Subsq RX 4th Course BRM	.	.	.	.	CoC	Treatment-Subsq & Other	
1716	Subsq RX 4th Course Oth	.	.	.	.	CoC	Treatment-Subsq & Other	
1717	Subsq RX 4th--Scope LN Su	.	.	.	.	CoC	Treatment-Subsq & Other	
1718	Subsq RX 4th--Surg Oth	.	.	.	.	CoC	Treatment-Subsq & Other	
1719	Subsq RX 4th--Reg LN Rem	.	.	.	.	CoC	Treatment-Subsq & Other	
1740	Reserved 09						Follow-up/Recurrence/Death	
1741	Subsq RX--Reconstruct Del	.	.	.	.	CoC	Treatment-Subsq & Other	
1750	Date of Last Contact	R	R	R	R	SEER/CoC	Follow-up/Recurrence/Death	
1751	Date of Last Contact Flag	R	R	R	R	NAACCR	Follow-up/Recurrence/Death	
1755	Date of Death--Canada	.	.	.	.	CCCR	Follow-up/Recurrence/Death	
1756	Date of Death--CanadaFlag	.	.	.	.	NAACCR	Follow-up/Recurrence/Death	
1760	Vital Status	R	R	R	R	SEER/CoC	Follow-up/Recurrence/Death	
1770	Cancer Status	R	.	R	.	CoC	Follow-up/Recurrence/Death	
1780	Quality of Survival	.	.	.	.	CoC	Follow-up/Recurrence/Death	
1782	Surv-Date Active Followup	R	.	.	R	NAACCR	Follow-up/Recurrence/Death	Revised; Central registry use only
1783	Surv-Flag Active Followup	R	.	.	R	NAACCR	Follow-up/Recurrence/Death	Revised; Central registry use only
1784	Surv-Mos Active Followup	R	.	.	R	NAACCR	Follow-up/Recurrence/Death	Revised; Central registry use only
1785	Surv-Date Presumed Alive	R	.	.	R	NAACCR	Follow-up/Recurrence/Death	Revised; Central registry use only
1786	Surv-Flag Presumed Alive	R	.	.	R	NAACCR	Follow-up/Recurrence/Death	Revised; Central registry use only
1787	Surv-Mos Presumed Alive	R	.	.	R	NAACCR	Follow-up/Recurrence/Death	Revised; Central registry use only
1788	Surv-Date DX Recode	R	.	.	R	NAACCR	Follow-up/Recurrence/Death	Revised; Central registry use only
1790	Follow-Up Source	R	R*	R	.	CoC	Follow-up/Recurrence/Death	
1791	Follow-up Source Central	R	R	.	.	NAACCR	Follow-up/Recurrence/Death	Central registry use only
1800	Next Follow-Up Source	S	.	R	.	CoC	Follow-up/Recurrence/Death	
1810	Addr Current--City	S	.	R	R	CoC	Follow-up/Recurrence/Death	
1820	Addr Current--State	S	.	R	R	CoC	Follow-up/Recurrence/Death	
1830	Addr Current--Postal Code	S	.	R	R	CoC	Follow-up/Recurrence/Death	
1832	Addr Current--Country	S	.	R	R	NAACCR	Demographic	
1835	Reserved 10						Patient-Confidential	
1840	County--Current	S	.	.	.	NAACCR	Follow-up/Recurrence/Death	
1842	Follow-Up Contact--City	.	.	.	.	SEER	Follow-up/Recurrence/Death	
1844	Follow-Up Contact--State	.	.	.	.	SEER	Follow-up/Recurrence/Death	
1846	Follow-Up Contact--Postal	.	.	.	.	SEER	Follow-up/Recurrence/Death	
1847	FollowUp Contact--Country	.	.	.	.	NAACCR	Demographic	
1850	Unusual Follow-Up Method	.	.	.	.	NAACCR	Follow-up/Recurrence/Death	
1860	Recurrence Date--1st	R	.	R	RC	CoC	Follow-up/Recurrence/Death	
1861	Recurrence Date--1st Flag	R	.	R	RC	NAACCR	Follow-up/Recurrence/Death	
1880	Recurrence Type--1st	R	.	R	RC	CoC	Follow-up/Recurrence/Death	
1900	Reserved 11						Hospital-Confidential	
1910	Cause of Death	R	R	.	R	SEER	Follow-up/Recurrence/Death	Revised; Reporting registries use 7777 or 7797
1920	ICD Revision Number	R	R	.	R	SEER	Follow-up/Recurrence/Death	Auto-coded by software
1930	Autopsy	R	.	.	.	NAACCR	Follow-up/Recurrence/Death	

Item #	Item Name	NHSCR	NPCR	COC	SEER	Source of Standard	Section Name	Notes
1940	Place of Death	RH	RH	.	.	NPCR	Follow-up/Recurrence/Death	
1942	Place of Death--State	R	R	.	R*	NAACCR	Demographic	Revised
1944	Place of Death--Country	R	R*	.	R*	NAACCR	Demographic	Revised
1960	Site (73-91) ICD-O-1	.	.	.	RH	SEER	Edit Overrides/Conversion	
1970	Morph (73-91) ICD-O-1	.	.	.	.		Edit Overrides/Conversion	
1971	Histology (73-91) ICD-O-1	.	.	.	RH	SEER	Edit Overrides/Conversion	
1972	Behavior (73-91) ICD-O-1	.	.	.	RH	SEER	Edit Overrides/Conversion	
1973	Grade (73-91) ICD-O-1	.	.	.	RH	SEER	Edit Overrides/Conversion	
1980	ICD-O-2 Conversion Flag	R	.	RH	R	SEER	Edit Overrides/Conversion	Auto-coded by software
1981	Over-ride SS/NodesPos	R	.	.	R	NAACCR	Edit Overrides/Conversion	Revised
1982	Over-ride SS/TNM-N	R	.	.	R	NAACCR	Edit Overrides/Conversion	Revised
1983	Over-ride SS/TNM-M	R	.	.	R	NAACCR	Edit Overrides/Conversion	Revised
1985	Over-ride Acsn/Class/Seq	R	.	R	.	CoC	Edit Overrides/Conversion	
1986	Over-ride HospSeq/DxConf	R	.	R	.	CoC	Edit Overrides/Conversion	
1987	Over-ride CoC-Site/Type	R	.	R	.	CoC	Edit Overrides/Conversion	
1988	Over-ride HospSeq/Site	R	.	R	.	CoC	Edit Overrides/Conversion	
1989	Over-ride Site/TNM-StgGrp	R	R	R	.	CoC	Edit Overrides/Conversion	
1990	Over-ride Age/Site/Morph	R	R	R	R	SEER	Edit Overrides/Conversion	
2000	Over-ride SeqNo/DxConf	R	R	.	R	SEER	Edit Overrides/Conversion	
2010	Over-ride Site/Lat/SeqNo	R	R	.	R	SEER	Edit Overrides/Conversion	
2020	Over-ride Surg/DxConf	R	R	R	R	SEER	Edit Overrides/Conversion	
2030	Over-ride Site/Type	R	R	R	R	SEER	Edit Overrides/Conversion	
2040	Over-ride Histology	R	R	R	R	SEER	Edit Overrides/Conversion	
2050	Over-ride Report Source	R	R	.	R	SEER	Edit Overrides/Conversion	
2060	Over-ride Ill-define Site	R	R	.	R	SEER	Edit Overrides/Conversion	
2070	Over-ride Leuk, Lymphoma	R	R	R	R	SEER	Edit Overrides/Conversion	
2071	Over-ride Site/Behavior	R	R	R	R	SEER	Edit Overrides/Conversion	
2072	Over-ride Site/EOD/DX Dt	R	.	.	R	SEER	Edit Overrides/Conversion	
2073	Over-ride Site/Lat/EOD	R	.	.	R	SEER	Edit Overrides/Conversion	
2074	Over-ride Site/Lat/Morph	R	R	R	R	SEER	Edit Overrides/Conversion	
2080	Reserved 13						Pathology	
2081	CRC CHECKSUM	S	.	.	S	NAACCR	Edit Overrides/Conversion	
2085	Date Case Initiated	.	.	.	.	NAACCR	Edit Overrides/Conversion	Auto-coded by software
2090	Date Case Completed	.	.	.	.	NAACCR	Edit Overrides/Conversion	
2092	Date Case Completed--CoC	D	.	D	.	CoC	Edit Overrides/Conversion	Auto-coded by software
2100	Date Case Last Changed	D	.	D	.	NAACCR	Edit Overrides/Conversion	Auto-coded by software
2110	Date Case Report Exported	R	R	.	.	NPCR	Edit Overrides/Conversion	Auto-coded by software
2111	Date Case Report Received	R	R	.	.	NPCR	Edit Overrides/Conversion	Auto-coded by software
2112	Date Case Report Loaded	R	R	.	.	NPCR	Edit Overrides/Conversion	Auto-coded by software
2113	Date Tumor Record Availbl	R	R	.	.	NPCR	Edit Overrides/Conversion	Auto-coded by software
2116	ICD-O-3 Conversion Flag	R	R	.	R	SEER/CoC	Edit Overrides/Conversion	May be auto-coded by software
2120	SEER Coding Sys--Current	.	.	.	R	NAACCR	Edit Overrides/Conversion	
2130	SEER Coding Sys--Original	.	.	.	R	NAACCR	Edit Overrides/Conversion	
2140	CoC Coding Sys--Current	R	.	R	.	CoC	Edit Overrides/Conversion	Auto-coded by software

Item #	Item Name	NHSCR	NPCR	COC	SEER	Source of Standard	Section Name	Notes
2150	CoC Coding Sys--Original	R	.	R	.	CoC	Edit Overrides/Conversion	Auto-coded by software
2161	Reserved 18						Treatment-1st Course	
2162	Reserved 19						Stage/Prognostic Factors	New
2163	Reserved 20						Stage/Prognostic Factors	New
2170	Vendor Name	R	.	R	.	NAACCR	Edit Overrides/Conversion	Auto-coded by software
2180	SEER Type of Follow-Up	.	.	.	R	SEER	Edit Overrides/Conversion	
2190	SEER Record Number	.	.	.	R	SEER	Edit Overrides/Conversion	
2200	Diagnostic Proc 73-87	.	.	.	RH	SEER	Edit Overrides/Conversion	
2210	Reserved 14						Text-Miscellaneous	
2220	State/Requestor Items	.	.	.	.	Varies	Special Use	Text--Managing Physician
2230	Name--Last	R	R	R	R	CoC	Patient-Confidential	
2240	Name--First	R	R	R	R	CoC	Patient-Confidential	
2250	Name--Middle	R	R	R	R	CoC	Patient-Confidential	
2260	Name--Prefix	R	.	.	.	NAACCR	Patient-Confidential	
2270	Name--Suffix	R	.	.	R	NAACCR	Patient-Confidential	
2280	Name--Alias	R	R	.	R	NAACCR	Patient-Confidential	
2290	Name--Spouse/Parent	S	.	.	.	NAACCR	Patient-Confidential	
2300	Medical Record Number	R	R	R	R	CoC	Patient-Confidential	
2310	Military Record No Suffix	.	.	.	.	CoC	Patient-Confidential	
2320	Social Security Number	R	R	R	R	CoC	Patient-Confidential	
2330	Addr at DX--No & Street	R	R	R	R	CoC	Patient-Confidential	
2335	Addr at DX--Supplementl	R	R	R*	R	CoC	Patient-Confidential	
2350	Addr Current--No & Street	S	.	R	R	CoC	Patient-Confidential	
2352	Latitude	R	R*	.	S	NAACCR	Patient-Confidential	Central registry use only
2354	Longitude	R	R*	.	S	NAACCR	Patient-Confidential	Central registry use only
2355	Addr Current--Supplementl	.	.	R*	R*	CoC	Patient-Confidential	Revised
2360	Telephone	S	.	R	R	CoC	Patient-Confidential	
2380	DC State File Number	R	R	.	R*	State	Patient-Confidential	Central registry use only
2390	Name--Maiden	R	R	.	R	NAACCR	Patient-Confidential	
2392	Follow-Up Contact--No&St	.	.	.	.	SEER	Patient-Confidential	
2393	Follow-Up Contact--Suppl	.	.	.	.	SEER	Patient-Confidential	
2394	Follow-Up Contact--Name	.	.	.	.	SEER	Patient-Confidential	
2400	Reserved 15						Hospital-Specific	
2410	*Institution Referred From*	R	.	.	.	CoC	Hospital-Confidential	
2415	NPI--Inst Referred From	R	.	R	.	CMS	Hospital-Confidential	
2420	*Institution Referred To*	R	.	.	.	CoC	Hospital-Confidential	
2425	NPI--Inst Referred To	R	.	R	.	CMS	Hospital-Confidential	
2440	Following Registry	R	.	.	RH	CoC	Hospital-Confidential	Revised
2445	NPI--Following Registry	R	.	.	RH*	CMS	Hospital-Confidential	Revised
2450	Reserved 16						Hospital-Specific	
2460	Physician--Managing	R*	.	.	.	NAACCR	Other-Confidential	Report as Text in Item #2220
2465	NPI--Physician--Managing	R*	.	R	.	CMS	Other-Confidential	
2470	Physician--Follow-Up	R*	.	.	R	CoC	Other-Confidential	
2475	NPI--Physician--Follow-Up	R*	.	R	R*	CMS	Other-Confidential	

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2480	Physician--Primary Surg	R*	.	.	.	CoC	Other-Confidential	
2485	NPI--Physician--Primary Surg	R*	.	R	.	CMS	Other-Confidential	
2490	Physician 3	R*	.	.	.	CoC	Other-Confidential	
2495	NPI--Physician 3	R*	.	R	.	CMS	Other-Confidential	
2500	Physician 4	R*	.	.	.	CoC	Other-Confidential	
2505	NPI--Physician 4	R*	.	R	.	CMS	Other-Confidential	
2510	Reserved 12						Other-Confidential	
2520	Text--DX Proc--PE	R	R	.	R	NPCR	Text-Diagnosis	May be met with one or several text block fields
2530	Text--DX Proc--X-ray/Scan	R	R	.	R	NPCR	Text-Diagnosis	May be met with one or several text block fields
2540	Text--DX Proc--Scopes	R	R	.	R	NPCR	Text-Diagnosis	May be met with one or several text block fields
2550	Text--DX Proc--Lab Tests	R	R	.	R	NPCR	Text-Diagnosis	May be met with one or several text block fields
2560	Text--DX Proc--Op	R	R	.	R	NPCR	Text-Diagnosis	May be met with one or several text block fields
2570	Text--DX Proc--Path	R	R	.	R	NPCR	Text-Diagnosis	May be met with one or several text block fields
2580	Text--Primary Site Title	R	R	.	R	NPCR	Text-Diagnosis	May be met with one or several text block fields
2590	Text--Histology Title	R	R	.	R	NPCR	Text-Diagnosis	May be met with one or several text block fields
2600	Text--Staging	R	R	.	R	NPCR	Text-Diagnosis	May be met with one or several text block fields
2610	RX Text--Surgery	R	R	.	R	NPCR	Text-Treatment	May be met with one or several text block fields
2620	RX Text--Radiation (Beam)	R	R	.	R	NPCR	Text-Treatment	May be met with one or several text block fields
2630	RX Text--Radiation Other	R	R	.	R	NPCR	Text-Treatment	May be met with one or several text block fields
2640	RX Text--Chemo	R	R	.	R	NPCR	Text-Treatment	May be met with one or several text block fields
2650	RX Text--Hormone	R	R	.	R	NPCR	Text-Treatment	May be met with one or several text block fields
2660	RX Text--BRM	R	R	.	R	NPCR	Text-Treatment	May be met with one or several text block fields
2670	RX Text--Other	R	R	.	R	NPCR	Text-Treatment	May be met with one or several text block fields
2680	Text--Remarks	S	.	.	R	NPCR	Text-Miscellaneous	
2690	Text--Place of Diagnosis	R	.	.	.	NPCR	Text-Miscellaneous	
2700	Reserved 17						Follow-up/Recurrence/Death	
2730	CS PreRx Tumor Size	.	.	.	.	AJCC	Stage/Prognostic Factors	
2735	CS PreRx Extension	.	.	.	.	AJCC	Stage/Prognostic Factors	
2740	CS PreRx Tum Sz/Ext Eval	.	.	.	.	AJCC	Stage/Prognostic Factors	
2750	CS PreRx Lymph Nodes	.	.	.	.	AJCC	Stage/Prognostic Factors	
2755	CS PreRx Reg Nodes Eval	.	.	.	.	AJCC	Stage/Prognostic Factors	
2760	CS PreRx Mets at DX	.	.	.	.	AJCC	Stage/Prognostic Factors	
2765	CS PreRx Mets Eval	.	.	.	.	AJCC	Stage/Prognostic Factors	
2770	CS PostRx Tumor Size	.	.	.	.	AJCC	Stage/Prognostic Factors	
2775	CS PostRx Extension	.	.	.	.	AJCC	Stage/Prognostic Factors	
2780	CS PostRx Lymph Nodes	.	.	.	.	AJCC	Stage/Prognostic Factors	
2785	CS PostRx Mets at DX	.	.	.	.	AJCC	Stage/Prognostic Factors	
2800	CS Tumor Size	RH	RH	RH	S	AJCC	Stage/Prognostic Factors	Revised; Historically collected for cases diagnosed 2004-2015
2810	CS Extension	RH	RH	RH	S	AJCC	Stage/Prognostic Factors	Revised; Historically collected for cases diagnosed 2004-2015
2820	CS Tumor Size/Ext Eval	RH	RH	RH	S	AJCC	Stage/Prognostic Factors	Revised; Historically collected for cases diagnosed 2004-2015
2830	CS Lymph Nodes	RH	RH	RH	S	AJCC	Stage/Prognostic Factors	Revised; Historically collected for cases diagnosed 2004-2015
2840	CS Lymph Nodes Eval	RH*	RH*	RH	S	AJCC	Stage/Prognostic Factors	Revised; Historically collected for cases diagnosed 2004-2015
2850	CS Mets at DX	RH	RH	RH	S	AJCC	Stage/Prognostic Factors	Revised; Historically collected for cases diagnosed 2004-2015
2851	CS Mets at Dx-Bone	RH	.	RH	RH	AJCC	Stage/Prognostic Factors	Revised; Historically collected for cases diagnosed 2004-2015

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2852	CS Mets at Dx-Brain	RH	.	RH	RH	AJCC	Stage/Prognostic Factors	Revised; Historically collected for cases diagnosed 2004-2015
2853	CS Mets at Dx-Liver	RH	.	RH	RH	AJCC	Stage/Prognostic Factors	Revised; Historically collected for cases diagnosed 2004-2015
2854	CS Mets at Dx-Lung	RH	.	RH	RH	AJCC	Stage/Prognostic Factors	Revised; Historically collected for cases diagnosed 2004-2015
2860	CS Mets Eval	RH	RH*	RH	S	AJCC	Stage/Prognostic Factors	Revised; Historically collected for cases diagnosed 2004-2015
2861	CS Site-Specific Factor 7	RS	RH	RS	RS	AJCC	Stage/Prognostic Factors	Revised; Site-specific
2862	CS Site-Specific Factor 8	RS	RS	RS	RS	AJCC	Stage/Prognostic Factors	Site-specific
2863	CS Site-Specific Factor 9	RS	RS	RS	RS	AJCC	Stage/Prognostic Factors	Site-specific
2864	CS Site-Specific Factor10	RS	RS	RS	RS	AJCC	Stage/Prognostic Factors	Revised; Site-specific
2865	CS Site-Specific Factor11	RS	RS	RS	RS	AJCC	Stage/Prognostic Factors	Site-specific
2866	CS Site-Specific Factor12	RS	RH	RS	RS	AJCC	Stage/Prognostic Factors	Revised; Site-specific
2867	CS Site-Specific Factor13	RS	RS	RS	RS	AJCC	Stage/Prognostic Factors	Site-specific
2868	CS Site-Specific Factor14	RS	RS	RS	RS	AJCC	Stage/Prognostic Factors	Site-specific
2869	CS Site-Specific Factor15	RS	RS	RS	RS	AJCC	Stage/Prognostic Factors	Site-specific
2870	CS Site-Specific Factor16	RS	RS	RS	RS	AJCC	Stage/Prognostic Factors	Site-specific
2871	CS Site-Specific Factor17	RS	RH	RS	RS	AJCC	Stage/Prognostic Factors	Revised; Site-specific
2872	CS Site-Specific Factor18	RS	.	RS	RS	AJCC	Stage/Prognostic Factors	Revised; Site-specific
2873	CS Site-Specific Factor19	RS	.	RS	RS	AJCC	Stage/Prognostic Factors	Revised; Site-specific
2874	CS Site-Specific Factor20	RS	.	RS	RS	AJCC	Stage/Prognostic Factors	Revised; Site-specific
2875	CS Site-Specific Factor21	RS	.	RS	RS	AJCC	Stage/Prognostic Factors	Revised; Site-specific
2876	CS Site-Specific Factor22	RS	.	RS	RS	AJCC	Stage/Prognostic Factors	Revised; Site-specific
2877	CS Site-Specific Factor23	RS	.	RS	RS	AJCC	Stage/Prognostic Factors	Revised; Site-specific
2878	CS Site-Specific Factor24	RS	.	RS	RS	AJCC	Stage/Prognostic Factors	Revised; Site-specific
2879	CS Site-Specific Factor25	RS	RS	RS	RS	AJCC	Stage/Prognostic Factors	Site-specific
2880	CS Site-Specific Factor 1	RS	RS	RS	RS	AJCC	Stage/Prognostic Factors	Site-specific
2890	CS Site-Specific Factor 2	RS	RS	RS	RS	AJCC	Stage/Prognostic Factors	Site-specific
2900	CS Site-Specific Factor 3	RS	RH	RS	RS	AJCC	Stage/Prognostic Factors	Revised; Site-specific
2910	CS Site-Specific Factor 4	RS	RH	RS	RS	AJCC	Stage/Prognostic Factors	Revised; Site-specific
2920	CS Site-Specific Factor 5	RS	RS	RS	RS	AJCC	Stage/Prognostic Factors	Revised; Site-specific
2930	CS Site-Specific Factor 6	RS	RS	RS	RS	AJCC	Stage/Prognostic Factors	Revised; Site-specific
2935	CS Version Input Original	R	R	R	S	AJCC	Stage/Prognostic Factors	Revised
2936	CS Version Derived	DH	RH	DH	S	AJCC	Stage/Prognostic Factors	Revised
2937	CS Version Input Current	R	R	R	S	AJCC	Stage/Prognostic Factors	Revised
2940	Derived AJCC-6 T	DH	.	DH	S	AJCC	Stage/Prognostic Factors	Revised
2950	Derived AJCC-6 T Descript	DH	.	DH	S	AJCC	Stage/Prognostic Factors	Revised
2960	Derived AJCC-6 N	DH	.	DH	S	AJCC	Stage/Prognostic Factors	Revised
2970	Derived AJCC-6 N Descript	DH	.	DH	S	AJCC	Stage/Prognostic Factors	Revised
2980	Derived AJCC-6 M	DH	.	DH	S	AJCC	Stage/Prognostic Factors	Revised
2990	Derived AJCC-6 M Descript	DH	.	DH	S	AJCC	Stage/Prognostic Factors	Revised
3000	Derived AJCC-6 Stage Grp	DH	.	DH	S	AJCC	Stage/Prognostic Factors	Revised
3010	Derived SS1977	DH	.	DH	S	AJCC	Stage/Prognostic Factors	Revised
3020	Derived SS2000	DH	RH	DH	R+	AJCC	Stage/Prognostic Factors	Revised
3030	Derived AJCC--Flag	DH	.	DH	S	AJCC	Stage/Prognostic Factors	Revised
3040	Derived SS1977--Flag	DH	.	DH	S	AJCC	Stage/Prognostic Factors	Revised
3050	Derived SS2000--Flag	DH	RH	DH	S	AJCC	Stage/Prognostic Factors	Revised

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3100	Archive FIN	R	.	R	.	CoC	Hospital-Specific	
3105	NPI--Archive FIN	R	.	R	.	CMS	Hospital-Specific	
3110	Comorbid/Complication 1	R	.	R	.	CoC	Stage/Prognostic Factors	For cases diagnosed 1/1/2011-9/30/2015
3120	Comorbid/Complication 2	R	.	R	.	CoC	Stage/Prognostic Factors	For cases diagnosed 1/1/2011-9/30/2015
3130	Comorbid/Complication 3	R	.	R	.	CoC	Stage/Prognostic Factors	For cases diagnosed 1/1/2011-9/30/2015
3140	Comorbid/Complication 4	R	.	R	.	CoC	Stage/Prognostic Factors	For cases diagnosed 1/1/2011-9/30/2015
3150	Comorbid/Complication 5	R	.	R	.	CoC	Stage/Prognostic Factors	For cases diagnosed 1/1/2011-9/30/2015
3160	Comorbid/Complication 6	R	.	R	.	CoC	Stage/Prognostic Factors	For cases diagnosed 1/1/2011-9/30/2015
3161	Comorbid/Complication 7	R	.	R	.	CoC	Stage/Prognostic Factors	For cases diagnosed 1/1/2011-9/30/2015
3162	Comorbid/Complication 8	R	.	R	.	CoC	Stage/Prognostic Factors	For cases diagnosed 1/1/2011-9/30/2015
3163	Comorbid/Complication 9	R	.	R	.	CoC	Stage/Prognostic Factors	For cases diagnosed 1/1/2011-9/30/2015
3164	Comorbid/Complication 10	R	.	R	.	CoC	Stage/Prognostic Factors	For cases diagnosed 1/1/2011-9/30/2015
3165	ICD Revision Comorbid	R	.	.	.	CoC	Stage/Prognostic Factors	May be auto-coded by software
3170	RX Date Mst Defn Srg	R	R	R	.	CoC	Treatment-1st Course	
3171	RX Date Mst Defn Srg Flag	R	R	R	.	NAACCR	Treatment-1st Course	
3180	RX Date Surg Disch	R	.	R	.	CoC	Treatment-1st Course	
3181	RX Date Surg Disch Flag	R	.	R	.	NAACCR	Treatment-1st Course	
3190	Readm Same Hosp 30 Days	R	.	R	.	CoC	Treatment-1st Course	
3200	Rad--Boost RX Modality	R	.	R	RC	CoC	Treatment-1st Course	
3210	Rad--Boost Dose cGy	R	.	R	.	CoC	Treatment-1st Course	
3220	RX Date Rad Ended	R	.	R	.	CoC	Treatment-1st Course	
3221	RX Date Rad Ended Flag	R	.	R	.	NAACCR	Treatment-1st Course	
3230	RX Date Systemic	R	.	R	RC	CoC	Treatment-1st Course	Revised
3231	RX Date Systemic Flag	R	.	R	RC	NAACCR	Treatment-1st Course	Revised
3250	RX Summ--Transplnt/Endocr	R	R	R	R	CoC	Treatment-1st Course	
3270	RX Summ--Palliative Proc	R	.	R	.	CoC	Treatment-1st Course	
3280	RX Hosp--Palliative Proc	R	.	R	.	CoC	Hospital-Specific	
3300	RuralUrban Continuum 1993	D	D	.	.	NAACCR	Demographic	Central registry use only
3310	RuralUrban Continuum 2003	D	D	.	.	NAACCR	Demographic	Central registry use only
3312	RuralUrban Continuum 2013	D	D	.	R	NAACCR	Demographic	New; Central registry use only
3400	Derived AJCC-7 T	DH	RH*	DH	S	AJCC	Stage/Prognostic Factors	Revised
3402	Derived AJCC-7 T Descript	DH	RH*	DH	S	AJCC	Stage/Prognostic Factors	Revised
3410	Derived AJCC-7 N	DH	RH*	DH	S	AJCC	Stage/Prognostic Factors	Revised
3412	Derived AJCC-7 N Descript	DH	RH*	DH	S	AJCC	Stage/Prognostic Factors	Revised
3420	Derived AJCC-7 M	DH	RH*	DH	S	AJCC	Stage/Prognostic Factors	Revised
3422	Derived AJCC-7 M Descript	DH	RH*	DH	S	AJCC	Stage/Prognostic Factors	Revised
3430	Derived AJCC-7 Stage Grp	DH	RH*	DH	S	AJCC	Stage/Prognostic Factors	Revised
3440	Derived PreRx-7 T	.	.	.	.	AJCC	Stage/Prognostic Factors	
3442	Derived PreRx-7 T Descrip	.	.	.	.	AJCC	Stage/Prognostic Factors	
3450	Derived PreRx-7 N	.	.	.	.	AJCC	Stage/Prognostic Factors	
3452	Derived PreRx-7 N Descrip	.	.	.	.	AJCC	Stage/Prognostic Factors	
3460	Derived PreRx-7 M	.	.	.	.	AJCC	Stage/Prognostic Factors	
3462	Derived PreRx-7 M Descrip	.	.	.	.	AJCC	Stage/Prognostic Factors	
3470	Derived PreRx-7 Stage Grp	.	.	.	.	AJCC	Stage/Prognostic Factors	

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3480	Derived PostRx-7 T	.	.	.	.	AJCC	Stage/Prognostic Factors	
3482	Derived PostRx-7 N	.	.	.	.	AJCC	Stage/Prognostic Factors	
3490	Derived PostRx-7 M	.	.	.	.	AJCC	Stage/Prognostic Factors	
3492	Derived PostRx-7 Stge Grp	.	.	.	.	AJCC	Stage/Prognostic Factors	
3600	Derived Neoadjuv Rx Flag	.	.	.	.	AJCC	Stage/Prognostic Factors	
3605	Derived SEER Path Stg Grp	.	.	.	R	SEER	Stage/Prognostic Factors	New
3610	Derived SEER Clin Stg Grp	.	.	.	R	SEER	Stage/Prognostic Factors	New
3614	Derived SEER Cmb Stg Grp	.	.	.	R	SEER	Stage/Prognostic Factors	New
3616	Derived SEER Combined T	.	.	.	R	SEER	Stage/Prognostic Factors	New
3618	Derived SEER Combined N	.	.	.	R	SEER	Stage/Prognostic Factors	New
3620	Derived SEER Combined M	.	.	.	R	SEER	Stage/Prognostic Factors	New
3622	Derived SEER Cmb T Src	.	.	.	R	SEER	Stage/Prognostic Factors	New
3624	Derived SEER Cmb N Src	.	.	.	R	SEER	Stage/Prognostic Factors	New
3626	Derived SEER Cmb M Src	.	.	.	R	SEER	Stage/Prognostic Factors	New
3650	NPCR Derived Clin Stg Grp	R	R	.	.	NPCR	Stage/Prognostic Factors	New; Central registry use only
3655	NPCR Derived Path Stg Grp	R	R	.	.	NPCR	Stage/Prognostic Factors	New; Central registry use only
3700	SEER Site-Specific Fact 1	.	.	.	.	SEER	Stage/Prognostic Factors	
3702	SEER Site-Specific Fact 2	.	.	.	.	SEER	Stage/Prognostic Factors	
3704	SEER Site-Specific Fact 3	.	.	.	.	SEER	Stage/Prognostic Factors	
3706	SEER Site-Specific Fact 4	.	.	.	.	SEER	Stage/Prognostic Factors	
3708	SEER Site-Specific Fact 5	.	.	.	.	SEER	Stage/Prognostic Factors	
3710	SEER Site-Specific Fact 6	.	.	.	.	SEER	Stage/Prognostic Factors	
3720	NPCR Specific Field	R	R	.	.	NPCR	Stage/Prognostic Factors	
3750	Over-ride CS 1	RH	.	RH	R	AJCC	Edit Overrides/Conversion	Revised
3751	Over-ride CS 2	RH	.	RH	R	AJCC	Edit Overrides/Conversion	Revised
3752	Over-ride CS 3	RH	.	RH	R	AJCC	Edit Overrides/Conversion	Revised
3753	Over-ride CS 4	RH	.	RH	R	AJCC	Edit Overrides/Conversion	Revised
3754	Over-ride CS 5	RH	.	RH	R	AJCC	Edit Overrides/Conversion	Revised
3755	Over-ride CS 6	RH	.	RH	R	AJCC	Edit Overrides/Conversion	Revised
3756	Over-ride CS 7	RH	.	RH	R	AJCC	Edit Overrides/Conversion	Revised
3757	Over-ride CS 8	RH	.	RH	R	AJCC	Edit Overrides/Conversion	Revised
3758	Over-ride CS 9	RH	.	RH	R	AJCC	Edit Overrides/Conversion	Revised
3759	Over-ride CS 10	RH	.	RH	R	AJCC	Edit Overrides/Conversion	Revised
3760	Over-ride CS 11	RH	.	RH	R	AJCC	Edit Overrides/Conversion	Revised
3761	Over-ride CS 12	RH	.	RH	R	AJCC	Edit Overrides/Conversion	Revised
3762	Over-ride CS 13	RH	.	RH	R	AJCC	Edit Overrides/Conversion	Revised
3763	Over-ride CS 14	RH	.	RH	R	AJCC	Edit Overrides/Conversion	Revised
3764	Over-ride CS 15	RH	.	RH	R	AJCC	Edit Overrides/Conversion	Revised
3765	Over-ride CS 16	RH	.	RH	R	AJCC	Edit Overrides/Conversion	Revised
3766	Over-ride CS 17	RH	.	RH	R	AJCC	Edit Overrides/Conversion	Revised
3767	Over-ride CS 18	RH	.	RH	R	AJCC	Edit Overrides/Conversion	Revised
3768	Over-ride CS 19	RH	.	RH	R	AJCC	Edit Overrides/Conversion	Revised
3769	Over-ride CS 20	RH	RH	RH	R	AJCC/NPCR	Edit Overrides/Conversion	Revised
3780	Secondary Diagnosis 1	R	.	R	.	CoC	Stage/Prognostic Factors	For cases diagnosed 10/1/15+

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3782	Secondary Diagnosis 2	R	.	R	.	CoC	Stage/Prognostic Factors	For cases diagnosed 10/1/15+
3784	Secondary Diagnosis 3	R	.	R	.	CoC	Stage/Prognostic Factors	For cases diagnosed 10/1/15+
3786	Secondary Diagnosis 4	R	.	R	.	CoC	Stage/Prognostic Factors	For cases diagnosed 10/1/15+
3788	Secondary Diagnosis 5	R	.	R	.	CoC	Stage/Prognostic Factors	For cases diagnosed 10/1/15+
3790	Secondary Diagnosis 6	R	.	R	.	CoC	Stage/Prognostic Factors	For cases diagnosed 10/1/15+
3792	Secondary Diagnosis 7	R	.	R	.	CoC	Stage/Prognostic Factors	For cases diagnosed 10/1/15+
3794	Secondary Diagnosis 8	R	.	R	.	CoC	Stage/Prognostic Factors	For cases diagnosed 10/1/15+
3796	Secondary Diagnosis 9	R	.	R	.	CoC	Stage/Prognostic Factors	For cases diagnosed 10/1/15+
3798	Secondary Diagnosis 10	R	.	R	.	CoC	Stage/Prognostic Factors	For cases diagnosed 10/1/15+
7010	Path Reporting Fac ID 1	.	.	.	.	HL7	Pathology	
7011	Path Reporting Fac ID 2	.	.	.	.	HL7	Pathology	
7012	Path Reporting Fac ID 3	.	.	.	.	HL7	Pathology	
7013	Path Reporting Fac ID 4	.	.	.	.	HL7	Pathology	
7014	Path Reporting Fac ID 5	.	.	.	.	HL7	Pathology	
7090	Path Report Number 1	.	.	.	.	HL7	Pathology	
7091	Path Report Number 2	.	.	.	.	HL7	Pathology	
7092	Path Report Number 3	.	.	.	.	HL7	Pathology	
7093	Path Report Number 4	.	.	.	.	HL7	Pathology	
7094	Path Report Number 5	.	.	.	.	HL7	Pathology	
7100	Path Order Phys Lic No 1	.	.	.	.	HL7	Pathology	
7101	Path Order Phys Lic No 2	.	.	.	.	HL7	Pathology	
7102	Path Order Phys Lic No 3	.	.	.	.	HL7	Pathology	
7103	Path Order Phys Lic No 4	.	.	.	.	HL7	Pathology	
7104	Path Order Phys Lic No 5	.	.	.	.	HL7	Pathology	
7190	Path Ordering Fac No 1	.	.	.	.	HL7	Pathology	
7191	Path Ordering Fac No 2	.	.	.	.	HL7	Pathology	
7192	Path Ordering Fac No 3	.	.	.	.	HL7	Pathology	
7193	Path Ordering Fac No 4	.	.	.	.	HL7	Pathology	
7194	Path Ordering Fac No 5	.	.	.	.	HL7	Pathology	
7320	Path Date Spec Collect 1	.	.	.	.	HL7	Pathology	
7321	Path Date Spec Collect 2	.	.	.	.	HL7	Pathology	
7322	Path Date Spec Collect 3	.	.	.	.	HL7	Pathology	
7323	Path Date Spec Collect 4	.	.	.	.	HL7	Pathology	
7324	Path Date Spec Collect 5	.	.	.	.	HL7	Pathology	
7480	Path Report Type 1	.	.	.	.	HL7	Pathology	
7481	Path Report Type 2	.	.	.	.	HL7	Pathology	
7482	Path Report Type 3	.	.	.	.	HL7	Pathology	
7483	Path Report Type 4	.	.	.	.	HL7	Pathology	
7484	Path Report Type 5	.	.	.	.	HL7	Pathology	
TBD	Area Level Education	R	.	.	.	NPCR/CER	Socio-Economic Status	Central registry use only; For cases diagnosed 2011
TBD	Area Level Income	R	.	.	.	NPCR/CER	Socio-Economic Status	Central registry use only; For cases diagnosed 2011
TBD	Area Level Poverty	R	.	.	.	NPCR/CER	Socio-Economic Status	Central registry use only; For cases diagnosed 2011
TBD	Area Level Urban/Rural	R	.	.	.	NPCR/CER	Socio-Economic Status	Central registry use only; For cases diagnosed 2011
TBD	Area Level Health Professional Availabilit	R	.	.	.	NPCR/CER	Socio-Economic Status	Central registry use only; For cases diagnosed 2011

Item #	Item Name	NHSCR	NPCR	COC	SEER	Source of Standard	Section Name	Notes
TBD	Area Level Poverty Index	R	.	.	.	NPCR/CER	Socio-Economic Status	Central registry use only; For cases diagnosed 2011
TBD	Area Level Health Insurance Estimate	R	.	.	.	NPCR/CER	Socio-Economic Status	Central registry use only; For cases diagnosed 2011
9751	Chemo 1 NSC Number	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9752	Chemo 2 NSC Number	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9753	Chemo 3 NSC Number	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9754	Chemo 4 NSC Number	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9755	Chemo 5 NSC Number	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9756	Chemo 6 NSC Number	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9761	Chemo 1 Num Doses Planned	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9762	Chemo 2 Num Doses Planned	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9763	Chemo 3 Num Doses Planned	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9764	Chemo 4 Num Doses Planned	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9765	Chemo 5 Num Doses Planned	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9766	Chemo 6 Num Doses Planned	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9771	Chemo 1 Planned Dose	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9772	Chemo 2 Planned Dose	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9773	Chemo 3 Planned Dose	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9774	Chemo 4 Planned Dose	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9775	Chemo 5 Planned Dose	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9776	Chemo 6 Planned Dose	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9781	Chemo 1 Planned Dose Unit	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9782	Chemo 2 Planned Dose Unit	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9783	Chemo 3 Planned Dose Unit	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9784	Chemo 4 Planned Dose Unit	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9785	Chemo 5 Planned Dose Unit	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9786	Chemo 6 Planned Dose Unit	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9791	Chemo 1 Num Doses Receivd	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9792	Chemo 2 Num Doses Receivd	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9793	Chemo 3 Num Doses Receivd	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9794	Chemo 4 Num Doses Receivd	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9795	Chemo 5 Num Doses Receivd	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9796	Chemo 6 Num Doses Receivd	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9801	Chemo 1 Received Dose	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9802	Chemo 2 Received Dose	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9803	Chemo 3 Received Dose	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9804	Chemo 4 Received Dose	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9805	Chemo 5 Received Dose	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9806	Chemo 6 Received Dose	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9811	Chemo 1 Received DoseUnit	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9812	Chemo 2 Received DoseUnit	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9813	Chemo 3 Received DoseUnit	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9814	Chemo 4 Received DoseUnit	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9815	Chemo 5 Received DoseUnit	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9816	Chemo 6 Received DoseUnit	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011

Item #	Item Name	NHSCR	NPCR	COC	SEER	Source of Standard	Section Name	Notes
9821	Chemo 1 Start Date	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9822	Chemo 2 Start Date	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9823	Chemo 3 Start Date	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9824	Chemo 4 Start Date	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9825	Chemo 5 Start Date	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9826	Chemo 6 Start Date	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9831	Chemo 1 Start Date Flag	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9832	Chemo 2 Start Date Flag	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9833	Chemo 3 Start Date Flag	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9834	Chemo 4 Start Date Flag	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9835	Chemo 5 Start Date Flag	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9836	Chemo 6 Start Date Flag	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9841	Chemo 1 End Date	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9842	Chemo 2 End Date	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9843	Chemo 3 End Date	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9844	Chemo 4 End Date	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9845	Chemo 5 End Date	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9846	Chemo 6 End Date	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9851	Chemo 1 End Date Flag	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9852	Chemo 2 End Date Flag	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9853	Chemo 3 End Date Flag	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9854	Chemo 4 End Date Flag	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9855	Chemo 5 End Date Flag	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9856	Chemo 6 End Date Flag	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9859	Chemo Completion Status	RS	.	.	.	NPCR/CER	Treatment-1st Course	For Breast, Colorectal, CML cases diagnosed 2011
9861	Hormone 1 NSC Number	RS	.	.	.	NPCR/CER	Hormone Therapy	For Breast, Colorectal, CML cases diagnosed 2011
9862	Hormone 2 NSC Number	RS	.	.	.	NPCR/CER	Hormone Therapy	For Breast, Colorectal, CML cases diagnosed 2011
9871	BRM 1 NSC Number	RS	.	.	.	NPCR/CER	Biological Response Modifier	For Breast, Colorectal, CML cases diagnosed 2011
9872	BRM 2 NSC Number	RS	.	.	.	NPCR/CER	Biological Response Modifier	For Breast, Colorectal, CML cases diagnosed 2011
9880	Granulocyt CSF Status	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9881	Erythrocyte Growth Factor Status	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9882	Thrombocyte Growth Factor Status	RS	.	.	.	NPCR/CER	Chemotherapy	For Breast, Colorectal, CML cases diagnosed 2011
9920	Reason Subsq RX	RS	.	.	.	NPCR/CER	Subsequent Treatment	For Breast, Colorectal, CML cases diagnosed 2011
9955	Subsq RX 2nd Date Flag CER	RS	.	.	.	NPCR/CER/PC	Treatment-Subsq & Other	For Breast, Colorectal, CML cases diagnosed 2011
9921	Subsq RX 2nd Course Surgery	RS	.	.	.	NPCR/CER/PC	Subsequent Treatment	For Breast, Colorectal, CML cases diagnosed 2011
9922	Subsq RX 2nd Course Radiation	RS	.	.	.	NPCR/CER	Subsequent Treatment	For Breast, Colorectal, CML cases diagnosed 2011
9923	Subsq RX 2nd Course Chemotherapy	RS	.	.	.	NPCR/CER/PC	Subsequent Treatment	For Breast, Colorectal, CML cases diagnosed 2011
9924	Subsq RX 2nd Course Hormone	RS	.	.	.	NPCR/CER	Subsequent Treatment	For Breast, Colorectal, CML cases diagnosed 2011
9925	Subsq RX 2nd Course BRM	RS	.	.	.	NPCR/CER/PC	Subsequent Treatment	For Breast, Colorectal, CML cases diagnosed 2011
9926	Subsq RX 2nd Course Other	RS	.	.	.	NPCR/CER/PC	Subsequent Treatment	For Breast, Colorectal, CML cases diagnosed 2011
9927	Subsq RX 2nd Course Trans/End	RS	.	.	.	NPCR/CER	Subsequent Treatment	For Breast, Colorectal, CML cases diagnosed 2011
9931	Subsq RX 2nd Chemo 1 NSC	RS	.	.	.	NPCR/CER	Subsequent Treatment	For Breast, Colorectal, CML cases diagnosed 2011
9932	Subsq RX 2nd Chemo 2 NSC	RS	.	.	.	NPCR/CER	Subsequent Treatment	For Breast, Colorectal, CML cases diagnosed 2011
9933	Subsq RX 2nd Chemo 3 NSC	RS	.	.	.	NPCR/CER	Subsequent Treatment	For Breast, Colorectal, CML cases diagnosed 2011

Item #	Item Name	NHSCR	NPCR	COC	SEER	Source of Standard	Section Name	Notes
9934	Subsq RX 2nd Chemo 4 NSC	RS	.	.	.	NPCR/CER	Subsequent Treatment	For Breast, Colorectal, CML cases diagnosed 2011
9935	Subsq RX 2nd Chemo 5 NSC	RS	.	.	.	NPCR/CER	Subsequent Treatment	For Breast, Colorectal, CML cases diagnosed 2011
9936	Subsq RX 2nd Chemo 6 NSC	RS	.	.	.	NPCR/CER	Subsequent Treatment	For Breast, Colorectal, CML cases diagnosed 2011
9941	Subsq RX 2nd Horm 1 NSC	RS	.	.	.	NPCR/CER	Subsequent Treatment	For Breast, Colorectal, CML cases diagnosed 2011
9942	Subsq RX 2nd Horm 2 NSC	RS	.	.	.	NPCR/CER	Subsequent Treatment	For Breast, Colorectal, CML cases diagnosed 2011
9951	Subsq RX 2nd BRM 1 NSC	RS	.	.	.	NPCR/CER	Subsequent Treatment	For Breast, Colorectal, CML cases diagnosed 2011
9952	Subsq RX 2nd BRM 2 NSC	RS	.	.	.	NPCR/CER	Subsequent Treatment	For Breast, Colorectal, CML cases diagnosed 2011
9960	Height	R	.	.	.	NPCR/CER	Work Up	For cases diagnosed 2011+
9961	Weight	R	.	.	.	NPCR/CER	Work Up	For cases diagnosed 2011+
9900	BCR-ABL Cytogenetic	RS	.	.	.	NPCR/CER	Biomarkers BCR-ABL	For CML cases diagnosed 2011
9901	BCR-ABL Cytogenetic Date	RS	.	.	.	NPCR/CER	Biomarkers BCR-ABL	For CML cases diagnosed 2011
9902	BCR-ABL Cytogenetic Date Flag	RS	.	.	.	NPCR/CER	Biomarkers BCR-ABL	For CML cases diagnosed 2011
9903	BCR-ABL FISH	RS	.	.	.	NPCR/CER	Biomarkers BCR-ABL	For CML cases diagnosed 2011
9904	BCR-ABL FISH Date	RS	.	.	.	NPCR/CER	Biomarkers BCR-ABL	For CML cases diagnosed 2011
9905	BCR-ABL FISH Date Flag	RS	.	.	.	NPCR/CER	Biomarkers BCR-ABL	For CML cases diagnosed 2011
9906	BCR-ABL RT-PCR Qualitative	RS	.	.	.	NPCR/CER	Biomarkers BCR-ABL	For CML cases diagnosed 2011
9907	BCR-ABL RT-PCR Qual Date	RS	.	.	.	NPCR/CER	Biomarkers BCR-ABL	For CML cases diagnosed 2011
9908	BCR-ABL RT-PCR Qual Date Flag	RS	.	.	.	NPCR/CER	Biomarkers BCR-ABL	For CML cases diagnosed 2011
9909	BCR-ABL RT-PCR Quantitative	RS	.	.	.	NPCR/CER	Biomarkers BCR-ABL	For CML cases diagnosed 2011
9910	BCR-ABL RT-PCR Quant Date	RS	.	.	.	NPCR/CER	Biomarkers BCR-ABL	For CML cases diagnosed 2011
9911	BCR-ABL RT-PCR Quant Date Flag	RS	.	.	.	NPCR/CER	Biomarkers BCR-ABL	For CML cases diagnosed 2011
9965	Tobacco Use Cigarettes	R*	.	.	.	NPCR/CER	Work Up	For cases diagnosed 2011+
9966	Tobacco Use Other Smoke	R*	.	.	.	NPCR/CER	Work Up	For cases diagnosed 2011+
9967	Tobacco Use Smokeless	R*	.	.	.	NPCR/CER	Work Up	For cases diagnosed 2011+
9968	Tobacco Use NOS	R*	.	.	.	NPCR/CER	Work Up	For cases diagnosed 2011+
9970	Source Comorbidity	R	.	.	.	NPCR/CER	Comorbidities	For cases diagnosed 2011+
9980	NBCCEDP Linkage Results	RS	.	.	.	NPCR/CER	NBCCEDP	Central registry use only; For Breast & Cervix cases
9981	NBCCEDP Linkage Date	RS	.	.	.	NPCR/CER	NBCCEDP	Central registry use only; For Breast & Cervix cases
8000	Active Follow Up Date	RS*				NPCR/PCO	Follow-up/Recurrence/Death	For Breast & Colorectal cases diagnosed 2011
8001	Completion 1st Course Therapy Status	RS*				NPCR/PCO	Follow-up/Recurrence/Death	For Breast & Colorectal cases diagnosed 2011
8002	Completion 1st Course Therapy Date	RS*				NPCR/PCO	Follow-up/Recurrence/Death	For Breast & Colorectal cases diagnosed 2011
8003	Completion 1st Course Therapy Data Sou	RS*				NPCR/PCO	Follow-up/Recurrence/Death	For Breast & Colorectal cases diagnosed 2011
8004	Documented Disease Free Status	RS*				NPCR/PCO	Follow-up/Recurrence/Death	For Breast & Colorectal cases diagnosed 2011
8005	First Disease Free Date	RS*				NPCR/PCO	Follow-up/Recurrence/Death	For Breast & Colorectal cases diagnosed 2011
8006	First Disease Free Status Data Sources Us	RS*				NPCR/PCO	Follow-up/Recurrence/Death	For Breast & Colorectal cases diagnosed 2011
8007	Additional Disease Free Status	RS*				NPCR/PCO	Follow-up/Recurrence/Death	For Breast & Colorectal cases diagnosed 2011
8008	Last Disease Free Date	RS*				NPCR/PCO	Follow-up/Recurrence/Death	For Breast & Colorectal cases diagnosed 2011
8009	Additional Disease Free Status Data Sour	RS*				NPCR/PCO	Follow-up/Recurrence/Death	For Breast & Colorectal cases diagnosed 2011
8010	Recurrence Status	RS*				NPCR/PCO	Follow-up/Recurrence/Death	For Breast & Colorectal cases diagnosed 2011
8011	First Recurrence Date	RS*				NPCR/PCO	Follow-up/Recurrence/Death	For Breast & Colorectal cases diagnosed 2011
8012	Type of Recurrence	RS*				NPCR/PCO	Follow-up/Recurrence/Death	For Breast & Colorectal cases diagnosed 2011
8013	Recurrence Status Data Sources Used	RS*				NPCR/PCO	Follow-up/Recurrence/Death	For Breast & Colorectal cases diagnosed 2011
8014	Progression/Residual Disease Status	RS*				NPCR/PCO	Follow-up/Recurrence/Death	For Breast & Colorectal cases diagnosed 2011
8015	Progression Date	RS*				NPCR/PCO	Follow-up/Recurrence/Death	For Breast & Colorectal cases diagnosed 2011

Item #	Item Name	NHSCR	NPCR	COC	SEER	Source of Standard	Section Name	Notes
8016	Progression Residual Disease Status Sour	RS*				NPCR/PCO	Follow-up/Recurrence/Death	For Breast & Colorectal cases diagnosed 2011
8017	Subsequent Primary Status	RS*				NPCR/PCO	Follow-up/Recurrence/Death	For Breast & Colorectal cases diagnosed 2011
8018	Subsequent Primary Date	RS*				NPCR/PCO	Follow-up/Recurrence/Death	For Breast & Colorectal cases diagnosed 2011
8019	Subsequent Primary Data Sources Used	RS*				NPCR/PCO	Follow-up/Recurrence/Death	For Breast & Colorectal cases diagnosed 2011

Patient Identification

ACCESSION NUMBER
Section One, page 6 provides a more detailed definition of this data item

Item Length: 9
NAACCR Item #550
Revised 01/04, 01/10

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
- When a patient is deleted from the database, **do not** reuse the accession number for another patient.
- The first four numbers specify the year 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* (NAACCR Item #560) 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 thirty-third 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* (NAACCR Item #560) will distinguish this primary.
200300010	Patient diagnosed in November 2002 at another facility enters the reporting facility in January 2003, and is the tenth case accessioned in 2003.
200300012	Patient diagnosed in staff physician office in December 2002 enters the reporting facility in January 2003, and is the twelfth 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* (NAACCR Item #560) will distinguish this primary.
200300001	First patient diagnosed and/or treated and entered into the registry database for 2003.
200300999	Nine hundred ninety-ninth patient diagnosed and/or treated and entered into the registry database for 2003.
200401504	One thousand five hundred fourth patient diagnosed and/or treated and entered into the registry database for 2004.

SEQUENCE NUMBER

Section One, page 6 provides a more detailed definition of this data item

Item Length: 2
Allowable Values: 00–88, 99
NAACCR Item #560
Revised 06/05, 04/07, 01/10, 01/13

Description
Indicates the sequence of malignant and nonmalignant neoplasms over the lifetime of the patient.

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 (*Behavior* equals 2 or 3). Codes 60–88 indicate neoplasms of non-malignant behavior (*Behavior* equals 0 or 1).
- 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 subsequent tumors sequentially.
- Code 60 only if the patient has a single non-malignant primary. 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.
- 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 affects the sequence.

Malignant or In Situ Primaries

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 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

Non-Malignant Primaries

Code	Definition
60	One nonmalignant primary only in the patient's lifetime
61	First of two or more independent nonmalignant primaries
62	Second of two or more independent nonmalignant primaries
…	
…	(Actual sequence of this nonmalignant primary)
…	
87	Twenty-seventh of 27 or more independent nonmalignant primaries
88	Unspecified number of independent nonmalignant primaries

Examples

Code	Reason
00	Patient with no previous history of cancer diagnosed with *in situ* breast carcinoma on June 13, 2003
01	The sequence number is changed when the patient with an *in situ* breast carcinoma diagnosed 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* diagnosis on June 13, 2003
04	A nursing home patient is admitted to the 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 on August 30, 2003.
63	Myeloproliferative disease (9975/1) is diagnosed by the facility in 2003 and accessioned as Sequence 60. A benign brain tumor was diagnosed and treated elsewhere in 2002; the patient comes to the facility with a second independent benign brain tumor in 2004. Unaccessioned earlier brain tumor is counted as Sequence 61, myeloproliferative disease is resequenced to 62, and second benign brain tumor is Sequence 63.

MEDICAL RECORD NUMBER

Item Length: 11
Right Justified, Leading Blanks
NAACCR Item #2300
Revised 01/11

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 (One-day surgery clinic)	Record standard abbreviations for departments that do not use HIM medical record numbers.
———UNK	Unknown

SOCIAL SECURITY NUMBER

Item Length: 9
NAACCR Item #2320

NOTE: The NHSCR relies on correct patient identification to identify multiple reports on the same patient. It is important to record the correct *SSN* for each patient so that cases reported by multiple sources are correctly merged and consolidated.

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 "B" or "D" as 999999999. The patient receives benefits under the spouse's number and this is the spouse's Social Security number.

Code	Definition
(fill spaces)	Record the patient's Social Security number without dashes
999999999	Patient does not have a Social Security number; SSN is not available.

LAST NAME

Item Length: 40
Mixed Case, Left Justified
NAACCR Item #2230
Revised 01/04, 01/10

NOTE: The NHSCR relies on correct patient identification to identify multiple reports on the same patient. It is important to record the correct the most complete name available (last, first, middle, and alias).

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 last name to Smith-Jones
UNKNOWN	Patient's last name is not known, use UNKNOWN

FIRST NAME

NOTE: The NHSCR relies on correct patient identification to identify multiple reports on the same patient. It is important to record the correct the most complete name available (last, first, middle, and alias).

Item Length: 40
Mixed Case, Left Justified
NAACCR Item #2240
Revised 01/10, 01/11

Description
Identifies the first name of the patient.

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

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's name is Michael David Hogan
(leave blank)	If patient's first name is not known, do not fill in the space.

MIDDLE NAME
(MIDDLE INITIAL)

Item Length: 40
Mixed Case, Left Justified
NAACCR Item #2250
Revised 01/10, 01/11

NOTE: The NHSCR relies on correct patient identification to identify multiple reports on the same patient. It is important to record the correct the most complete name available (last, first, middle, and alias).

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. 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.

Name--Maiden

Alternate Name: Maiden Name (COC)

NOTE: The NHSCR relies on correct patient identification to identify multiple reports on the same patient. It is important to record the correct the most complete name available (last, first, middle, and alias).

Item Length: 40
Allowable Values: Blanks, spaces, hyphens, apostrophes are allowed; do not use other punctuation
NAACCR Item #2390
NHSCR-Specific

Description
Maiden name of female patients who are or have been married.

Rationale
This is used to link reports on a woman who changed her name between reports. It also is critical when using Spanish surname algorithms to categorize ethnicity.

Instructions for Coding
The field should be left blank if the maiden name is not known or not applicable. Since a value in this field may be used by linkage software or other computer algorithms, only legitimate surnames are allowable, and any variation of "unknown" or "not applicable" is not allowable.

Note: This data item is no longer supported by CoC (as of January 1, 2003).

Name--Alias

Alternate Name: Alias (CoC)

Item Length: 40
Allowable Values: Blanks, spaces, hyphens, apostrophes are allowed; do not use other punctuation
NAACCR Item #2280
NHSCR-Specific

Description
Records an alternate name or "AKA" (also known as) used by the patient, if known. Note that maiden name is entered in Name-Maiden [NAACCR Item #2390].

Name--Prefix

Alternate Name: Name Prefix (CoC)

Item Length: 3

NAACCR Item #2260
NHSCR-Specific

Description
Abbreviated title that precedes name in a letter (e.g., "Rev," "Ms").

Name--Suffix

Alternate Name: Name Suffix (CoC)

Item Length: 3

NAACCR Item #2270
NHSCR-Specific

Description
Title that follows a patient's last name, such as a generation order or credential status (e.g., "MD," "Jr.").

Note: These data items are no longer supported by CoC (as of January 1, 2003).

PATIENT ADDRESS (NUMBER AND STREET) AT DIAGNOSIS Item Length: 60
Uppercase, Left Justified
NAACCR Item #2330
Revised 01/10, 01/12

Description
Identifies the patient's address (number and street) at the time of diagnosis.[1]

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.

Instructions for Coding

- Record the number and street address or the rural mailing address of the patient's usual residence when the tumor was diagnosed.[2]
- 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 (for example, 39.2 RD), slashes for fractional addresses (101 1/2 MAIN ST), and hyphens when a hyphen carries meaning (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 (425 FLOWER BLVD #72).[3]
- 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" in Section One 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.

Additional Instructions for Coding:
[1]Non-analytic cases usually have vague information. As such, the *Address at Diagnosis* for many non-analytic cases may be unknown. Registries should ensure the patient's recorded residence is place of residence at the time he/she was diagnosed and/or treated.
[2]This address field is used to record only the number and street address of the patient. If a PO Box address is the only available information, record UNKNOWN in the *Patient Address at Diagnosis* data field, and record the PO Box address in the *Patient Address at Diagnosis-Supplemental* data field.
[3]Record address units (e.g. number of an apartment, unit, lot, space, suite, room, etc.) in the *Patient Address at Diagnosis-Supplemental* data field.

Place of Residence at Diagnosis

SEER registries collect information on place of residence at diagnosis. Information relating to address is not transmitted to SEER. The SEER rules for determining residency at diagnosis are either identical or comparable to rules used by the U.S. Census Bureau, to ensure comparability of definitions of cases (numerator) and the population at risk (denominator).

Coding Priorities/Sources

1. Code the **street address** of usual residence as stated by the patient. Definition: U.S. Census Bureau Instructions: "The place where he or she lives and sleeps most of the time or the place the person says is his or her usual home." The residency rules of departments of vital statistics may differ from those of the U.S. Census Bureau/SEER.
2. **A post office box** is not a reliable source to identify the residency at diagnosis. Post office box addresses do not provide accurate geographical information for analyzing cancer incidence. Use the post office box address only if no street address information is available after follow-back.
3. Use residency information from a **death certificate** only when the residency from other sources is coded as unknown. Review each case carefully and apply the U.S. Census Bureau/SEER rules for determining residence.
    a. For example, the death certificate may give the person's previous home address rather than the nursing home address as the place of residence. If the person was a resident of a nursing home at diagnosis, use the nursing home address as the place of residence.
4. Do not use **legal status** or **citizenship** to code residence

Persons with More than One Residence

1. Code the residence where the patient spends the majority of time (usual residence)
2. If the usual residence is not known or the information is not available, code the residence the patient specifies at the time of diagnosis

***Examples*:** 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

Homeless people and transients are examples of persons with no usual residence. Code the patient's residence at the time of diagnosis such as the shelter or the hospital where diagnosis was confirmed.

Temporary Residents of SEER Area

Code the place of usual residence rather than the temporary address for

Migrant workers
Educators temporarily assigned to a university in the SEER area
Persons **temporarily residing** with family during cancer treatment
Military personnel on **temporary** duty assignments (TDY)
Boarding school students below college level (code the parent's residence)

Code the residence where the student is living while attending **college**.

Source: Adamo M, Dickie, L, Ruhl J. (January 2016). SEER Program Coding and Staging Manual 2016. National Cancer Institute, Bethesda, MD 20850-9765. Available at: http://seer.cancer.gov/tools/codingmanuals/

Code the address of the institution for **Persons in Institutions**.

***Note*:** Code the physical address of the institution. Do not code the post office box.

U.S. Census Bureau definition: "Persons under formally authorized, supervised care or custody" are residents of the institution."

Persons who are incarcerated
Persons who are physically handicapped, mentally challenged, or mentally ill who are residents of homes, schools, hospitals or wards
Residents of nursing, convalescent, and rest homes
Long-term residents of other hospitals such as Veterans Administration (VA) hospitals

Persons in the Armed Forces and on Maritime Ships (including Merchant Marine) Armed Forces

For military personnel and their family members, code the address of the military installation or surrounding community as stated by the patient.

Personnel Assigned to Navy, Coast Guard, and Maritime Ships

The U.S. Census Bureau has detailed rules for determining residency for personnel assigned to these ships. The rules refer to the ship's deployment, port of departure, destination, and its homeport. Refer to U.S. Census Bureau Publications for detailed rules.

Source: Adamo M, Dickie, L, Ruhl J. (January 2016). SEER Program Coding and Staging Manual 2016. National Cancer Institute, Bethesda, MD 20850-9765. Available at: *http://seer.cancer.gov/tools/codingmanuals/*

PATIENT ADDRESS AT DIAGNOSIS–SUPPLEMENTAL

Item Length: 60
Uppercase, Left Justified
NAACCR Item #2335
Revised 09/06, 01/10, 01/12

Description
Provides the ability to store additional address information such as the name of a place or facility (for example, 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 (for example, 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" in Section One 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.

*Record address units (e.g. number of an apartment, unit, lot, space, suite, room, etc.) in the *Patient Address at Diagnosis-Supplemental* data field.

CITY/TOWN AT DIAGNOSIS
(CITY OR TOWN)

Item Length: 50
Uppercase, Left Justified
NAACCR Item #70
Revised 01/10

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" in Section One 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.

*Refer to *Appendix J: New Hampshire Town/County & Zip Codes*. Use the city/town names listed to record the *City/ Town at Diagnosis*. (i.e. Patient lives in the town of Beans Purchase, NH. Record as Gorham, NH.)

STATE AT DIAGNOSIS
(STATE)

Item Length: 2
Uppercase
NAACCR Item #80
Revised 09/06, 01/10, 01/11, 01/12

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
IL	If the state in which the patient resides at the time of diagnosis and treatment is Illinois, then use the USPS code for the state of Illinois.
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		State		State	
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	WV
Delaware	DE	Nevada	NV	Wisconsin	WI
District of Columbia	DC	New Hampshire	NH	Wyoming	WY
Florida	FL	New Jersey	NJ	United States, state unknown	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		Province/Territory	
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

POSTAL CODE AT DIAGNOSIS (ZIP CODE)

Item Length: 9
Left Justified
NAACCR Item #100
Revised 01/04

Refer to *Appendix F: New Hampshire Town/County & Zip Codes*.

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" in Section One for further instructions.

Code	Definition
(fill spaces)	The patient's nine-digit U.S. extended postal code. Do not record hyphens.
60611_ _ _ _	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.

ADDRESS AT DX--COUNTRY

Item Length: 3
Uppercase
NAACCR Item #102
Added 01/01/2013

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 *Addr 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 E 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

COUNTY AT DIAGNOSIS

For NH county codes, refer to *Appendix J: New Hampshire Town/County & Zip Codes*. The NH county codes listed on this table are the only acceptable county codes for the NHSCR.

Item Length: 3
Allowable Values: 001–997, 998, 999
NAACCR Item #90
Revised 09/06, 01/10, 01/15

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.

PATIENT ADDRESS (NUMBER AND STREET) CURRENT Item Length: 60
Uppercase, Left Justified
NAACCR Item #2350
Revised 09/04, 01/10, 01/12

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* (NAACCR #2330).

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 (for example, 39.2 RD), slashes for fractional addresses (101 1/2 MAIN ST), and hyphens when a hyphen carries meaning (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 (425 FLOWER BLVD #72).
- Update this data item if the patient's address changes.
- Do not change this item when the patient dies.
- See "Residency Rules" in Section One 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.

PATIENT ADDRESS CURRENT–SUPPLEMENTAL

Item Length: 60
Uppercase, Left Justified
NAACCR Item #2355
Revised 09/06, 01/10, 01/12

Description
Provides the ability to store additional address information such as the name of a place or facility (for example, 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 (for example, a nursing home or name of an apartment complex) of the patient's current usual residence.
- If the patient has multiple tumors, the address may be different for subsequent primaries.
- Update this data item if a patient's address changes.
- Do not use this data item to record the number and street address of the patient.
- Do not change this item when the patient dies.
- See "Residency Rules" in Section One 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/TOWN–CURRENT

Item Length: 50
Uppercase, Left Justified
NAACCR Item #1810
Revised 09/04

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

Rationale
This data item provides a current city or town used for follow-up purposes. It is different from *City/Town at Diagnosis* (NAACCR Item #70).

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 current city or town should be the same for all tumors.
- Update this data item if the patient's city or town of residence changes.
- Do not change this item when the patient dies.
- See "Residency Rules" in Section One 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 is unknown.

STATE–CURRENT

Item Length: 2
Uppercase
NAACCR Item #1820
Revised 09/06, 01/11, 01/12

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* (NAACCR Item #80).

Instructions for Coding
- Use U.S. Postal Service abbreviation for the state, territory, commonwealth, U.S. possession, or Canadian province or 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.

Examples:

Code	Definition
IL	If the state in which the patient resides at the time of diagnosis and treatment is Illinois, then use the USPS code for the state of Illinois.
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 U.S. abbreviations (refer to the ZIP Code directory for further listings):

State		State		State	
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	WV
Delaware	DE	Nevada	NV	Wisconsin	WI
District of Columbia	DC	New Hampshire	NH	Wyoming	WY
Florida	FL	New Jersey	NJ	United States, state unknown	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 or Territory abbreviations:

Province/Territory		Province/Territory	
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

POSTAL CODE–CURRENT (ZIP CODE)

Item Length: 9
Left Justified
NAACCR Item #1830
Revised 01/04

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* (NAACCR Item #100).

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.
- 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.
60611_ _ _ _	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.

ADDRESS CURRENT--COUNTRY

Item Length: 3
Uppercase
NAACCR Item #1832
Added 01/01/2013

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, and is useful for follow-up.

Instructions for Coding

- This item corresponds to Address Current--State..
- See Appendix E 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.

Common Country Codes

Code	Country
USA	United States
CAN	Canada

TELEPHONE

Item Length: 10
NAACCR Item #2360

Description
Records the current telephone number with area code for the patient.

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.

Code	Definition
(fill spaces)	Number is entered without dashes.
0000000000	Patient does not have a telephone.
9999999999	Telephone number is unavailable or unknown.

BIRTHPLACE--STATE

For cases diagnosed 01/01/2013 and later, Birthplace - State (#252) and Birthplace - Country (#254) replace Place of Birth (#250). See the 2013 NAACCR Implementation Guidelines for further information.

Item Length: 2
Uppercase
NAACCR Item #252
Added 01/13

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 E 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*.

Examples:

Code	Definition
IL	If the state in which the 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.

BIRTHPLACE--COUNTRY

For cases diagnosed 01/01/2013 and later, Birthplace - State (#252) and Birthplace - Country (#254) replace Place of Birth (#250). See the 2013 NAACCR Implementation Guidelines for further information.

Item Length: 3
Uppercase
NAACCR Item #254
Added 01/01/2013

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 E 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
ZZU	Place of birth is unknown, not mentioned in patient record.

DATE OF BIRTH

Item Length: 8
NAACCR Item #240
Revised 1/10

*NOTE: The NHSCR relies on correct patient identification to identify multiple reports on the same patient. It is important to record the correct *Date of Birth* for each patient so that cases reported by multiple sources are correctly merged and consolidated.

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* (NAACCR Item #241)
- 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 date 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* (NAACCR Item #241) 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

Item Length: 2
NAACCR Item #241
Valid Codes: 12, Blank
New Item: 1/1/2010

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date of Birth* (NAACCR Item #240).

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

Instructions for Coding
- Leave this item blank if *Date of Birth* (NAACCR Item #240) 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 value is provided in item *Date of Birth* (NAACCR Item #240)

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date of Birth* (NAACCR Item #240) and *Date of Birth Flag* (NAACCR Item #241). ***In the table below, the lowercase letter "b" is used to represent each blank space.***

Description	Traditional Birth Date	Interoperable Birth Date	Date of Birth Flag
	Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999	**Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown.**	
Full date known	MMDDCCYY (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

Item Length: 3
Allowable Values: 000–120, 999
Right Justified, Zero-filled
NAACCR Item #230
Revised 09/01/08

Description
Records the age of the patient at his or her last 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; diagnosed *in utero*
001	One year old but less than two years old
002	Two years old
...	Actual age in years
120	One hundred twenty years old
999	Unknown age *

*Registry software automatically calculates the age at diagnosis. When the date of diagnosis is unknown (99/99/9999), confirm that *Age at Diagnosis* is recorded as 999.

RACE 1

Item length: 2
Allowable Values: 01–08, 10–17, 20–22, 25–28, 30–32, 96–99
NAACCR Item #160
Revised 01/04, 09/08, 01/10, 01/12

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* (NAACCR Item #190). 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* (NAACCR Item #161) through *Race 5* (NAACCR Item #164), 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 *Race Coding System–Current* (NAACCR Item #170) is less than six (6) for cases diagnosed prior to January 1, 2000, then *Race 2* through *Race 5* must be blank.
- If a patient diagnosed prior to January 1, 2000, develops a subsequent primary after that date, then *Race Coding System–Current* must be six (6), and data items *Race 2* through *Race 5* that do not have specific race recorded must be coded 88.

Code	Label	Code	Label
01	White	20	Micronesian, NOS
02	Black	21	Chamorro/Chamoru
03	American Indian, Aleutian, or Eskimo (includes all indigenous populations of the Western hemisphere)	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 (formerly code 09)	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* (NAACCR Item #190).
02	A black female patient.
05	A patient has a Japanese father and a Caucasian mother. (Caucasian will be coded in *Race 2*).

RACE 2

Item Length: 2
Allowable Values: 01–08, 10–17, 20–22, 25–28, 30–32, 88, 96–99
NAACCR Item #161
Revised 01/04, 09/08, 01/10, 01/12

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* (NAACCR Item #190). Both items must be recorded. All tumors for the same patient should have the same race code.
- If *Race 1* (NAACCR Item #160) is coded 99, then *Race 2* must 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.
- See the instructions for *Race 1* (NAACCR Item #160) for coding sequences for entering multiple races.

Code	Label	Code	Label
01	White	20	Micronesian, NOS
02	Black	21	Chamorro/Chamoru
03	American Indian, Aleutian, or Eskimo (includes all indigenous populations of the Western hemisphere)	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	88	No additional races
13	Kampuchean (Cambodian)	96	Other Asian, including Asian, NOS and Oriental, NOS
14	Thai	97	Pacific Islander, NOS
15	Asian Indian or Pakistani, NOS (formerly code 09)	98	Other
16	Asian Indian	99	Unknown
17	Pakistani		

RACE 3

Item Length: 2
Allowable Values: 01–08, 10–17, 20–22, 25–28, 30–32, 88, 96–99
NAACCR Item #162
Revised 01/04, 09/08, 01/10, 01/12

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* (NAACCR Item #190). Both items must be recorded. All tumors for the same patient should have the same race code.
- If *Race 2* (NAACCR Item #161) is coded 88 or 99, then *Race 3* must be coded with the same value.
- 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 (NAACCR Item #160) for coding sequences for entering multiple races.

Code	Label	Code	Label
01	White	20	Micronesian, NOS
02	Black	21	Chamorro/Chamoru
03	American Indian, Aleutian, or Eskimo (includes all indigenous populations of the Western hemisphere)	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	88	No additional races
13	Kampuchean (Cambodian)	96	Other Asian, including Asian, NOS and Oriental, NOS
14	Thai	97	Pacific Islander, NOS
15	Asian Indian or Pakistani, NOS (formerly code 09)	98	Other
16	Asian Indian	99	Unknown
17	Pakistani		

RACE 4

Item Length: 2
Allowable Values: 01–08, 10–17, 20-22, 25–28, 30–32, 88, 96–99
NAACCR Item #163
Revised 01/04, 09/08, 01/10, 01/12

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* (NAACCR Item #190). Both items must be recorded. All tumors for the same patient should have the same race code.
- If *Race 3* (NAACCR Item #162) is coded 88 or 99, then *Race 4* must be coded with the same value.
- 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* (NAACCR Item #160) for coding sequences for entering multiple races.

Code	Label	Code	Label
01	White	20	Micronesian, NOS
02	Black	21	Chamorro/Chamoru
03	American Indian, Aleutian, or Eskimo (includes all indigenous populations of the Western hemisphere)	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	88	No additional races
13	Kampuchean (Cambodian)	96	Other Asian, including Asian, NOS and Oriental, NOS
14	Thai	97	Pacific Islander, NOS
15	Asian Indian or Pakistani, NOS (formerly code 09)	98	Other
16	Asian Indian	99	Unknown
17	Pakistani		

RACE 5

Item Length: 2
Allowable Values: 01–08, 10–17, 20-22, 25–28, 30–32, 88, 96–99
NAACCR Item #164
Revised 01/04, 09/08, 01/10, 01/12

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* (NAACCR Item #190). Both items must be recorded. All tumors for the same patient should have the same race code.
- If *Race 4* (NAACCR Item #163) is coded 88 or 99, then *Race 5* must be coded with the same value.
- 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* (NAACCR Item #160) for coding sequences for entering multiple races.

Code	Label	Code	Label
01	White	20	Micronesian, NOS
02	Black	21	Chamorro/Chamoru
03	American Indian, Aleutian, or Eskimo (includes all indigenous populations of the Western hemisphere)	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	88	No additional races
13	Kampuchean (Cambodian)	96	Other Asian, including Asian, NOS and Oriental, NOS
14	Thai	97	Pacific Islander, NOS
15	Asian Indian or Pakistani, NOS (formerly code 09)	98	Other
16	Asian Indian	99	Unknown
17	Pakistani		

SPANISH ORIGIN–ALL SOURCES (SPANISH/HISPANIC ORIGIN)

Item Length: 1
Allowable Values: 0–7, 9
NAACCR Item #190
Revised 09/04

Description
Identifies persons of Spanish or Hispanic origin.

Rationale
This code is used by hospital 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) of *Race 1*through *Race 5* (NAACCR Item #s 160–164).

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 America (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 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

SEX

Item Length: 1
Allowable Values: 1–4, 9
NAACCR Item #220
Revised 01/15, 01/16

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.
- 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) Hermaphrodite
4	Transsexual, NOS
5	Transsexual, natal male
6	Transsexual, natal female
9	Not stated in patient record *

Definitions
- **Intersex:** A person born with ambiguous reproductive or sexual anatomy; chromosomal genotype and sexual phenotype other than XY-male and XX-female
- **Transsexual:** A person who was assigned to one gender at birth based on physical characteristics but who self-identifies psychologically and emotionally as the other gender
- **Transgender:** See Transsexual
- **Transgendered person:** A person who identifies with or expresses a gender identity that differs from the one which corresponds to the person's sex at birth

*When gender is not known
a. Assign code **1** when the primary site is C600-C639
b. Assign code **2** when the primary site is C510-C589
c. Assign code **9** for primary sites not included above

Marital Status at DX

Alternate Name: Marital Status at Diagnosis (SEER/COC)

Item Length: 1
Allowable Values: 1-6, 9
NAACCR Item #150
NHSCR-Specific

Description

Code for the patient's marital status at the time of diagnosis for the reportable tumor. If the patient has multiple tumors, marital status may be different for each tumor.

Rationale

Incidence and survival with certain cancers vary by marital status. The item also helps in patient identification.

Instructions for Coding

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, other than common law marriage)
9	Unknown

Text--Usual Occupation

Item Length: 100
Allowable Values: Neither carriage return nor line feed characters allowed
Free text
NAACCR Item #310
NHSCR-Specific

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.

The data item "usual occupation" is defined identically as on death certificates and conforms to the 1989 revision of the U.S. Standard Certificate of Death.*

Abstracting Instructions
Record the patient's usual occupation (i.e., the kind of work performed during most of the patient's working life before diagnosis of this tumor). Do not record "retired." If usual occupation is not available or is unknown, record the patient's current or most recent occupation, or any available occupation.

If later documentation in the patient's record provides an occupation that is more likely to be the usual occupation than what was originally recorded, facility registrars are encouraged to update the abstract with the new information. However, it is not the responsibility of the facility registrars to update abstracts with occupation information provided on death certificates. Comparison with death certificate information should be the function of a central or regional registry.

If the patient was a househusband/housewife and also worked outside the home during most of his/her adult life, record the usual occupation outside the home; if the patient was a househusband/housewife and did not work outside the home for most of his/her adult life, record "househusband" or "housewife." If the patient was not a student or housewife and had never worked, record "never worked" as the usual occupation.

If no information is available, record "unknown."

This data item usually is collected only for patients who are age 14 years or older at the time of diagnosis.

*National Center for Health Statistics. Guidelines for Reporting Occupation and Industry on Death Certificates. Hyattsville, MD: National Center for Health Statistics; March 1988. PHS Pub. No. 88-1149.

Text--Usual Industry

Item Length: 100
Allowable Values: Neither carriage return nor line feed characters allowed
Free text
NAACCR Item #320
NHSCR-Specific

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.

The data item "usual industry" is defined identically as on death certificates and conforms to the 1989 revision of the U.S. Standard Certificate of Death.*

Abstracting Instructions
Record the primary type of activity carried on by the business/industry at the location where the patient was employed for the most number of years before diagnosis of this tumor. Be sure to distinguish among "manufacturing," "wholesale," "retail," and "service" components of an industry that 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 for facility registrars to record the name of the company (with city or town) in which the patient performed his/her usual industry. In these situations, if resources permit, a central or regional registry may be able to use the employer name and city/town to determine the type of activity conducted at that location.

As noted in the Text--Usual Occupation [NAACCR Item #310] section, in those situations where the usual occupation is not available or is unknown, the patient's current or most recent occupation is recorded, if available. The information for industry should be based upon the information in occupation. Therefore, if current or most recent occupation rather than usual occupation was recorded, record the patient's current or most recent business/industry.

If later documentation in the patient's record provides an industry that is more likely to be the usual industry than what was originally recorded, facility registrars are encouraged to update the abstract with the new information. However, it is not the responsibility of the facility registrars to update abstracts with industry information provided on death certificates. Comparison with death certificate information should be the function of a central or regional registry.

There should be an entry for Text--Usual Industry if any occupation is recorded. If no information is available regarding the industry in which the reported occupation was carried out, record "unknown." If the patient was not a student or housewife and had never worked, record "never worked" as the usual industry. This data item usually is collected only for patients who are age 14 years or older at the time of diagnosis.

*National Center for Health Statistics. Guidelines for Reporting Occupation and Industry on Death Certificates. Hyattsville, MD: National Center for Health Statistics; March 1988. PHS Pub. No. 88-1149.

PRIMARY PAYER AT DIAGNOSIS

Item Length: 2
Allowable Values: 01, 02, 10, 20, 21, 31, 35, 60–68, 99
NAACCR Item #630
Revised 06/05, 01/10

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 21and 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 a 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 described in code 35.
35	Medicaid administered through a Managed Care plan	Patient is enrolled in **Medicaid** through a Managed Care program (for example, 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 65 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 (for example, HMO or PPO). The Managed Care plan pays for all incurred costs.

Code	Label	Definition
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.
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. Formally 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 a 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.

COMORBIDITIES AND COMPLICATIONS #1 (Secondary Diagnoses)

Item Length: 5
Allowable Values: 00000, 00100–13980, 24000–99990, E8700–E8799, E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049
Left Justified, Zero-filled
NAACCR Item #3110
Revised 06/05, 01/11, 01/12, 01/13

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 #1* (NAACCR Item #3780) to record ICD-10-CM codes. During the adoption of ICD-10-CM codes, it is possible 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* (NAACCR Item #3190) is coded 1, 2, or 3, report *Comorbidities and Complications* ICD-9-CM codes appearing on the "readmission" discharge abstract.
- If no ICD-9-CM 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 ICD-9-CM secondary diagnoses are listed, then code the diagnoses listed, and leave the remaining *Comorbidities and Complications* data items blank.

Code	Definition, specific instructions
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
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 (Secondary Diagnoses)

Item Length: 5
Allowable Values: 00100–13980, 24000–99990, E8700–E8799, E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049
Left Justified, Zero-filled
NAACCR Item #3120
Revised 06/05, 01/11, 01/12, 01/13, 01/15

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* (NAACCR Item #3782) to record ICD-10-CM codes. During the adoption of ICD-10-CM codes, it is possible 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 the remaining *Comorbidities and Complications* items blank.
- For further Instructions for Coding, see *Comorbidities and Complications #1* (NAACCR Item #3110).

Code	Definition, specific instructions
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 (Secondary Diagnoses)

Item Length: 5
Allowable Values: 00100–13980, 24000–99990, E8700–E8799, E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049
Left Justified, Zero-filled
NAACCR Item #3130
Revised 06/05, 01/11, 01/12, 01/13, 01/15

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* (NAACCR Item #3784) to record ICD-10-CM codes. During adoption of ICD-10-CM codes, it is possible 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 the remaining *Comorbidities and Complications* items blank.
- For further Instructions for Coding, see *Comorbidities and Complications #1* (NAACCR Item #3110).

Code	Definition, specific instructions
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 (Secondary Diagnoses)

Item Length: 5
Allowable Values: 00100–13980, 24000–99990, E8700–E8799, E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049
Left Justified, Zero-filled
NAACCR Item #3140
Revised 06/05, 01/11, 01/12, 01/13, 01/15

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* (NAACCR Item #3786) to record ICD-10-CM codes. During adoption of ICD-10-CM, it is possible 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 the remaining *Comorbidities and Complications* items blank.
- For further Instructions for Coding, see *Comorbidities and Complications #1* (NAACCR Item #3110).

Code	Definition, specific instructions
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 (Secondary Diagnoses)

Item Length: 5
Allowable Values: 00100–13980, 24000–99990, E8700–E8799, E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049
Left Justified, Zero-filled
NAACCR Item #3150
Revised 06/05, 01/11, 01/12, 01/13, 01/15

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 risk 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* (NAACCR Item #3788) to record ICD-10-CM codes. During the adoption of ICD-10-CM codes, it is possible 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 the remaining *Comorbidities and Complications* items blank.
- For further Instructions for Coding, see *Comorbidities and Complications #1* (NAACCR Item #3110).

Code	Definition, specific instructions
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 (Secondary Diagnoses)

Item Length: 5
Allowable Values: 00100–13980,24000–99990, E8700–E8799, E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049
Left Justified, Zero-filled
NAACCR Item #3160
Revised 06/05, 01/11, 01/12, 01/13, 01/15

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* (NAACCR Item #3790) to record ICD-10-CM codes. During the adoption of ICD-10-CM codes, it is possible both will appear in the 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 the remaining *Comorbidities and Complications* items blank.
- For further Instructions for Coding, see *Comorbidities and Complications #1* (NAACCR Item #3110).

Code	Definition, specific instructions
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 (Secondary Diagnoses)

Item Length: 5
Allowable Values: 00100–13980, 24000–99990, E8700–E8799, E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049
Left Justified, Zero-filled
NAACCR Item #3161
Revised 01/11, 01/12, 01/13, 01/15

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 (NAACCR Item #3792) to record ICD-10-CM codes. During the adoption of ICD-10-CM codes, it is possible 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 the remaining *Comorbidities and Complications* items blank.

For further Instructions for Coding, see *Comorbidities and Complications #1* (NAACCR Item #3110).

Code	Definition, specific instructions
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 (Secondary Diagnoses)

Item Length: 5
Allowable Values: 00100–13980, 24000–99990, E8700–E8799, E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049
Left Justified, Zero-filled
NAACCR Item #3162
Revised 01/11, 01/12, 01/13, 01/15

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* (NAACCR Item #3792) to record ICD-10-CM. During the adoption of ICD-10-CM codes, it is possible 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 the remaining *Comorbidities and Complications* items blank.
- For further Instructions for Coding, see *Comorbidities and Complications #1* (NAACCR Item #3110).

Code	Definition, specific instructions
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 (Secondary Diagnoses)

Item Length: 5
Allowable Values: 00100–13980, 24000–99990, E8700–E8799, E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049
Left Justified, Zero-filled
NAACCR Item #3163
Revised 01/11, 01/12, 01/13, 01/15

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* (NAACCR Item #3796) to record ICD-10-CM codes. During the adoption of ICD-10-CM codes, it is possible 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 the remaining *Comorbidities and Complications* items blank.
- For further Instructions for Coding, see *Comorbidities and Complications #1* (NAACCR Item #3110).

Code	Definition, specific instructions
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 (Secondary Diagnoses)

Item Length: 5
Allowable Values: 00100–13980, 24000–99990, E8700–E8799, E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049
Left Justified, Zero-filled
NAACCR Item #3164
Revised 01/11, 01/12, 01/13, 01/15

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 #10* (NAACCR Item #3798) to record ICD-10-CM codes. During the adoption of ICD-10-CM codes, it is possible 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 10 comorbid conditions or complications are listed, then leave this data item blank.
- For further Instructions for Coding, see *Comorbidities and Complications #1* (NAACCR Item #3110).

Code	Definition, specific instructions
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
(Secondary Diagnoses)

Item Length: 7
Allowable Values: 0000000; all values beginning with A-B, E, G-P, R-S; and the following ranges: T36-T50996ZZ, Y62-Y849ZZZ, Z1401-Z229ZZZ, Z681-Z6854ZZ, Z80-Z809ZZZ, Z8500-Z9989ZZ
Left Justified, omit decimals
All alpha characters capitalized
Trailing blanks allowed
NAACCR Item #3780
New 01/01/2013

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
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-10-CM codes. Use *Comorbidities and Complications #1* (NAACCR Item #3110) to record ICD-9-CM codes. During the adoption of ICD-10-CM codes, it is possible 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* (NAACCR Item #3190) 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
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 E873.2)
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
(Secondary Diagnoses)

Item Length: 7
Allowable Values: 0000000; all values beginning with A-B, E, G-P, R-S; and the following ranges: T36-T50996ZZ, Y62-Y849ZZZ, Z1401-Z229ZZZ, Z681-Z6854ZZ, Z80-Z809ZZZ, Z8500-Z9989ZZ
Left Justified, omit decimals
All alpha characters capitalized
Trailing blanks allowed
NAACCR Item #3782
Revised 01/15

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
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-10-CM codes. Use *Comorbidities and Complications #2* (NAACCR Item #3120) to record ICD-9-CM codes. During the adoption of ICD-10-CM codes, it is possible 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* (NAACCR Item #3190) 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
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 E873.2)
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	Fewer than two applicable ICD-10-CM codes are recorded in this patient's record

SECONDARY DIAGNOSIS #3
(Secondary Diagnoses)

Item Length: 7
Allowable Values: 0000000; all values beginning with A-B, E, G-P, R-S; and the following ranges: T36-T50996ZZ, Y62-Y849ZZZ, Z1401-Z229ZZZ, Z681-Z6854ZZ, Z80-Z809ZZZ, Z8500-Z9989ZZ
Left Justified, omit decimals
All alpha characters capitalized
Trailing blanks allowed
NAACCR Item #3784
Revised 01/15

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
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-10-CM codes. Use *Comorbidities and Complications #4* (NAACCR Item #3130) to record ICD-9-CM codes. During the adoption of ICD-10-CM codes, it is possible 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* (NAACCR Item #3190) 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
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 E873.2)
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	Fewer than three applicable ICD-10-CM codes are recorded in this patient's record

SECONDARY DIAGNOSIS #4
(Secondary Diagnoses)

Item Length: 7
Allowable Values: 0000000; all values beginning with A-B, E, G-P, R-S; and the following ranges: T36-T50996ZZ, Y62-Y849ZZZ, Z1401-Z229ZZZ, Z681-Z6854ZZ, Z80-Z809ZZZ, Z8500-Z9989ZZ
Left Justified, omit decimals
All alpha characters capitalized
Trailing blanks allowed
NAACCR Item #3786
Revised 01/15

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
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-10-CM codes. Use *Comorbidities and Complications #4* (NAACCR Item #3140) to record ICD-9-CM codes. During the adoption of ICD-10-CM codes, it is possible 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* (NAACCR Item #3190) 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
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 E873.2)
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	Fewer than four applicable ICD-10-CM codes are recorded in this patient's record

SECONDARY DIAGNOSIS #5
(Secondary Diagnoses)

Item Length: 7
Allowable Values: 0000000; all values beginning with A-B, E, G-P, R-S; and the following ranges: T36-T50996ZZ, Y62-Y849ZZZ, Z1401-Z229ZZZ, Z681-Z6854ZZ, Z80-Z809ZZZ, Z8500-Z9989ZZ
Left Justified, omit decimals
All alpha characters capitalized
Trailing blanks allowed
NAACCR Item #3788
Revised 01/15

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
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-10-CM codes. Use *Comorbidities and Complications #5* (NAACCR Item #3150) to record ICD-9-CM codes. During the adoption of ICD-10-CM codes, it is possible 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* (NAACCR Item #3190) 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
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 E873.2)
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	Fewer than five applicable ICD-10-CM codes are recorded in this patient's record

SECONDARY DIAGNOSIS #6
(Secondary Diagnoses)

Item Length: 7
Allowable Values: 0000000; all values beginning with A-B, E, G-P, R-S; and the following ranges: T36-T50996ZZ, Y62-Y849ZZZ, Z1401-Z229ZZZ, Z681-Z6854ZZ, Z80-Z809ZZZ, Z8500-Z9989ZZ
Left Justified, omit decimals
All alpha characters capitalized
Trailing blanks allowed
NAACCR Item #3790
Revised 01/15

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
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-10-CM codes. Use *Comorbidities and Complications #6* (NAACCR Item #3160) to record ICD-9-CM codes. During the adoption of ICD-10-CM codes, it is possible 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* (NAACCR Item #3190) 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
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 E873.2)
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	Fewer than six applicable ICD-10-CM codes are recorded in this patient's record

SECONDARY DIAGNOSIS #7
(Secondary Diagnoses)

Item Length: 7
Allowable Values: 0000000; all values beginning with A-B, E, G-P, R-S; and the following ranges: T36-T50996ZZ, Y62-Y849ZZZ, Z1401-Z229ZZZ, Z681-Z6854ZZ, Z80-Z809ZZZ, Z8500-Z9989ZZ
Left Justified, omit decimals
All alpha characters capitalized
Trailing blanks allowed
NAACCR Item #3792
Revised 01/15

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
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-10-CM codes. Use *Comorbidities and Complications #7* (NAACCR Item #3161) to record ICD-9-CM codes. During the adoption of ICD-10-CM codes, it is possible 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* (NAACCR Item #3190) 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
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 E873.2)
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	Fewer than seven applicable ICD-10-CM codes are recorded in this patient's record

SECONDARY DIAGNOSIS #8
(Secondary Diagnoses)

Item Length: 7
Allowable Values: 0000000; all values beginning with A-B, E, G-P, R-S; and the following ranges: T36-T50996ZZ, Y62-Y849ZZZ, Z1401-Z229ZZZ, Z681-Z6854ZZ, Z80-Z809ZZZ, Z8500-Z9989ZZ
Left Justified, omit decimals
All alpha characters capitalized
Trailing blanks allowed
NAACCR Item #3794
Revised 01/15

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
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-10-CM codes. Use *Comorbidities and Complications #8* (NAACCR Item #3162) to record ICD-9-CM codes. During the adoption of ICD-10-CM codes, it is possible 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* (NAACCR Item #3190) 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
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 E873.2)
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	Fewer than eight applicable ICD-10-CM codes are recorded in this patient's record

SECONDARY DIAGNOSIS #9
(Secondary Diagnoses)

Item Length: 7
Allowable Values: 0000000; all values beginning with A-B, E, G-P, R-S; and the following ranges: T36-T50996ZZ, Y62-Y849ZZZ, Z1401-Z229ZZZ, Z681-Z6854ZZ, Z80-Z809ZZZ, Z8500-Z9989ZZ
Left Justified, omit decimals
All alpha characters capitalized
Trailing blanks allowed
NAACCR Item #3796
Revised 01/15

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
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-10-CM codes. Use *Comorbidities and Complications #9* (NAACCR Item #3163) to record ICD-9-CM codes. During the adoption of ICD-10-CM codes, it is possible 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* (NAACCR Item #3190) 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
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 E873.2)
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	Fewer than nine applicable ICD-10-CM codes are recorded in this patient's record

SECONDARY DIAGNOSIS #10
(Secondary Diagnoses)

Item Length: 7
Allowable Values: 0000000; all values beginning with A-B, E, G-P, R-S; and the following ranges: T36-T50996ZZ, Y62-Y849ZZZ, Z1401-Z229ZZZ, Z681-Z6854ZZ, Z80-Z809ZZZ, Z8500-Z9989ZZ
Left Justified, omit decimals
All alpha characters capitalized
Trailing blanks allowed
NAACCR Item #3798
Revised 01/15

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
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-10-CM codes. Use *Comorbidities and Complications #10* (NAACCR Item #3164) to record ICD-9-CM codes. During the adoption of ICD-10-CM codes, it is possible 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* (NAACCR Item #3190) 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
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 E873.2)
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	Fewer than ten applicable ICD-10-CM codes are recorded in this patient's record

NPI–MANAGING PHYSICIAN

Item Length: 10
Allowable Value: 10 digits
NAACCR Item #2465
Revised 04/07, 09/08

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 accordance with CoC Standards. In most cases, the managing physician is responsible for AJCC staging.

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.

Physician--Managing

Alternate Name: Managing Physician (COC)
Attending Physician (pre-96 COC)

Item Length: 8
Left justified
NAACCR Item #2460
NHSCR-Specific

Description

Code for the physician who is responsible for the overall management of the patient during diagnosis and/or treatment for this cancer. Registry may use physicians' medical license numbers or may create individual numbering systems.

Rationale

Used to monitor patient care.

Instructions for Coding*

Codes in addition to medical license numbers or facility-generated codes:

Code	Definition
99999999	Managing physician unknown or ID number not assigned

Note 1: Registry software should transmit this variable in text format in NAACCR Item #2220 State/Requestor Items

Note 2: This item is not supported by CoC as of January 1, 2010, (the respective NPI item is required).

NPI–FOLLOWING PHYSICIAN

Item Length: 10
Allowable Value: 10 digits
NAACCR Item #2475
Revised 04/07, 09/08, 01/11

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.

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–PRIMARY SURGEON

Item Length: 10
Allowable Value: 10 digits
NAACCR Item #2485
Revised 04/07, 09/08, 01/11

Description
Identifies the physician who performed the most definitive surgical procedure.

Rationale
Administrative, physician, and service referral reports are based on this item.

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	Definitions
(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. The physician who performed the surgical procedure was not a surgeon (for example, general practitioner).

NPI–PHYSICIAN #3 (Radiation Oncologist–CoC Preferred)

Item Length: 10
Allowable Value: 10 digits
NAACCR Item #2495
Revised 4/07, 9/08, 1/10, 1/11

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.

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://npes.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 primary radiation oncologist.
(leave blank)	NPI for the primary radiation oncologist is unknown or not available.

NPI–PHYSICIAN #4 (Medical Oncologist–CoC Preferred)

Item Length: 10
Allowable Value: Ten digits
NAACCR Item #2505
Revised 4/07, 9/08, 1/10, 1/11, 1/12

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.

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 primary medical oncologist.
(leave blank)	NPI for the primary medical oncologist is unknown or not available.

Cancer Identification

Type of Reporting Source

Item Length: 1
Allowable Values: 1-8
NAACCR Item #500
NHSCR-Specific

Description
This variable 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. This is a change to reflect the addition of codes 2 and 8 and to prioritize laboratory reports over nursing home reports. The source facilities included in the previous code 1 (hospital inpatient and outpatient) are split between codes 1, 2, and 8.

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 coded with '2' usually have complete information on the cancer diagnosis, staging, and treatment.

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 office.

Code	Definition
1	Hospital inpatient; Managed health plans with comprehensive, unified medical records
2	Radiation Treatment Centers or Medical Oncology Centers (hospital-affiliated or independent)
3	Laboratory only (hospital-affiliated or independent)
4	Physician's office/private medical practitioner (LMD)
5	Nursing/convalescent home/hospice
6	Autopsy only
7	Death certificate only
8	Other hospital outpatient units/surgery centers

Casefinding Source

Item Length: 2
Allowable Values: 10, 20-30, 40, 50, 60, 70, 75, 80, 85, 90, 95, 99
NAACCR Item #501
NHSCR-Specific

Effective with cases diagnosed on or after January 1, 2006.

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

This variable is intended to 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.

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, codes 23; includes nuclear medicine)
27	Tumor Board
28	Hospital Rehabilitation Service or Clinic
29	Other Hospital Source (including clinic, NOS or outpatient department, NOS)

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

Text--Place of Diagnosis

Alternate Name: Place of Diagnosis

Item Length: 60
Allowable Values: Neither carriage return nor line feed characters allowed
Free text
NAACCR Item #2690
NHSCR-Specific

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 within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

Instructions
• Prioritize entered information in the order of the fields listed below.
• NAACCR-approved abbreviations should be utilized.
• 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.

Note: For software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

Suggestions for text:
• The complete name of the hospital or the 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
After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item Numbers: 2410, 2420, 500, 540, 610, 670, 740

CLASS OF CASE

Certain nonanalytic cases are required by the NHSCR. See coding instructions and codes listed below.

Item Length: 2
Allowable Values: 00, 10-14, 20-22, 30-38, 40-43, 49, 99
NAACCR Item #610
Revised 09/08, 01/10, 05/10, 01/11, 01/12, 01/14, 01/15

Description
Class of Case divides cases into two groups. Analytic cases (codes 00–22) are those that are required by CoC to be abstracted because of the program's primary responsibility in managing the cancer. Analytic cases are grouped according to the location of diagnosis and first course of treatment. Nonanalytic 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. Nonanalytic cases are grouped according to the reason a patient who received care at the facility is nonanalytic, 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–Institution Referred To* (NAACCR Item #2425) or the applicable physician NPI (NAACCR #s 2585, 2495, 2505) 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 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). CIS, CIN III, and PIN III are not reportable to NHSCR.
- Physicians who are not employed by the hospital 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 infusion elsewhere and continues at the reporting facility, and the care is not in-transit, then the case is analytic (*Class of Case* 21).

Codes

Analytic Classes of Case (Required by CoC to be abstracted by accredited programs)		
	Initial diagnosis at reporting facility or in a staff physician's office	
00		Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done elsewhere
10		Initial diagnosis at the reporting facility or in an office of a physician with admitting privileges AND part or all of 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	
20		Initial diagnosis elsewhere AND all or part 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
Classes of Case not required by CoC to be abstracted (May be required by Cancer Committee, state or regional registry, or other entity)*		
	Patient appears in person at reporting facility	
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 by CoC 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 all or part of first course treatment by reporting facility
36		Type of case not required by CoC 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 the 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		Nonstaff 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 DCO cases are accessioned only by NHSCR.
99		Nonanalytic case of unknown relationship to facility (not for use by CoC accredited cancer programs for analytic cases).

*Non-analytic cases are required by NHSCR to be abstracted and reported by New Hampshire reporting facilities only IF the case has not been reported by the diagnosing or treating facility. See NHSCR Non-Analytic Tracking Form procedure found at: *http://geiselmed.dartmouth.edu/nhscr/registrars/*

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 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 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.

NPI–INSTITUTION REFERRED FROM

Item Length: 10
Allowable Value: Ten digits
NAACCR Item #2415
Revised 04/07, 09/08, 01/11

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.

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 on *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–INSTITUTION REFERRED TO

Item Length: 10
Allowable Value: 10 digits
NAACCR Item #2425
Revised 04/07, 09/08, 01/11

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.

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 on *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 another facility.

DATE OF FIRST CONTACT

Item Length: 8
NAACCR Item #580
Revised 09/06, 01/04, 01/10, 01/11

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.
- 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 First Contact Flag* (NAACCR Item #581) 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

Patient undergoes a biopsy in a staff 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.	September 14, 2009
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.	December 7, 2010
Information is limited to the description "Spring," 2011.	April 2011
Information is limited to the description "The middle of the year," 2011.	July 2011
Information is limited to the description "Fall," 2011.	October 2011
If information is limited to the description "Winter," try to determine if this means the beginning or the end of the year.	December or January

DATE OF FIRST CONTACT FLAG

Item Length: 2
NAACCR Item #581
Valid codes: 12, Blank
New Item: 1/1/2010

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date of First Contact* (NAACCR Item #580).

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

Instructions for Coding

- Leave this item blank if *Date of First Contact* (NAACCR Item #580) has a full or partial date recorded.
- Code 12 if the *Date of First Contact* can not 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 (that is, the date of first contact is unknown)
(blank)	A valid date value is provided in item *Date of First Contact* (NAACCR Item #580)

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date of First Contact* (NAACCR Item #580) and *Date of First Contact Flag* (NAACCR Item #581). ***In the table below, the lowercase letter "b" is used to represent each blank space.***

Description	Traditional Date of First Contact	Interoperable Date of First Contact	Date of First Contact Flag
	Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999	**Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown.**	
Full date known	MMDDCCYY (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

DATE OF INITIAL DIAGNOSIS

Item Length: 8
NAACCR Item #390
Revised 09/04, 09/08, 1/10, 01/11

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 established.
- 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" in Section One 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* (NAACCR Item #610) 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.
- 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* 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).

PRIMARY SITE

Item Length: 4
NAACCR Item #400
Revised 01/04, 09/08, 01/10

Description
Identifies the primary site.

Rationale
Primary site is a basis for staging and the determination of treatment options. It 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 *SEER 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 different subsites of 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 2007 Multiple Primary and Histology Coding Rules*.
C16–	Stomach (sub-site as identified). An extranodal lymphoma of the stomach is coded to C16.– (sub-site as identified).

Text--Primary Site Title

Item Length: 100
Allowable Values: Neither carriage return nor line feed characters allowed
Free text
NAACCR Item #2580
NHSCR-Specific

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 within 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 reporter independently from the code(s). If 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
• Prioritize entered information in the order of the fields listed below.
• Text automatically generated from coded data is not acceptable.
• NAACCR-approved abbreviations should be utilized.
• 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.

Note: For software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

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
After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item Name	Item Number
Primary Site	400
Laterality	410

LATERALITY

Item Length: 1
Allowable Values: 0–4, 9
NAACCR Item #410
Revised 01/10, 05/10, 01/13

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 Section One for additional information.)
- 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, single histology; bilateral retinoblastomas; bilateral Wilms tumors
5	Paired site: midline tumor
9	Paired site, but no information concerning laterality

HISTOLOGY

Item Length: 4
NAACCR Item #522
Revised 09/06, 01/10, 03/10

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, pp. 69–104) and in the Alphabetic Index (ICD-O-3, pp. 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.

Text--Histology Title

Item Length: 100
Allowable Values: Neither carriage return nor line feed characters allowed
Free text
NAACCR Item #2590
NHSCR-Specific

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 within 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 reporter independently from the code(s). If 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
• Prioritize entered information in the order of the fields listed below.
• Text automatically generated from coded data is not acceptable.
• NAACCR-approved abbreviations should be utilized.
• 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.

Note: For software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

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
After manual entry of the text field, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes in the following fields:

Item Name	Item Number
Histology (92-00) ICD-O-2	420
Behavior (92-00) ICD-O-2	430
Histologic Type ICD-O-3	522
Behavior Code ICD-O-3	523
Grade	440

Thornton ML, (ed). Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Record Layout Version 16, 20th ed. Springfield, IL: North American Association of Central Cancer Registries, September 2015, revised October 2015, revised November 2015.

BEHAVIOR CODE

Item Length: 1
Allowable Values: 0–3
NAACCR Item #523
Revised 04/04, 01/10, 01/12, 01/13, 01/15

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 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 by agreement of North American registry standard-setters. Refer to "Case Eligibility" in Section One for information. **Gastro-intestinal stromal tumors (GIST) and thymomas are frequently non-malignant. However, they must be abstracted and assigned a *Behavior Code* of 3 if they are noted to have multiple foci, metastasis or positive lymph nodes.**

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	Adenocarcinoma in an adenomatous polyp with no invasion of stalk
		Bowen disease (not reportable for C44._)
		Clark level 1 for melanoma (limited to epithelium)
		Comedocarcinoma, noninfiltrating (C50.–)
		Confined to epithelium
		Hutchinson melanotic freckle, NOS (C44.–)
		Intracystic, noninfiltrating.(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, noninfiltrating (C50.–) (carcinoma)
		Noninfiltrating (carcinoma)

Code	Label	Definition
2	In situ and synonymous with in situ (continued)	Noninvasive (carcinoma only)
		No stromal invasion or involvement
		Papillary, noninfiltrating or intraductal (carcinoma)
		Precancerous melanosis (C44.–)
		Queyrat erythroplasia (C60.–)
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 whether malignant or benign)
3	Malignant GIST

GRADE/DIFFERENTIATION

Item Length: 1
Allowable Values: 1–9
NAACCR Item #440
Revised 01/04, 09/08, 01/10, 01/11, 01/12, 01/13, 01/15

Description
Describes the tumor's resemblance to normal tissue. Well differentiated (Grade 1) is the most like normal tissue, and undifferentiated (Grade 4) 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.

Instructions for Coding
- See "Morphology: Grade" in the "Cancer Identification" of *Section I* for instructions for coding this item for cases diagnosed in 2014 or subsequently. Consult the applicable version of **FORDS** for cases 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.

Code	Label
1	Well differentiated; differentiated, NOS
2	Moderately differentiated; moderately well differentiated; intermediate differentiation
3	Poorly differentiated; dedifferentiated
4	Undifferentiated; anaplastic
5	T cell; T-precursor
6	B cell; pre-B; B-precursor
7	Null cell; non T-non B
8	NK (natural killer) cell (effective with diagnosis 1/1/95 and after)
9	Cell type not determined, not stated or not applicable; unknown primary; high grade dysplasia (adenocarcinoma in situ)

LYMPH-VASCULAR INVASION

Item Length: 1
Allowable Values: 0-1, 8-9
NAACCR Item #1182
Revised 01/11

Description
Indicates the presence or absence of tumor cells in 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 the CS algorithm to map AJCC T for some primary sites.

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.

DIAGNOSTIC CONFIRMATION

Item Length: 1
Allowable Values: 1, 2, 4–9
NAACCR Item #490
Revised 01/04, 01/10, 01/11, 01/12, 01/13

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 has 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. CoC does not require programs to abstract cases that contain ambiguous terminology regarding a cytologic diagnosis.
- 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.

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 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. Examples include alpha-fetoprotein for liver primaries. Elevated PSA is not diagnostic of cancer. However, if the physician uses the 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 nonanalytic).

The codes for hematopoietic and lymphoid neoplasms are on the next page.

Codes for Hematopoietic and Lymphoid Neoplasms

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 nonanalytic).

REGIONAL LYMPH NODES EXAMINED

Item Length: 2
Allowable Values: 00–90, 95–99
NAACCR Item #830
Revised 09/06, 01/10

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 became a component of the Collaborative Staging System (CS). In 2016 use of CS was discontinued, however this data item continued to be required.

Rationale
This data item serves as 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.

REGIONAL LYMPH NODES POSITIVE

Item Length: 2
Allowable Values: 00–99
Right Justified, Zero-filled
NAACCR Item #820
Revised 09/06, 01/10

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 became a component of the Collaborative Staging System (CS). In 2016 use of CS was discontinued, however this data item continued 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 definition of regional nodes differs between the AJCC Cancer Staging Manual and the SEER Program Coding and Staging Manual use the AJCC definition.

Text--DX Proc--Lab Tests

Item Length: 1000
Allowable Values: Neither carriage return nor line feed characters allowed
Free text
NAACCR Item #2550
NHSCR-Specific

Description
Text area for manual documentation of information from laboratory examinations other than cytology or histopathology.

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 within 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 reporter independently from the code(s). If 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
• Prioritize entered information in the order of the fields listed below.
• Text automatically generated from coded data is not acceptable.
• NAACCR-approved abbreviations should be utilized.
• 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.

Note: For software that allows unlimited text, NAACCR recommends that the software indicate to the registrar the portion of the text that will be transmitted to the central registry.

Suggestions for text:
• Type of lab test/tissue specimen(s)
• Record both positive and negative findings. Record positive test results first.
• Information can include tumor markers, serum and urine electrophoresis, special studies, etc.
• Date(s) of lab test(s)
• 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)

Text--DX Proc--Path

Item Length: 1000
Allowable Values: Neither carriage return nor line feed characters allowed
Free text
NAACCR Item #2570
NHSCR-Specific

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

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 within 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 reporter independently from the code(s). If 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
• Prioritize entered information in the order of the fields listed below.
• Text automatically generated from coded data is not acceptable.
• NAACCR-approved abbreviations should be utilized (See appendix G).
• 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.

Note: For software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

Suggestions for text:
• Date(s) of procedure(s)
• 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 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

Text--DX Proc--PE

Item Length: 1000
Allowable Values: Neither carriage return nor line feed characters allowed
Free text
NAACCR Item #2520
NHSCR-Specific

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

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 within 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 reporter independently from the code(s). If 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
• Prioritize entered information in the order of the fields listed below.
• Text automatically generated from coded data is not acceptable.
• NAACCR-approved abbreviations should be utilized.
• 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.

Note: For software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

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

Text--Remarks

Item Length: 1000
Allowable Values: Neither carriage return nor line feed characters allowed
Free text
NAACCR Item #2680
NHSCR-Specific

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.

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 within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

Instructions
• NAACCR-approved abbreviations should be utilized.
• 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.

Note: For software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

Suggestions for text:
• Smoking history
• Family and personal history of cancer
• 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 for clarifying anything unusual such as reason for reporting a case seemingly not reportable for that facility or reason for coding numerous fields is "unknown."

Stage of Disease at Diagnosis

DATE OF SURGICAL DIAGNOSTIC AND STAGING PROCEDURE

Item Length: 8
NAACCR Item #1280
Revised 01/10, 01/11

Description
Records the date on which the surgical diagnostic and/or staging procedure was performed.

Rationale:
This data item is used to track the use of surgical procedure resources that are not considered treatment.

Coding Instructions:

- Record the date on which the surgical diagnostic and/or staging procedure described in *Surgical Diagnostic and Staging Procedure* (NAACCR Item #1350) 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 Surgical Diagnostic and Staging Procedure* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of Surgical Diagnostic and Staging 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 *RX Date-DX/Stg Proc Flag* (NAACCR Item #1281) is used to explain why *Date of Surgical Diagnostic and Staging Procedure* is not a known date. See *RX Date-DX/Stg Proc Flag* for an illustration of the relationships among these items.

RX DATE–DX/STG PROC FLAG

Item Length: 2
NAACCR Item 1281
Valid codes 10–12, Blank
Revised 01/12

Description
This flag explains why there is no appropriate value in the corresponding date data item, *Date of Surgical Diagnostic and Staging Procedure* (NAACCR Item #1280).

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

Coding Instructions
- Leave this item blank if *Date of Surgical Diagnostic and Staging Procedure* (NAACCR Item #1280) 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 Surgical Diagnostic and Staging 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 value is provided in item *Date of Surgical Diagnostic and Staging Procedure* (NAACCR Item #1280). 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 Surgical Diagnostic and Staging Procedure* (NAACCR Item #1280-) and *RX Date–DX/Stg Proc Flag* (NAACCR Item #1281). ***In this table, the lower-case letter "b" is used to represent each blank space.***

	Traditional Date of Surgical Diagnostic or Staging Procedure	**Interoperable Date of Surgical Diagnostic or Staging Procedure**	**RX Date–DX/Stg Proc Flag**
Description	**Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999**	**Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown or not applicable.**	
	Date entry	**Date entry**	**Flag value**
Full date known	MMDDCCYY (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

SURGICAL DIAGNOSTIC AND STAGING PROCEDURE

Item Length: 2
Allowable Values: 00–07, 09
NAACCR Item #1350
Revised 09/06, 09/08, 01/12, 01/15

Description
Identifies the positive surgical procedure(s) performed to diagnose and/or stage disease.

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 lymphoma, use code 02. If there is only a single lymph node involved with lymphoma, use the data item *Surgical Procedure of Primary Site* (NAACCR Item #1290) 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* (NAACCR Item #1292) 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 Surgical Diagnostic and Staging Procedure* (NAACCR Item #1280). See instructions for *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292).
- Code brushings, washings, cell aspiration, and hematologic findings (peripheral blood smears) as positive cytologic diagnostic confirmation in the data item *Diagnostic Confirmation* (NAACCR Item #490). 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 *Surgical Procedure of Primary Site* (NAACCR Item #1290) to code these procedures.
- 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 as such in the *Surgical Diagnostic and Staging Procedure* (NAACCR Item #1350) data item and the excisional biopsy or more extensive surgery in the *Surgical Procedure of the Primary Site* data item (NAACCR Item #1290).
- Do not code palliative surgical procedures in this data item. Use the data item *Palliative Procedure* (NAACCR Item #3270) 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 site. 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 of procedure is unknown.
09	No information of whether a diagnostic or staging procedure was performed.

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.
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 for 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.

SURGICAL DIAGNOSTIC AND STAGING PROCEDURE AT THIS FACILITY

Item Length: 2
Allowable Values: 00–07, 09
NAACCR Item #740
Revised 01/04, 09/08, 01/12

Description
Identifies the positive surgical procedure(s) performed to diagnose and/or stage disease.

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 at this 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 lymphoma, use code 02. If there is only a single lymph node involved with lymphoma, use the data item *Surgical Procedure of Primary Site at This Facility* (NAACCR Item #670) 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 at This Facility* (NAACCR Item #672) 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 Surgical Diagnostic and Staging Procedure* (NAACCR Item #1280). See instructions for *Scope of Regional Lymph Node Surgery at This Facility* (NAACCR Item #672).
- Code brushings, washings, cell aspiration, and hematologic findings (peripheral blood smears) as positive cytologic diagnostic confirmation in the data item *Diagnostic Confirmation* (NAACCR Item #490). 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 *Surgical Procedure of Primary Site at This Facility* (NAACCR Item #670) to code these procedures.
- 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 as such in the *Surgical Diagnostic and Staging Procedure at this Facility* (NAACCR Item #740) data item and the excisional biopsy or more extensive surgery in the *Surgical Procedure of the Primary Site at this Facility* data item (NAACCR Item #670).

- Do not code palliative surgical procedures in this data item. Use the data item *Palliative Procedure at This Facility* (NAACCR Item #3280) 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 site. 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 of procedure is unknown.
09	No information of whether a diagnostic or staging procedure was performed.

Text--DX Proc--Op

Item Length: 1000
Allowable Values: Neither carriage return nor line feed characters allowed
Free text
NAACCR Item #2560
NHSCR-Specific

Description
Text area for manual documentation of all surgical procedures that provide information for staging.

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 within 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 reporter independently from the code(s). If 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
• Prioritize entered information in the order of the fields listed below.
• Text automatically generated from coded data is not acceptable.
• NAACCR-approved abbreviations should be utilized.
• 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.

Note: For software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

Suggestions for text:
• Dates and descriptions of biopsies and all other surgical procedures from which staging information was derived
• Number of lymph nodes removed
• Size of tumor removed
• Documentation of residual tumor
• Evidence of invasion of surrounding areas
• Reason primary site surgery could not be completed

Text--DX Proc--Scopes

Item Length: 1000
Allowable Values: Neither carriage return nor line feed characters allowed
Free text
NAACCR Item #2540
NHSCR-Specific

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

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 within 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 reporter independently from the code(s). If 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
• Prioritize entered information in the order of the fields listed below.
• Text automatically generated from coded data is not acceptable.
• NAACCR-approved abbreviations should be utilized.
• 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.

Note: For software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

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.
• Record positive and negative clinical findings. Record positive results first

Text--DX Proc--X-ray/Scan

Item Length: 1000
Allowable Values: Neither carriage return nor line feed characters allowed
Free text
NAACCR Item #2530
NHSCR-Specific

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

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 within 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 reporter independently from the code(s). If 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
• Prioritize entered information in the order of the fields listed below.
• Text automatically generated from coded data is not acceptable.
• NAACCR-approved abbreviations should be utilized.
• 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.

Note: For software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

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

Tumor Size Clinical

Item Length: 3
Allowable Values 000-990, 998, 999
NAACCR Item #752
NHSCR-Specific (New 01/01/2016)

Description

This data item records the size of a solid primary tumor before **any** treatment.

Rationale

Clinical tumor size (pretreatment size) is essential for treatment decision making and prognosis determination for many types of cancer.

Instructions

Code	Definition
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	Alternate descriptions of tumor size for specific sites: Familial/multiple polyposis: Rectosigmoid and rectum (C19.9, C20.9) Colon (C18.0, C18.2-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

Tumor Size Pathologic

Item Length: 3
Allowable Values: 000-990, 998, 999
NAACCR Item #754
NHSCR-Specific (New 01/01/2016)

Description
This data item records the size of a solid primary tumor that has been resected.

Rationale
Pathologic tumor size is an important prognostic indicator and valuable for clinical practice and research on surgically treated patients.

Instructions

Code	Definition
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	Alternate descriptions of tumor size for specific sites: Familial/multiple polyposis: Rectosigmoid and rectum (C19.9, C20.9) Colon (C18.0, C18.2-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

TUMOR SIZE SUMMARY

Item Length: 3
Allowable Values: 000-990, 998, 999
NAACCR Item #756
Revised 01/16

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; find 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 (22mm).

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 one space to the right, converting the measurement to millimeters).

   Examples:

   Breast cancer described as 6.5 millimeters in size. Round up Tumo*r Size as 007.*

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

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

   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 reports it.

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

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

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

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

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

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

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

8. **Record the largest dimension or diameter of 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, C18.2-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 (See Section 15, below.)

METS AT DIAGNOSIS – BONE

Item Length: 1
Allowable Values: 0, 1, 8, 9
NAACCR Item #1112
Revised 01/16

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. CoC requires this data item be recorded in its accredited cancer program cancer registries beginning with cases diagnosed January 1, 2016.

Instructions for Coding

1. **Code information about bone metastases 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 Site	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, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS

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

Code	Description
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

Item Length: 1
Allowable Values: 0, 1, 8, 9
NAACCR Item #1113
Revised 01/16

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. CoC requires this data item be recorded in its accredited cancer program cancer registries beginning with cases diagnosed January 1, 2016.

Instructions for Coding

1. **Code information about brain metastases 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 Site	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, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS

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

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

METS AT DIAGNOSIS – DISTANT LYMPH NODES

Item Length: 1
Allowable Values: 0, 1, 8, 9
NAACCR Item #1114
Revised 01/16

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. CoC requires this data item be recorded in its accredited cancer program cancer registries 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 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 Site	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, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS

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

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

METS AT DIAGNOSIS – LIVER

Item Length: 1
Allowable Values: 0, 1, 8, 9
NAACCR Item #1115
Revised 01/16

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. CoC requires this data item be recorded in its accredited cancer program cancer registries beginning with cases diagnosed January 1, 2016.

Instructions for Coding

1. **Code information about liver metastases 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 Site	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, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS

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

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

METS AT DIAGNOSIS – LUNG

Item Length: 1
Allowable Values: 0, 1, 8, 9
NAACCR Item #1116
Revised 01/16

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. CoC requires this data item be recorded in its accredited cancer program cancer registries beginning with cases diagnosed January 1, 2016.

Instructions for Coding

1. **Code information about lung metastases 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 Site	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, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS

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

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

METS AT DIAGNOSIS – OTHER

Item Length: 1
Allowable Values: 0, 1, 8, 9
NAACCR Item #1117
Revised 01/16

Description
This data item identifies whether other metastatic involvement, other than bone, brain, liver, lung or distant lymph nodes exists. Some examples include but are not limited to the adrenal gland, bone marrow, pleura, peritoneum and skin. 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. CoC requires this data item be recorded in its accredited cancer program cancer registries 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 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 combination for which a code for distant metastasis is not clinically relevant.

ICD-O-3 Site	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, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS

d. Use code 9 when it cannot be determined from the medical record whether the patient has metastases other than bone, brain, liver, lung and distant lymph node(s); 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	Description
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

CLINICAL T

NHSCR requires both AJCC and SEER Summary Stage on cases diagnosed prior to year 2004 and 2015+. Collaborative Staging must be used for cases diagnosed 2004-2015. NHSCR also required AJCC staging for breast and colorectal cancer diagnosed in year 2011.

Item Length: 4
Upper-case Alphanumeric
Left Justified
NAACCR Item #940
Revised 9/06, 1/08, 9/8, 1/10, 1/16

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 CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2008 the CoC requires that AJCC clinical TNM staging be recorded in its accredited cancer program cancer registries. 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 the AJCC T, N, and M data items [940, 950, 960, 880, 890, and 900]. 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 data item must be recorded for *Class of Case* 10-22.
- It is strongly recommended that the clinical T staging data item 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 cTX.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.

Code	Definition
(blank)	Not recorded
cX	cTX
c0	cT0
pA	pTa
pIS	pTis
pISU	pTispu
pISD	pTispd
c1MI	cT1mi, cT1mic
c1	cT1
c1A	cT1a
c1A1	cT1a1
c1A2	cT1a2

Code	Definition
c1B	cT1b
c1B1	cT1b1
c1B2	cT1b2
c1C	cT1c
c1D	cT1d
c2	cT2
c2A	cT2a
c2A1	cT2a1
c2A2	cT2a2
c2B	cT2b
c2C	cT2c
c2D	cT2d

Code	Definition
c3	cT3
c3A	cT3a
c3B	cT3b
c3C	cT3c
c3D	cT3d
c4	cT4
c4A	cT4a
c4B	cT4b
c4C	cT4c
c4D	cT4d
c4E	cT4e
88	Not applicable

CLINICAL N

NHSCR requires both AJCC and SEER Summary Stage on cases diagnosed prior to year 2004 and 2015+. Collaborative Staging must be used for cases diagnosed 2004-2015. NHSCR also required AJCC staging for breast and colorectal cancer diagnosed in year 2011.

Item Length: 4
Upper-case Alphanumeric
Left Justified
NAACCR Item #950
Revised 9/06, 1/08, 9/08, 1/10, 1/16

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 CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2008 the CoC requires that AJCC clinical TNM staging be recorded in its accredited cancer program cancer registries. 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 the AJCC T, N, and M data items [940, 950, 960, 880, 890, and 900]. 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 data item must be recorded for *Class of Case* 10-22.
- It is strongly recommended that the clinical N staging data item 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
(blank)	Not recorded
cX	cNX
c0	cN0
c0A	cN0a
c0B	cN0b
c1	cN1
c1A	cNla

Code	Definition
c1B	cN1b
c1C	cN1c
c2	cN2
c2A	cN2a
c2B	cN2b
c2C	cN2c
c3	cN3

Code	Definition
c3A	cN3a
c3B	cN3b
c3C	cN3c
c4	cN4
88	Not applicable

CLINICAL M

NHSCR requires both AJCC and SEER Summary Stage on cases diagnosed prior to year 2004 and 2015+. Collaborative Staging must be used for cases diagnosed 2004-2015. NHSCR also required AJCC staging for breast and colorectal cancer diagnosed in year 2011.

Item Length: 4
Upper-case Alphanumeric
Left Justified
NAACCR Item #960
Revised 9/06, 1/08, 9/08, 1/10, 1/11, 1/16

Description

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

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2008 the CoC requires that AJCC clinical TNM staging be recorded in its accredited cancer program cancer registries. 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 the AJCC T, N, and M data items [940, 950, 960, 880, 890, and 900]. 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 data item must be recorded for *Class of Case* 10-22.
- It is strongly recommended that the clinical M staging data item 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
(blank)	Not recorded
c0	cM0
c0I+	cM0(i+)
c1	cM1
c1A	cM1a
c1B	cM1b
c1C	cM1c
c1D	cM1d
c1E	cM1e

Code	Definition
p1	pM1
p1A	pM1a
p1B	pM1b
p1C	pM1c
p1D	pM1d
p1E	pM1e
88	Not applicable

CLINICAL STAGE GROUP

NHSCR requires both AJCC and SEER Summary Stage on cases diagnosed prior to year 2004 and 2015+. Collaborative Staging must be used for cases diagnosed 2004-2015. NHSCR also required AJCC staging for breast and colorectal cancer diagnosed in year 2011.

Item Length: 4
Upper-case Alphanumeric
Left Justified
NAACCR Item #970
Revised 9/06, 1/08, 9/08, 1/10, 1/11, 1/16

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

Rationale
The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2008 the CoC requires that AJCC clinical TNM staging be recorded in its accredited cancer program cancer registries. 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, T, N and/or M components can be determined, interpret 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 (PREFIX/SUFFIX) DESCRIPTOR

Item Length: 1
Allowable Values: 0-3, 5, 9
NAACCR Item #980
Revised 09/06, 01/08, 09/08, 01/10, 02/10, 05/10, 01/11, 01/16

Description
Identifies the AJCC clinical stage (prefix/suffix) descriptor of the tumor ***prior*** to the start of any therapy. Stage descriptors identify special cases that need separate analysis. The descriptors are adjuncts to and do not change the stage group.

Rationale
The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2008 the CoC requires that AJCC clinical TNM staging be recorded in its accredited cancer program cancer registries. 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	Description
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 patient record	A prefix or suffix would describe this stage, but it is not known which would be correct.

STAGED BY (CLINICAL STAGE)

NHSCR requires both AJCC and SEER Summary Stage on cases diagnosed prior to year 2004 and 2015+. Collaborative Staging must be used for cases diagnosed 2004-2015. NHSCR also required AJCC staging for breast and colorectal cancer diagnosed in year 2011.

Item Length: 1
Allowable Values: 00, 10-15, 20, 30, 40, 50, 60, 88, 99
NAACCR Item #990
Revised 09/06, 01/08, 09/08, 01/10, 01/16

Description
Identifies the person who assigned the clinical AJCC staging data items and the Stage Group.

Rationale
Effective January 1, 2008 the CoC requires that AJCC clinical TNM staging be recorded in its accredited cancer program cancer registries. Data captured in this data item can be used to evaluate the accuracy and completeness of staging recorded in the registry 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, 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 portions 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 or 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:

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 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 staging 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 **Item Length: 4**

NHSCR requires both AJCC and SEER Summary Stage on cases diagnosed prior to year 2004 and 2015+. Collaborative Staging must be used for cases diagnosed 2004-2015. NHSCR also required AJCC staging for breast and colorectal cancer diagnosed in year 2011.

Upper-case Alphanumeric
Left Justified
NAACCR Item #880
Revised 9/06, 1/08, 9/08, 1/10, 1/15, 1/16

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 CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2015 the CoC requires that AJCC pathologic TNM staging be recorded in its accredited cancer program cancer registries. 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 the AJCC T, N, and M data items [940, 950, 960, 880, 890, and 900]. 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 data item 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
(blank)	Not recorded
pX	pTX
p0	pT0
pA	pTa
pIS	pTis
pISU	pTispu
pISD	pTispd
p1MI	pT1mi, pT1 mic
p1	pT1
p1A	pT1a
p1A1	pT1a1
p1A2	pT1a2

Code	Definition
p1B	pT1b
p1B1	pT1b1
p1B2	pT1b2
p1C	pT1c
p1D	pT1d
p2	pT2
p2A	pT2a
p2A1	pT2a1
p2A2	pT2a2
p2B	pT2b
p2C	pT2c
p2D	pT2d

Code	Definition
p3	pT3
p3A	pT3a
p3B	pT3b
p3C	pT3c
p3D	pT3d
p4	pT4
p4A	pT4a
p4B	pT4b
p4C	pT4c
p4D	pT4d
p4E	pT4e
88	Not applicable

PATHOLOGIC N

NHSCR requires both AJCC and SEER Summary Stage on cases diagnosed prior to year 2004 and 2015+. Collaborative Staging must be used for cases diagnosed 2004-2015. NHSCR also required AJCC staging for breast and colorectal cancer diagnosed in year 2011.

Item Length: 4
Upper-case Alphanumeric
Left Justified
NAACCR Item #890
Revised 9/06, 1/08, 9/08, 1/10, 1/15, 1/16

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 CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2015 the CoC requires that AJCC pathologic TNM staging be recorded in its accredited cancer program cancer registries. 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 the AJCC T, N, and M data items [940, 950, 960, 880, 890, and 900]. 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 data item 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 considered as "impossible diagnoses" in the AJCC manual code 88 for clinical and pathologic T, N, and M as well as stage group.
- Use of the new category of cN0 for this data item is limited to in situ tumors only in 2016.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.

Code	Definition
(blank)	Not recorded
pX	pNX
c0	cN0
p0	pN0
p0I-	pN0i-
p0I+	pN0i+
p0M-	pN0m-
p0M+	pN0m+
p1MI	pN1mi

Code	Definition
p0A	pN0a
p0B	pN0b
p1	pN1
p1A	pNla
p1B	pN1b
p1C	pN1c
p2	pN2
p2A	pN2a
p2B	pN2b

Code	Definition
p2C	pN2c
p3	pN3
p3A	pN3a
p3B	pN3b
p3C	pN3c
p4	pN4
88	Not applicable

PATHOLOGIC M

NHSCR requires both AJCC and SEER Summary Stage on cases diagnosed prior to year 2004 and 2015+. Collaborative Staging must be used for cases diagnosed 2004-2015. NHSCR also required AJCC staging for breast and colorectal cancer diagnosed in year 2011.

Item Length: 4
Upper-case Alphanumeric
Left Justified
NAACCR Item #900
Revised 9/06, 1/08, 9/08, 1/10, 1/15, 1/16

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

Rationale
The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2015 the CoC requires that AJCC pathologic TNM staging be recorded in its accredited cancer program cancer registries. 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 the AJCC T, N, and M data items [940, 950, 960, 880, 890, and 900]. 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 data item 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 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 considered as "impossible diagnoses" in 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
(blank)	Not recorded
c0	cM0
c0I+	cM0(i+)
p1	pM1
p1A	pM1a
p1B	pM1b

Code	Definition
p1C	pM1c
p1D	pM1d
p1E	pM1e
c1	cM1
c1A	cM1a
c1B	cM1b

Code	Definition
c1C	cM1c
c1D	cM1d
c1E	cM1e
88	Not applicable

PATHOLOGIC STAGE GROUP

NHSCR requires both AJCC and SEER Summary Stage on cases diagnosed prior to year 2004 and 2015+. Collaborative Staging must be used for cases diagnosed 2004-2015. NHSCR also required AJCC staging for breast and colorectal cancer diagnosed in year 2011.

Item Length: 4
Upper-case Alphanumeric
Left Justified
NAACCR Item #910
Revised 09/06, 01/08, 09/08, 01/10, 01/11, 01/15

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

Rationale
The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2015 the CoC requires that AJCC pathologic TNM staging be recorded in its accredited cancer program cancer registries. 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, T, N and/or M components can be determined, interpret missing components as "X".
- If pathologic M (NAACCR Item #900) is coded as either X or blank and clinical M (NAACCR Item #960) is coded as 0, 1, 1A, 1B, or 1C, then the combination of staging data items pT, pN, and cM (NAACCR Item #880, 890, 960) 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 (PREFIX/SUFFIX) DESCRIPTOR

Item Length: 1
Allowable Values: 0–6, 9
NAACCR Item #920
Revised 9/06, 1/08, 1/10, 1/14, 1/16

Description
Identifies the AJCC pathologic stage (prefix/suffix) descriptor known ***following*** the completion surgical therapy.

Rationale
Stage descriptors identify special cases that need separate analysis. The descriptors are adjuncts to and do not change the stage group. The CoC requires that AJCC TNM staging be used in its accredited cancer programs. The AJCC developed its staging system for evaluating trends in the treatment and control of cancer. This staging 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 treating physician(s) 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(s).
- If the tumor is not staged using AJCC rules, 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 organ of origin **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 patient record	A prefix or suffix would describe this stage, but it is not known which would be correct.

STAGED BY (PATHOLOGIC STAGE)

Item Length: 1
Allowable Values: 0–9
NAACCR Item #930
Revised 09/06, 01/08, 09/08, 01/10, 01/16

Description
Identifies the person who recorded the pathologic AJCC staging data items.

Rationale
Effective January 1, 2015 the CoC requires that AJCC pathologic TNM staging be recorded in its accredited cancer program cancer registries. Data captured in this data item can be used to evaluate the accuracy and completeness of staging recorded in the registry 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, 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 portions 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.

NHSCR requires both AJCC and SEER Summary Stage on cases diagnosed prior to year 2004 and 2015+. Collaborative Staging must be used for cases diagnosed 2004-2015. NHSCR also required AJCC staging for breast and colorectal cancer diagnosed in year 2011.

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 or 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	An AJCC staging scheme has not been developed for this site. The histology is excluded from an AJCC site scheme.
99	Staged but unknown who assigned stage	A stage was found in the medical record but it is unknown who assigned it.

SEER SUMMARY STAGE 2000

Item Length: 1
Allowable Values: 0-5, 7, 8, 9
NAACCR Item #759
Revised 01/16

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, CoC relied on the item Derived SS2000 [3020] for the value of SEER Summary Stage 2000 as generated by the collaborative Staging algorithm. Effective with cases diagnosed January 1, 2016 the CoC requires that directly-assigned SEER Summary Stage 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	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
8	Not applicable
9	Unstaged

NHSCR requires both AJCC and SEER Summary Stage on cases diagnosed prior to year 2004 and 2015+. Collaborative Staging must be used for cases diagnosed 2004-2015. NHSCR also required AJCC staging for breast and colorectal cancer diagnosed in year 2011.

Text--Staging

Item Length: 1000
Allowable Values: Neither carriage return nor line feed characters allowed
Free text
NAACCR Item #2600
NHSCR-Specific

Description
Additional text area for staging information not already entered in the Text--DX Proc areas.

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 within 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 reporter independently from the code(s). If 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
• Prioritize entered information in the order of the fields listed below.
• Text automatically generated from coded data is not acceptable.
• NAACCR-approved abbreviations should be utilized.
• 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.

Note: For software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

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

Collaborative Stage Input Data Items

Recorded for Cases Diagnosed 2004 through 2015 Only

NHSCR requires both AJCC and SEER Summary Stage on cases diagnosed prior to year 2004 and 2015+. Collaborative Staging must be used for cases diagnosed 2004-2015. NHSCR also required AJCC staging for breast and colorectal cancer diagnosed in year 2011.

CS TUMOR SIZE

Item Length: 3
Allowable Values: 000–995, 999
NAACCR Item #2800
Revised 09/06, 09/08, 01/10, 01/11

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 by CoC for accredited cancer program cancer registries.

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

Item Length: 2
Allowable Values: 00–80, 95, 99
NAACCR Item #2810
Revised 09/06, 09/08, 01/10, 01/11

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 by CoC for accredited cancer program cancer registries.

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

Item Length: 1
Allowable Values: 0–3, 5, 6, 8, 9
NAACCR Item #2820
Revised 09/06, 09/08, 01/10, 01/11

Description
Records how the codes for the two items *CS Tumor Size* (NAACCR Item #2800) and *CS Extension* (NAACCR Item #2810) 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 by CoC for accredited cancer program cancer registries.

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

Item Length: 2
Allowable Values: 00–80, 90
NAACCR Item #2830
Revised 09/06, 09/08, 01/10, 01/11

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 by CoC for accredited cancer program cancer registries.

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 EVAL
(CS REG NODES EVAL)

Item Length: 1
Allowable Values: 0–3, 5, 6, 8, 9
NAACCR Item #2840
Revised 09/06, 09/08, 01/10, 01/11

Description
Records how the code for *CS Lymph Nodes* (NAACCR Item #2830) 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 by CoC for accredited cancer program cancer registries.

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 DX

Item Length: 2
Allowable Values: site-specific
NAACCR Item #2850
Revised 09/06, 09/08, 01/10, 01/11, 01/14

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 by CoC for accredited cancer program cancer registries.

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 DX–BONE

Item Length: 1
Allowable Values: 0, 1, 8, 9
NAACCR Item #2851
Revised 01/11

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 for some sites. Effective for cases diagnosed January 1, 2016 and later, this data item is no longer required by CoC for accredited cancer program cancer registries.

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 DX–BRAIN

Item Length: 1
Allowable Values: 0, 1, 8, 9
NAACCR Item #2852
Revised 01/11

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 for some sites. Effective for cases diagnosed January 1, 2016 and later, this data item is no longer required by CoC for accredited cancer program cancer registries.

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 DX–LIVER

Item Length: 1
Allowable Values: 0, 1, 8, 9
NAACCR Item #2853
Revised 01/11

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 for some sites. Effective for cases diagnosed January 1, 2016 and later, this data item is no longer required by CoC for accredited cancer program cancer registries.

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 DX–LUNG

Item Length: 1
Allowable Values: 0, 1, 8, 9
NAACCR Item #2854
Revised 01/11

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 for some sites. Effective for cases diagnosed January 1, 2016 and later, this data item is no longer required by CoC for accredited cancer program cancer registries.

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 EVAL

Item Length: 1
Allowable Values: 0–3, 5, 6, 8, 9
NAACCR Item #2860
Revised 09/06, 09/08, 01/10, 01/11

Description
Records how the code for *CS Mets at Dx* (NAACCR Item #2850) 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 by CoC for accredited cancer program cancer registries.

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.

Collaborative Stage Site-Specific Factors

Recorded for Cases Diagnosed 2004+

CS SITE-SPECIFIC FACTOR 1

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2880
Revised 04/07, 09/08, 01/10, 02/10, 03/10, 01/11, 01/12

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 prognostic factors of clinical significance, and for research purposes. This data item is required by CoC for accredited cancer program cancer registries on a sites-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 web site at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS SITE-SPECIFIC FACTOR 2

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2890
Revised 09/06, 09/08, 01/10, 03/10, 01/11, 01/12

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 prognostic factors of clinical significance, and for research purposes. This data item is required by CoC for accredited cancer program cancer registries on a sites-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 web site at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS SITE-SPECIFIC FACTOR 3

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2900
Revised 04/07, 09/08, 01/10, 02/10, 03/10, 01/11, 01/12

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 prognostic factors of clinical significance, and for research purposes. This data item is required by CoC for accredited cancer program cancer registries on a sites-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 web site at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS SITE-SPECIFIC FACTOR 4

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2910
Revised 09/06, 09/08, 01/10, 02/10, 03/10, 01/11, 01/12

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 prognostic factors of clinical significance, and for research purposes. This data item is required by CoC for accredited cancer program cancer registries on a sites-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 web site at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS SITE-SPECIFIC FACTOR 5

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2920
Revised 09/06, 09/08, 01/10, 02/10, 03/10, 01/11, 01/12

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 prognostic factors of clinical significance, and for research purposes. This data item is required by CoC for accredited cancer program cancer registries on a sites-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 web site at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS SITE-SPECIFIC FACTOR 6

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2930
Revised 09/06, 09/08, 01/10, 02/10, 03/10, 01/11, 01/12

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 prognostic factors of clinical significance, and for research purposes. This data item is required by CoC for accredited cancer program cancer registries on a sites-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 web site at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS SITE-SPECIFIC FACTOR 7

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2861
Revised 02/10, 03/10, 01/11, 01/12

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 prognostic factors of clinical significance, and for research purposes. This data item is required by CoC for accredited cancer program cancer registries on a sites-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 web site at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS SITE-SPECIFIC FACTOR 8

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2862
Revised 02/10, 03/10, 01/11, 01/12

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 prognostic factors of clinical significance, and for research purposes. This data item is required by CoC for accredited cancer program cancer registries on a sites-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 web site at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS SITE-SPECIFIC FACTOR 9

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2863
Revised 02/10, 03/10, 01/11, 01/12

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 prognostic factors of clinical significance, and for research purposes. This data item is required by CoC for accredited cancer program cancer registries on a sites-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 web site at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS SITE-SPECIFIC FACTOR 10

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2864
Revised 02/10, 03/10, 01/11, 01/12

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 prognostic factors of clinical significance, and for research purposes. This data item is required by CoC for accredited cancer program cancer registries on a sites-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 web site at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS SITE-SPECIFIC FACTOR 11

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2865
Revised 02/10, 03/10, 01/11, 01/12

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 prognostic factors of clinical significance, and for research purposes. This data item is required by CoC for accredited cancer program cancer registries on a sites-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 web site at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS SITE-SPECIFIC FACTOR 12

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2866
Revised 02/10, 03/10, 01/11, 01/12

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 prognostic factors of clinical significance, and for research purposes. This data item is required by CoC for accredited cancer program cancer registries on a sites-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 web site at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS SITE-SPECIFIC FACTOR 13

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2867
Revised 02/10, 03/10, 01/11, 01/12

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 prognostic factors of clinical significance, and for research purposes. This data item is required by CoC for accredited cancer program cancer registries on a sites-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 web site at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS SITE-SPECIFIC FACTOR 14

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2868
Revised 02/10, 03/10, 01/11, 01/12

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 prognostic factors of clinical significance, and for research purposes. This data item is required by CoC for accredited cancer program cancer registries on a sites-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 web site at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS SITE-SPECIFIC FACTOR 15

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2869
Revised 03/10, 01/11, 01/12

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 prognostic factors of clinical significance, and for research purposes. This data item is required by CoC for accredited cancer program cancer registries on a sites-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 web site at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS SITE-SPECIFIC FACTOR 16

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2870
Revised 03/10, 01/11, 01/12

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 prognostic factors of clinical significance, and for research purposes. This data item is required by CoC for accredited cancer program cancer registries on a sites-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 web site at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS SITE-SPECIFIC FACTOR 17

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2871
Revised 03/10, 01/11, 01/12

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 prognostic factors of clinical significance, and for research purposes. This data item is required by CoC for accredited cancer program cancer registries on a sites-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 web site at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS SITE-SPECIFIC FACTOR 18

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2872
Revised 03/10, 01/11, 01/12

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 prognostic factors of clinical significance, and for research purposes. This data item is required by CoC for accredited cancer program cancer registries on a sites-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 web site at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS SITE-SPECIFIC FACTOR 19

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2873
Revised 03/10, 01/11, 01/12

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 prognostic factors of clinical significance, and for research purposes. This data item is required by CoC for accredited cancer program cancer registries on a sites-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 web site at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS SITE-SPECIFIC FACTOR 20

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2874
Revised 03/10, 01/11, 01/12

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 prognostic factors of clinical significance, and for research purposes. This data item is required by CoC for accredited cancer program cancer registries on a sites-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 web site at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS SITE-SPECIFIC FACTOR 21

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2875
Revised 03/10, 01/11, 01/12

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 prognostic factors of clinical significance, and for research purposes. This data item is required by CoC for accredited cancer program cancer registries on a sites-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 web site at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS SITE-SPECIFIC FACTOR 22

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2876
Revised 03/10, 01/11, 01/12

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 prognostic factors of clinical significance, and for research purposes. This data item is required by CoC for accredited cancer program cancer registries on a sites-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 web site at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS SITE-SPECIFIC FACTOR 23

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2877
Revised 03/10, 01/11, 01/12

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 prognostic factors of clinical significance, and for research purposes. This data item is required by CoC for accredited cancer program cancer registries on a sites-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 web site at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS SITE-SPECIFIC FACTOR 24

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2878
Revised 03/10, 01/11, 01/12

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 prognostic factors of clinical significance, and for research purposes. This data item is required by CoC for accredited cancer program cancer registries on a sites-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 web site at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

CS SITE-SPECIFIC FACTOR 25

Item Length: 3
Allowable Values: 000–999
NAACCR Item #2879
Revised 02/10, 01/11, 01/12

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

Rationale
CS Site-Specific Factor25 is used to discriminate between CS staging schema (for cases 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 as shown below.

Instructions for Coding
- Refer to the site and histology-specific instructions in the current *CS Manual* for coding instructions.
- Refer to the CS coding instructions on the Collaborative Stage web site at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

Collaborative Stage Derived Data Items

Derived and Recorded for Cases Diagnosed 2004-2015

DERIVED AJCC-6 T

Item Length: 2
NAACCR Item #2940
Revised 09/08, 01/10

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

Rationale
Derived AJCC-6 T 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 by CoC for accredited cancer program cancer registries, and should no longer be derived and recorded in the hospital registry database.

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 "T" descriptions.

DERIVED AJCC-6 T DESCRIPT

Item Length: 1
NAACCR Item #2950
Revised 09/04, 01/10

Description

This item is the derived AJCC "T Descriptor" from coded data items using the CS algorithm.

Rationale

Derived AJCC-6 T Descript 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 by CoC for accredited cancer program cancer registries, and should no longer be derived and recorded in the hospital registry database.

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

Item Length: 2
NAACCR Item #2960
Revised 01/10

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

Rationale
The CS *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 by CoC for accredited cancer program cancer registries, and should no longer be derived and recorded in the hospital registry database.

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 DESCRIPT

Item Length: 1
NAACCR Item #2970
Revised 09/04, 01/10

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

Rationale
Derived AJCC-6 N Descript 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 by CoC for accredited cancer program cancer registries, and should no longer be derived and recorded in the hospital registry database.

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

Item Length: 2
NAACCR Item #2980
Revised 01/10

Description
This item is the derived AJCC "M" staging data item from coded data items 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 by CoC for accredited cancer program cancer registries, and should no longer be derived and recorded in the hospital registry database.

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 DESCRIPT

Item Length: 1
NAACCR Item #2990
Revised 09/04, 01/10

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

Rationale
Derived AJCC-6 M Descript 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 by CoC for accredited cancer program cancer registries, and should no longer be derived and recorded in the hospital registry database.

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

Item Length: 2
NAACCR Item #3000
Revised 01/10, 01/11

Description
This item is the derived AJCC "Stage Group" from coded data items using the CS 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 by CoC for accredited cancer program cancer registries, and should no longer be derived and recorded in the hospital registry database.

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 Stage Group descriptions.

DERIVED AJCC-7 T

Item Length: 2
NAACCR Item #3400
New Item 01/10, 01/16

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

Rationale
Derived AJCC-7 T 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 by CoC for accredited cancer program cancer registries, and should no longer be derived and recorded in the hospital registry database.

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 "T" descriptions.

DERIVED AJCC-7 T DESCRIPT

Item Length: 1
NAACCR Item #3402
New Item 01/10, 01/16

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

Rationale
Derived AJCC-7 T Descript 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 by CoC for accredited cancer program cancer registries, and should no longer be derived and recorded in the hospital registry database.

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

Item Length: 2
NAACCR Item #3410
New Item 01/10, 01/16

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

Rationale
The CS *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 by CoC for accredited cancer program cancer registries, and should no longer be derived and recorded in the hospital registry database.

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 DESCRIPT

Item Length: 1
NAACCR Item #3412
New Item 01/10, 01/16

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

Rationale
Derived AJCC-7 N Descript 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 by CoC for accredited cancer program cancer registries, and should no longer be derived and recorded in the hospital registry database.

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

Item Length: 2
NAACCR Item #3420
New Item 01/10, 01/16

Description
This item is the derived AJCC "M" staging data item from coded data items 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 by CoC for accredited cancer program cancer registries, and should no longer be derived and recorded in the hospital registry database.

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 DESCRIPT

Item Length: 1
NAACCR Item #3422
New Item 01/10, 01/16

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

Rationale
Derived AJCC-7 M Descript 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 by CoC for accredited cancer program cancer registries, and should no longer be derived and recorded in the hospital registry database.

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

Item Length: 2
NAACCR Item #3430
Revised 01/11, 01/16

Description
This item is the derived AJCC "Stage Group" from coded data items 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 by CoC for accredited cancer program cancer registries, and should no longer be derived and recorded in the hospital registry database.

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 Stage Group descriptions.

DERIVED SS1977

Item Length: 1
Allowable Values: 0–5, 7, 9
NAACCR Item #3010
Revised 09/08, 01/10, 01/16

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 by CoC for accredited cancer program cancer registries, and should no longer be derived and recorded in the hospital registry database.

Instructions for Coding
- Refer to the *SEER Summary Staging Manual, 1977* for descriptions of the 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

Item Length: 1
Allowable Values: 0–5, 7, 9
NAACCR Item #3020
Revised 09/08, 01/10, 01/16

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 by CoC for accredited cancer program cancer registries, and should no longer be derived and recorded in the hospital registry database.

Instructions for Coding
- Refer to the *SEER Summary Staging Manual, 2000* for descriptions of the 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.

First Course of Treatment

DATE OF FIRST COURSE OF TREATMENT

This data item is required by NHSCR. Registries should be careful not to confuse this data item with *Date of Initial RX --SEER* (NAACCR Item #1260).

Item Length: 8
NAACCR Item #1270
Revised 01/10, 01/11

Description

Records the date on which treatment (surgery, radiation, systemic, or other therapy) 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* (NAACCR Item #1200), *Date Radiation Started* (NAACCR Item #1210), *Date Systemic Therapy Started* (NAACCR Item #3230), or *Date Other Treatment Started* (NAACCR Item #1250).
- If active surveillance or watchful waiting is selected as the first course of treatment (*RX Summ–Treatment Status* [NAACCR Item #1285] = 2) record the date this decision is made.
- In cases of nontreatment (*RX Summ–Treatment Status* [NAACCR Item #1285] = 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 Crs Rx Flag* (NAACCR Item #1271) is used to explain why *Date of First Course of Treatment* is not a known date. See *Date 1st Crs Rx Flag* for an illustration of the relationships among these items.

Examples

A patient has a core biopsy on February 12, 2004, and subsequently undergoes an excisional biopsy on February 14, 2004	February 14, 2004
A patient begins receiving preoperative radiation therapy elsewhere on April 21, 2005, and subsequent surgical therapy at this facility on June 2, 2005	April 21, 2005

DATE 1st CRS RX FLAG

Item Length: 2
NAACCR Item #1271
Valid Codes: 10-12, Blank
Revised 01/12, 01/15

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date of First Course of Treatment* (NAACCR Item #1270).

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

Coding Instructions
- Leave this item blank if *Date of First Course of Treatment* (NAACCR Item #1270) has a full or partial date recorded.
- Code 12 if the *Date of First Course of Treatment* can not 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 value is provided in item *Date of First Course of Treatment* (NAACCR Item #1270).

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* (NAACCR Item #1270) and *Date 1st Crs Rx Flag* (NAACCR Item #1271). ***In this table, the lower-case letter "b" is used to represent each blank space.***

Description	Traditional Date of First Course of Treatment	Interoperable Date of First Course of Treatment	Date 1st Crs Rx Flag
	Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999	**Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown or not applicable.**	
Full date known	MMDDCCYY (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

RX SUMM – TREATMENT STATUS

Item Length: 1
Allowable Values: 0-2, 9
NAACCR Item #1285
Revised 01/11

Description
This data item summarizes whether the patient received any treatment or the tumor was under active surveillance.

Rationale
This item documents active surveillance (watchful waiting) and eliminate searching each treatment modality to determine whether treatment was given. It is used in conjunction with *Date of First Course of Treatment* [NAACCR Item #1270] 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 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* [NAACCR Item #1430] = 8)
2	Treatment plan for a lymphoma patient is active surveillance.

DATE OF FIRST SURGICAL PROCEDURE

Item Length: 8
NAACCR Item #1200
Revised 01/10, 01/11

Description
Records the earliest date on which any first course surgical procedure was performed. Formerly called "Date of Cancer-Directed Surgery."

Rationale
This 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 *Surgical Procedure of Primary Site* (NAACCR Item #1290), *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292) or *Surgical Procedure/Other Site* (NAACCR Item #1294) performed at this or any facility.
- The date in this item may be the same as that in *Date of Most Definitive Surgical Resection of the Primary Site* (NAACCR Item #3170), 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* (NAACCR Item #1270).
- 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 Surgical Procedure* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of First Surgical 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 *Rx Date–Surgery Flag* (NAACCR Item #1201) is used to explain why *Date of First Surgical Procedure* is not a known date. See *Rx Date–Surgery Flag* for an illustration of the relationships among these items.

Examples

A melanoma patient had an excisional biopsy on March 23, 2008, then a wide excision on March 28, 2008.	March 23, 2008
The patient had a small (0.5 cm) lump removed from her breast on November 16, 2009.	November 16, 2009
The patient's primary tumor was treated with radiation beginning on April 16, 2007, after a distant metastasis was removed surgically on March 27, 2007.	March 27, 2007

RX DATE–SURGERY FLAG

Item Length: 2
NAACCR Item #1201
Valid Codes: 10-12, Blank
New Item: 1/1/2010

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date of First Surgical Procedure* (NAACCR Item #1200).

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

Coding Instructions
- Leave this item blank if *Date of First Surgical Procedure* (NAACCR Item #1200) has a full or partial date recorded.
- Code 12 if the *Date of First Surgical Procedure* can not 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).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, surgery was performed but the date is unknown).
(blank)	A valid date value is provided in item *Date of First Surgical Procedure* (NAACCR Item #1200).

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date of First Surgical Procedure* (NAACCR Item #1200) and *Rx Date–Surgery Flag* (NAACCR Item #1201). ***In this table, the lower-case letter "b" is used to represent each blank space.***

Description	Traditional Date of First Surgical Procedure	Interoperable Date of First Surgical Procedure	Rx Date–Surgery Flag
	Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999	Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown or not applicable.	
Full date known	MMDDCCYY (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 MOST DEFINITIVE SURGICAL RESECTION OF THE PRIMARY SITE

Item Length: 8
NAACCR Item #3170
Revised 09/08, 01/10, 01/11

Description
Records the date of the most definitive surgical procedure of the primary site performed as part of the first course of treatment.

Rationale
This item is used to measure the lag time between diagnosis and the most definitive surgery of the primary site. It is also used in conjunction with *Date of Surgical Discharge* (NAACCR Item #3180) to calculate the duration of hospitalization following the most definitive primary site surgical procedure. This can then be used to evaluate treatment efficacy.

Instructions for Coding
- Record the date on which the surgery described by *Surgical Procedure of Primary Site* (NAACCR Item #1290) 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 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 Most Definitive Surgical Resection of the Primary Site* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of Most Definitive Surgical Resection of the Primary Site* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *RX Date Mst Defn Srg Flag* (NAACCR Item #3171) is used to explain why *Date of Most Definitive Surgical Resection of the Primary Site* is not a known date. See *RX Date Mst Defn Srg Flag* for an illustration of the relationships among these items.

RX DATE MST DEFN SRG FLAG

Item Length: 2
NAACCR Item #3171
Valid Codes: 10-12, Blank
Revised 01/11

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date of Most Definitive Surgical Resection of the Primary Site* (NAACCR Item #3170).

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

Coding Instructions
- Leave this item blank if *Date of Most Definitive Surgical Resection of the Primary Site* (NAACCR Item #3170) has a full or partial date recorded.
- Code 12 if the *Date of Most Definitive Surgical Resection of the Primary Site* can not 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	Description
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).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, surgery was performed but the date is unknown).
(blank)	A valid date value is provided in item *Date of Most Definitive Surgical Resection of the Primary Site* (NAACCR Item #3170). 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 Most Definitive Surgical Resection of the Primary Site* (NAACCR Item #3170) and *Rx Date Mst Defn Srg Flag* (NAACCR Item #3171). ***In this table, the lower-case letter "b" is used to represent each blank space.***

Description	**Traditional Date of Most Definitive Surgical Resection of the Primary Site**	**Interoperable Date of Most Definitive Surgical Resection of the Primary Site**	**Rx Date Mst Defn Srg Flag**
	Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999	**Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown or not applicable.**	
Full date known	MMDDCCYY (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

SURGICAL PROCEDURE OF PRIMARY SITE

Item Length: 2
Allowable Values: 00, 10␣80, 90, 98, 99
L/R Justified, Zero-filled
NAACCR Item #1290
Revised 06/05, 01/10, 01/12, 01/15

Description
Records the surgical procedure(s) performed to the primary site.

Rationale
This data item can be used to compare the efficacy of treatment options.

Registries with software allowing for multiple treatments to be coded, code ALL surgical procedures performed. Refer to the *NHSCR Table of Required Data Items* in *Section Two* for a list of required data items.

Instructions for Coding
- Site-specific codes for this data item are found in 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 as such in the *Surgical Diagnostic and Staging Procedure* (NAACCR Item #1350) data item and the excisional biopsy or more extensive surgery in the *Surgical Procedure of the Primary Site* data item (NAACCR Item #1290).
- 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* (NAACCR Item #3270).
- 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.

SURGICAL PROCEDURE OF PRIMARY SITE AT THIS FACILITY Item Length: 2

Registries with software allowing for multiple treatments to be coded, code ALL surgical procedures performed. Refer to the *NHSCR Table of Required Data Items* in *Section Two* for a list of required data items.

Allowable Values: 00, 10-80, 90, 98, 99
L/R Justified, Zero-filled
NAACCR Item #670
Revised 09/04, 01/10, 01/12, 01/15

Description
Records the surgical procedure(s) performed to the primary site at this facility.

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 found in 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 collected, this item refers to the most invasive surgical procedure for 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 as such in the *Surgical Diagnostic and Staging Procedure* (NAACCR Item #1350) data item and the excisional biopsy or more extensive surgery in the *Surgical Procedure of the Primary Site* data item (NAACCR Item #1290).
- 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.
- 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 at This Facility* (NAACCR Item #3280).

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 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.

APPROACH – SURGERY OF THE PRIMARY SITE AT THIS FACILITY (RX HOSP – SURG APP 2010)

Item Length: 1
Allowable Values: 0-5, 9
NAACCR Item #668
Revised 05/10, 01/11, 01/13, 01/15

Registries with software allowing for multiple treatments to be coded, code ALL surgical procedures performed. Refer to the *NHSCR Table of Required Data Items* in *Section Two* for a list of required data items.

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.

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 procedures, 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 published in Registry Operations and Data Standards (ROADS), *Surgical Approach* (NAACCR Item #1310)

Code	Definition
0	No surgical procedure of primary site at this facility; Diagnosed at autopsy
1	Robotic assisted
2	Robotic converted to open
3	Minimally invasive (such as endoscopic or laparoscopic)
4	Minimally invasive (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	Endoscopic surgery was performed
3	Patient treated with RFA of kidney
5	The surgical report described conventional open surgery, but did not use the term “open”

SURGICAL MARGINS OF THE PRIMARY SITE

Registries with software allowing for multiple treatments to be coded, code ALL surgical procedures performed. Refer to the *NHSCR Table of Required Data Items* in *Section Two* for a list of required data items.

Item Length: 1
Allowable Values: 0–3, 7–9
NAACCR Item #1320
Revised 08/02, 01/10, 02/10, 01/13

Description
Records the final status of the surgical margins after resection of the primary tumor.

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 site (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, and 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	It 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).

SCOPE OF REGIONAL LYMPH NODE SURGERY

Item Length: 1
Allowable Values: 0–7, 9
NAACCR Item #1292
Revised 01/04, 09/08, 02/10, 01/11, 01/12, 04/12, 01/13, 01/15

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.

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* (NAACCR Item #1270) and/or *Date of First Surgical Procedure* (NAACCR Item #1200) 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 site (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, and 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* (NAACCR Item #1294).
- 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* (NAACCR Item #3270).

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*.

Codes and Labels

The following instructions should be applied to all surgically treated cases for all types of cancers. The treatment of breast and skin cancer is where the distinction between sentinel lymph node biopsies (SLNBx) and more extensive dissection of regional lymph nodes is most frequently encountered. For all other sites, non-sentinel regional node dissections are typical, and codes 2, 6 and 7 are infrequently used.

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 (SLNBx), 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), an 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 lymph node 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 of 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 operative 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	• 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 (code 2). If review of the operative report confirms that a regional lymph node dissection followed the SLNBx, code these cases as 6.	SLNBx who fail to map will often undergo ALND. Code these cases as 2 if no ALND was performed, or 6 when ALND was performed during the same operative event. Enter the appropriate number of nodes examined and positive in the data items *Regional Lymph Nodes Examined* (NAACCR Item #830) and *Regional Lymph Nodes Positive* (NAACCR Item #820).
3	Number of regional lymph 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). • 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. • 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 of 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.	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		
5	4 or more regional lymph nodes removed		
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.	• Generally, 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

		• If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only. • Infrequently, a SNLBx is attempted and the patient fails to map (i.e. no sentinel lymph nodes are identified by the dye and/or radio label injection.) When mapping fails, the surgeon usually performs a more extensive dissection of regional lymph nodes. Code these cases as 6.	SLNBx, or whether a SLNBx plus an ALND was performed.
7	Sentinel node biopsy and code 3, 4, or 5 at different times	• SNLBx and regional lymph node dissection (code 3, 4, or 5) in separate surgical events. • Generally, SLNBx followed by regional lymph node completion will yield a relatively large number of nodes. However, it is possible for these procedures to harvest only a few nodes. • If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only.	• Generally, 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 data item *Surgery of Primary Site* [NAACCR Item #1290]). 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	**(50.4-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 lymph node surgery in patient record.

SCOPE OF REGIONAL LYMPH NODE SURGERY AT THIS FACILITY Item Length: 1
Allowable Values: 0–7, 9
NAACCR Item #672
Revised 1/04, 9/08, 2/10, 1/12

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 at this facility.

Rationale
This 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.
- If a surgical procedure which aspirates, biopsies, or removes regional lymph nodes to diagnose or stage this cancer, record the scope of regional lymph nodes surgery in this data item. Record the date of this surgical procedure in data item *Date of First Course of Treatment* (NAACCR Item #1270) and/or *Date of First Surgical Procedure* (NAACCR Item #1200) as appropriate.
- 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 primaries of the meninges, brain, spinal cord, cranial nerves, and other parts of the central nervous system (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 all unknown or ill-defined primary sites (C76.0–76.8, 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, and 9975-9992), code 9.
- Do not code *distant* lymph nodes removed during surgery to the primary site for this data item. They are coded in the data field *Surgical Procedure/Other Site* (NAACCR Item #1294).
- 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 at This Facility* (NAACCR Item #3280).

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*.

Codes and Labels

The following instructions should be applied to all surgically treated cases for all types of cancers. The treatment of breast and skin cancer is where the distinction between sentinel lymph node biopsies (SLNBx) and more extensive dissection of regional lymph nodes is most frequently encountered. For all other sites, non-sentinel regional node dissections are typical, and codes 2, 6 and 7 are infrequently used.

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 (SLNBx), 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), an 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 lymph node surgery	No regional lymph node surgery.	
1	Biopsy or aspiration of regional lymph node(s)	Review the operative report of 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 of 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 operative 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	• 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 (code 2). If review of the operative report confirms that a regional lymph node dissection followed the SLNBx, code these cases as 6.	SLNBx who fail to map will often undergo ALND. Code these cases as 2 if no ALND was performed, or 6 when ALND was performed during the same operative event. Enter the appropriate number of nodes examined and positive in the data items *Regional Lymph Nodes Examined* (NAACCR Item #830) and *Regional Lymph Nodes Positive* (NAACCR Item #820).
3	Number of regional lymph 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). • 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. • 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 of 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.	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		
5	4 or more regional lymph nodes removed		
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	• Generally, 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

		pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only. • Infrequently, a SNLBx is attempted and the patient fails to map (i.e. no sentinel lymph nodes are identified by the dye and/or radio label injection.) When mapping fails, the surgeon usually performs a more extensive dissection of regional lymph nodes. Code these cases as 6.	ALND was performed.
7	Sentinel node biopsy and code 3, 4, or 5 at different times	• SNLBx and regional lymph node dissection (code 3, 4, or 5) in separate surgical events. • Generally, SLNBx followed by regional lymph node completion will yield a relatively large number of nodes. However, it is possible for these procedures to harvest only a few nodes. • If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only.	• Generally, 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 data item *Surgery of Primary Site* [NAACCR Item #1290]). Review surgically treated cases coded 9 in *Scope of Regional Lymph Node Surgery* to confirm the code.	

SURGICAL PROCEDURE/OTHER SITE

Item Length: 1
Allowable Values: 0–5, 9
NAACCR Item #1294
Revised 01/04, 09/08, 01/10, 02/10, 01/12, 01/13

Description
Records the surgical removal of *distant lymph nodes* or other tissue(s) or organ(s) removed beyond the primary site

Rationale
The removal of nonprimary 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 or organs are removed during primary site surgery that are not specifically defined by the site-specific *Surgical Procedure of the Primary Site* (NAACCR Item #1290 or #670) code, assign the highest numbered code that describes the surgical resection of other tissue or organs beyond the primary site surgical code.Assign the highest numbered code that describes the surgical resection of *distant lymph node(s)*.
- Incidental removal of tissue or organs is not a "Surgical Procedure/Other 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.
- *Surgical Procedure/Other 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 (C76.0–76.8, 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, 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* (NAACCR Item #3270).

Code	Label	Definition
0	None	No surgical procedure of nonprimary site was performed. Diagnosed at autopsy.
1	Nonprimary surgical procedure performed	Nonprimary surgical resection to other site(s), unknown if whether the site(s) is regional or distant.
2	Nonprimary surgical procedure to other regional sites	Resection of regional site.
3	Nonprimary surgical procedure to *distant lymph node(s)*	Resection of *distant lymph node(s)*.
4	Nonprimary 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 nonprimary 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.

SURGICAL PROCEDURE/OTHER SITE AT THIS FACILITY

Item Length: 1
Allowable Values: 0–5, 9
NAACCR Item #674
Revised 01/04, 01/10, 02/10, 01/12

Description

Records the surgical removal of *distant lymph nodes* or other tissue(s)/organ(s) beyond the primary site at this facility.

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

- If other tissue or organs are removed during primary site surgery that are not specifically defined by the site-specific *Surgical Procedure of the Primary Site* (NAACCR Item #1290 or #670) code, assign the highest numbered code that describes the surgical resection of other tissue or organs beyond the primary site surgical code.
- Assign the highest numbered code that describes the surgical resection of other tissue or organs beyond the primary site surgical code.
- Assign the highest numbered code that describes the surgical resection of *distant lymph node(s)*.
- Incidental removal of tissue or organs is not a "Surgical Procedure/Other 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.
- *Surgical Procedure/Other 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 (C76.0–76.8, 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, 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 at This Facility* (NAACCR Item #3280).

Code	Label	Definition
0	None	No nonprimary surgical site resection was performed. Diagnosed at autopsy.
1	Nonprimary surgical procedure performed	Nonprimary surgical resection to other site(s), unknown if whether the site(s) is regional or distant.
2	Nonprimary surgical procedure to other regional sites	Resection of regional site.
3	Nonprimary surgical procedure to *distant lymph node(s)*	Resection of *distant lymph node(s)*.
4	Nonprimary 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 nonprimary site was performed. Death certificate only.

DATE OF SURGICAL DISCHARGE

Item Length: 8
NAACCR Item #3180
Revised 01/10, 01/11

Description
Records the date the patient was discharged following primary site surgery. The date corresponds to the event recorded in *Surgical Procedure of Primary Site* (NAACCR Item #1290), and *Date of Most Definitive Surgical Resection* (NAACCR Item #3170).

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 Most Definitive Surgical Resection* (NAACCR Item #3170), 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 *Surgical Procedure of Primary Site* (NAACCR Item #1290).
- If the patient died following the event recorded in *Surgical Procedure of Primary Site* (NAACCR Item #1290), 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* (NAACCR Item #1750).
- 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 Most Definitive Surgical Resection of the Primary Site* (NAACCR Item #3170).
- 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 *RX Date Surg Disch Flag* (NAACCR ITEM #3181) is used to explain why *Date of Surgical Discharge* is not a known date. See *RX Date Surg Disch Flag* for an illustration of the relationships among these items.

RX DATE SURG DISCH FLAG

Item Length: 2
NAACCR Item #3181
Valid Codes: 10-12, Blank
New Item: 01/2010

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date of Surgical Discharge* (NAACCR Item #3180).

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

Coding Instructions
- Leave this item blank if *Date of Surgical Discharge* (NAACCR Item #3180) has a full or partial date recorded.
- Code 12 if the *Date of Surgical Discharge* can not 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	Description
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any surgery was performed).
11	No proper value is applicable in this context (for example, no surgery performed).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, surgery was performed but the date is unknown).
(blank)	A valid date value is provided in item *Date of Surgical Discharge* (NAACCR Item #3180). 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* (NAACCR Item #3180) and *Rx Date Surg Disch Flag* (NAACCR Item #3181). ***In this table, the lower-case letter "b" is used to represent each blank space.***

Description	Traditional Date of Surgical Discharge	Interoperable Date of Surgical Discharge	Rx Date Surg Disch Flag
	Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999	**Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown or not applicable.**	
Full date known	MMDDCCYY (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

READMISSION TO THE SAME HOSPITAL WITHIN 30 DAYS OF SURGICAL DISCHARGE

Item Length: 1
Allowable Values: 0–3, 9
NAACCR Item #3190
Revised 06/05, 01/10

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.

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* (NAACCR Item #3180).
- 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* (NAACCR Item #3110, 3120, 3130, 3140, 3150, 3160, 3161, 3162, 3163, 3124).
- 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.

REASON FOR NO SURGERY OF PRIMARY SITE

Item Length: 1
Allowable Values: 0–2, 5–9
NAACCR Item #1340
Revised 01/04, 01/13

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 *Surgical Procedure of Primary Site* (NAACCR Item #1290) 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 *Surgical Procedure of Primary Site* (NAACCR Item #1290) 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.
- Code 8 if it is known that a physician recommended primary site surgery, but no further documentation is available yet to determine whether surgery was performed.
- Cases 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, progression of tumor prior to planned surgery 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 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.

RX Text--Surgery

Item Length: 1000
Allowable Values: Neither carriage return nor line feed characters allowed
Free text
NAACCR Item #2610
NHSCR-Specific

Description
Text area for information describing all surgical procedures performed as part of treatment.

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 within 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 reporter independently from the code(s). If 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
• Prioritize entered information in the order of the fields listed below.
• Text automatically generated from coded data is not acceptable.
• NAACCR-approved abbreviations should be utilized.
• 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.

Note: For software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

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.

DATE RADIATION STARTED

Item Length: 8
NAACCR Item #1210
Revised 06/05, 01/10, 01/11

Description
Records the date on which radiation therapy began at any facility that is part of the first course of treatment.

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* (NAACCR Item #1270).
- 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 *RX Date–Radiation Flag* (NAACCR ITEM #1211) is used to explain why *Date Radiation Started* is not a known date. See *RX Date–Radiation Flag* for an illustration of the relationships among these items.

Examples

A patient has external beam radiation on December 15, 2003.	December 15, 2003
A patient with a primary tumor of the brain undergoes stereotactic radiosurgery using a Gamma Knife on October 12, 2003.	October 12, 2003
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.	June 2, 2003

RX DATE–RADIATION FLAG

Item Length: 2
NAACCR Item #1211
Valid Codes: 10-12, 15, Blank
New Item: 01/2010

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date Radiation Started* (NAACCR Item #1210).

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

Coding Instructions
- Leave this item blank if *Date Radiation Started* (NAACCR Item #1210) has a full or partial date recorded.
- Code 12 if the *Date Radiation Started* can not be determined, but the patient did receive first course radiation.
- Code 10 if it is unknown whether any radiation was given.
- 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	Description
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 (that is, radiation was given but the date is unknown).
15	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 the first course of therapy, but had not been started at the time of the most recent follow-up).
(blank)	A valid date value is provided in item *Date Radiation Started* (NAACCR Item #1210).

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date Radiation Started* (NAACCR Item #1210) and *Rx Date–Radiation Flag* (NAACCR Item #1211). ***In this table, the lower-case letter "b" is used to represent each blank space.***

Description	Traditional Date Radiation Started	Interoperable Date Radiation Started	Rx Date–Radiation Flag
	Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999	**Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown or not applicable.**	
Full date known	MMDDCCYY (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

LOCATION OF RADIATION TREATMENT

Item Length: 1
Allowable Values: 0–4, 8, 9
NAACCR Item #1550
Revised 01/04, 01/12

Description
Identifies the location of the facility where radiation therapy was administered during the first course 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 of 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 items *Palliative Care* (NAACCR Item #3270) and/or *Palliative Care at This Facility* (NAACCR Item #3280), as appropriate.

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 the above 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 a 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.

RADIATION TREATMENT VOLUME

Item Length: 2
Allowable Values: 00–41, 50, 60, 98, 99
NAACCR Item #1540
Revised 01/04, 01/11, 01/12, 01/15

Description
Identifies the volume or anatomic target of the most clinically significant radiation therapy delivered to the patient during the first course 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.

Code	Label	Definition
13	Stomach	The primary malignancy is in the stomach. Radiation is directed to the stomach and possibly adjacent lymph nodes.
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 fit 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 [NAACCR Item #1290] 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 should 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 may 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).

Code	Label	Definition
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 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. If entire pelvis is included in a portion of the treatment, then code 29 (Pelvis, NOS).
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.

Code	Reason
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 a 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.

REGIONAL TREATMENT MODALITY

Record all radiation that is given as part of first course therapy, even if it is palliative.

Item Length: 2
Allowable Values: 00, 20–32, 40–43, 50–55, 60–62, 98, 99
NAACCR Item #1570
Revised 09/06, 09/08, 01/11, 01/15

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.

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.

Code	Label	Definition
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.
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 administered, but the treatment modality is not specified or is unknown.
99	Unknown	It is unknown whether radiation therapy was administered.

Examples

Code	Reason
00	A patient was treated for melanoma with PUVA (psoralen and long-wave ultraviolet radiation). Code this treatment as *Other Treatment* (NAACCR Item #1420, 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 as 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 pelvic 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.
98	A patient with a head and neck cancer underwent regional radiation treatment elsewhere and was referred to reported facility for an HDR brachytherapy boost. Detailed treatment records from the other facility are not available.

****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.

REGIONAL DOSE: cGy

Item Length: 5
Right Justified, Zero-filled
NAACCR Item #1510
Revised 01/04, 01/15

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).

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 of 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* (NAACCR Item #1570)–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 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 is delivered to a small volume in the breast. Record the primary target of the breast as 5,500cGy.

BOOST TREATMENT MODALITY

Item Length: 2
Allowable Values: 00, 20–32, 40–43, 50–55, 60–62, 98, 99
NAACCR Item #3200
Revised 01/04, 09/08

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.

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 that multiple radiation therapy boost modalities were employed during 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 field, 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.

Code	Label	Definition
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.
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 6 MV photons. The primary site and involved regional lymph nodes are then boosted, ie, 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.

Code	Reason
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 is referred to another institution for an HDR brachytherapy boost. Detailed treatment records from the other institution are not available.

BOOST DOSE: cGy

Item Length: 5
Right Justified, Zero-filled
NAACCR Item #3210
Revised 06/05, 01/2015

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).

Rationale
To evaluate patterns of radiation oncology care, it is necessary to capture information describing the prescribed boost 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 of treatment. Determination of the additional boost dose of 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 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* (NAACCR Item #3200)–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 receives 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 receives 6,000 cGy to the left supraclavicular region. The dose is calculated at a prescribed depth of 3 cm. A secondary calculation shows a D_{max} dose (dose at depth of maximum dose) of 6,450 cGy. Do not confuse D_{max} doses with 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 central axis dose in 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 dose 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

Item Length: 3
Allowable Values: 000–999
Right Justified, Zero-filled
NAACCR Item #1520
Revised 09/04, 01/10, 05/10, 01/12

Description
Records the total number of treatment sessions (fractions) administered during the first course 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. Or, 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 in 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 as 1 treatment.

RADIATION/SURGERY SEQUENCE

Item Length: 1
Allowable Values: 0, 2–6, 9
NAACCR Item #1380
Revised 01/04, 01/10, 01/11, 01/12

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 *Surgical Procedure of Primary Site* (NAACCR Item #1290); *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292); *Surgical Procedure/Other Site* (NAACCR Item #1294). 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: *Surgical Procedure of Primary Site, 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 therapy 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.

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.

DATE RADIATION ENDED

Item Length: 8
NAACCR Item #3220
Revised 06/05, 01/10, 01/11, 01/12

Description
The date on which the patient completes or receives the last radiation treatment at any facility.

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* (NAACCR Item #1210).
- 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 *RX Date–Radiation Flag* (NAACCR Item #1211) is used to explain why *Date Radiation Ended* is not a known date. See *RX Date–Rad Ended Flag* for an illustration of the relationships among these items.

Examples

A patient starts IMRT radiation treatment on December 15, 2004 and treatment continues until January 4, 2005.	January 4, 2005
A patient receives one radiation treatment on October 2, 2009, then refuses further treatments.	October 2, 2009
A patient with a primary tumor of the brain undergoes stereotactic radiosurgery using a Gamma Knife on April 4, 2006.	April 4, 2006

RX DATE RAD ENDED FLAG

Item Length: 2
NAACCR Item #3221
Valid Codes: 10-12, 15, Blank
New Item: 01/2010, revised 02/10, 03/10

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date Radiation Ended* (NAACCR Item #3200).

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

Coding Instructions
- Leave this item blank if *Date Radiation Ended* (NAACCR Item #3200) has a full or partial date recorded.
- Code 12 if the *Date Radiation Ended* can not be determined, but the patient did receive first course radiation.
- Code 10 if it is unknown whether any radiation was given.
- 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	Description
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 was administered).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, radiation was given but the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (that is, radiation therapy had begun at the time of the most recent follow-up but was not yet completed).
(blank)	A valid date value is provided in item *Date Radiation Ended* (NAACCR Item #3200).

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date Radiation Ended* (NAACCR Item #3200) and *Rx Date Rad Ended Flag* (NAACCR ITEM #3201). ***In this table, the lower-case letter "b" is used to represent each blank space.***

Description	Traditional Date Radiation Ended	Interoperable Date Radiation Ended	Rx Date–Rad Ended Flag
	Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999	**Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown or not applicable.**	
Full date known	MMDDCCYY (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

REASON FOR NO RADIATION

Item Length: 1
Allowable Values: 0–2, 5–9
NAACCR Item #1430
Revised 09/04, 01/13

Description
Records the reason that no regional radiation therapy was administered to the patient.

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* (NAACCR Item #1570) is coded 00, then record the reason based on documentation in 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.
- Code 8 if it is known that a physician recommended radiation treatment, but no further documentation is available yet to confirm its administration.
- Code 8 to indicate referral to a radiation oncologist was made and the registry should follow to determine whether radiation was administered. If follow-up to the specialist or facility determines the patient was never there and no other documentation can be found, code 1.
- Cases 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 administered.
1	Radiation therapy was not administered 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 other patient risk factors (comorbid conditions, advanced age, progression of tumor prior to planned radiation etc.).
5	Radiation therapy was not administered because the patient died prior to planned or recommended therapy.
6	Radiation therapy was not administered; it was recommended by the patient's physician, but was not administered as part of first course treatment. 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 patient record.
8	Radiation therapy was recommended, but it is unknown whether it was administered.
9	It is unknown if radiation therapy was recommended or administered. Death certificate cases only.

Example

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.

RX Text--Radiation (Beam)

Item Length: 1000
Allowable Values: Neither carriage return nor line feed characters allowed
Free text
NAACCR Item #2620
NHSCR-Specific

RX Text--Radiation Other

Item Length: 1000
Allowable Values: Same as above
Free text
NAACCR Item #2630
NHSCR-Specific

Description
Text area for manual documentation of information regarding treatment of the tumor being reported with radiation (beam and other).

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 within 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 reporter independently from the code(s). If 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
• Prioritize entered information in the order of the fields listed below.
• Text automatically generated from coded data is not acceptable.
• NAACCR-approved abbreviations should be utilized.
• 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.

Note: For software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

Suggestions for text:
• Date when radiation treatment was started
• 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
• Type(s) of nonbeam radiation,e.g., High Dose rate brachytherapy, seed implant, Radioisotopes (I-131)
• Other treatment information, e.g., patient discontinued after 5 treatments; unknown if radiation was given

DATE SYSTEMIC THERAPY STARTED

Item Length: 8
NAACCR Item #3230
Revised 01/10, 01/11

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 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 systemic therapy was administered. Systemic therapy includes *Chemotherapy* (NAACCR Item #1390), *Hormone Therapy* (NAACCR Item #1400), *Immunotherapy* (NAACCR Item #1410), and *Hematologic Transplant and Endocrine Procedures* (NAACCR Item #3250).
- 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 Systemic Therapy Started* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date Systemic Therapy 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 *RX Date Systemic Flag* (NAACCR Item #3231) is used to explain why *Date Systemic Therapy Started* is not a known date. See *RX Date Systemic Flag* for an illustration of the relationships among these items.

Examples

A patient with breast cancer begins her regimen of chemotherapy on December 15, 2003, and is subsequently given Tamoxifen on January 20, 2004.	December 15, 2003
A patient with Stage IV prostate cancer has an orchiectomy on June 2, 2003. He is then started on a regime of hormonal agents on June 9, 2003.	June 2, 2003

RX DATE SYSTEMIC FLAG

Item Length: 2
NAACCR Item #3231
Valid Codes: 10-12, 15, Blank
Revised 01/12

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date Systemic Therapy Started* (NAACCR Item #3230).

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

Coding Instructions
- Leave this item blank if *Date Systemic Therapy Started* (NAACCR Item #3230) has a full or partial date recorded.
- Code 12 if the *Date Systemic Therapy Started* can not be determined, but the patient did receive first course systemic therapy.
- Code 10 if it is unknown whether any systemic therapy was given.
- Code 11 if no systemic therapy is planned or given.
- Code 15 if systemic therapy is planned, but not yet started. Follow this patient for systemic therapy and update this item, *Date Systemic Therapy Started*, and all relevant systemic therapy items.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Description
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 (that is, systemic therapy was given but the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (that is, systemic 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 value is provided in item *Date Systemic Therapy Started* (NAACCR Item #3230).

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date Systemic Therapy Started* (NAACCR Item #3230) and *Rx Date Systemic Flag* (NAACCR Item #3231). ***In this table, the lower-case letter "b" is used to represent each blank space.***

Description	Traditional Date Systemic Therapy Started	Interoperable Date Systemic Therapy Started	Rx Date Systemic Flag
	Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999	**Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown or not applicable.**	
Full date known	MMDDCCYY (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 is planned, not yet begun	88888888 (example: 88888888)	bbbbbbbb (example: bbbbbbbb)	15

DATE CHEMOTHERAPY STARTED

Item Length: 8
NAACCR Item #1220
Revised 01/11

Description
Records the date of initiation of chemotherapy that is part of the first course of 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 chemotherapy was administered by any facility. This date corresponds to administration of the agents coded in *Chemotherapy* (NAACCR Item #1390).
- 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 Chemotherapy Started* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date Chemotherapy 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 *RX Date–Chemo Flag* (NAACCR Item #1221) is used to explain why *Date Chemotherapy Started* is not a known date. See *RX Date–Chemo Flag* for an illustration of the relationships among these items.

RX DATE–CHEMO FLAG

Item Length: 2
NAACCR Item #1221
Valid Codes: 10-12, 15, Blank
New Item: 01/2010

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date Chemotherapy Started* (NAACCR Item #1220).

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

Coding Instructions
- Leave this item blank if *Date Chemotherapy Started* (NAACCR Item #1220) has a full or partial date recorded.
- Code 12 if the *Date Chemotherapy Started* can not 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 Chemotherapy Started*, and the 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 Chemotherapy Started* at that time.

Code	Description
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 (that is, chemotherapy was given but the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (that is, 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 value is provided in item *Date Chemotherapy Started* (NAACCR Item #1220). Case was diagnosed between 2003 and 2009 and the facility did not record *Date Chemotherapy Started* (NAACCR Item #1220) at that time.

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date Chemotherapy Started* (NAACCR Item #1220) and *Rx Date–Chemo Flag* (NAACCR Item #1221). ***In this table, the lower-case letter "b" is used to represent each blank space.***

Description	Traditional Date Chemotherapy Started	Interoperable Date Chemotherapy Started	Rx Date–Chemo Flag
	Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999	**Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown or not applicable.**	
Full date known	MMDDCCYY (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

CHEMOTHERAPY

Item Length: 2
Allowable Values: 00–03, 82, 85–88, 99
NAACCR Item #1390
Revised 06/05, 09/08, 01/10, 01/15

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.

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 a medical oncologist and the registry must follow to determine whether it was given. If follow-up with the 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 *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 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 administered in the item Palliative Care (NAACCR Item #3270).

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 (ie, 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 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.

CHEMOTHERAPY AT THIS FACILITY

Item Length: 2
Allowable Values: 00–03, 82, 85–88, 99
NAACCR Item #700
Revised 06/05, 09/08, 01/10, 01/12, 01/13, 01/15

Description
Records the type of chemotherapy administered as first course treatment at this facility. 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.

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
- Record only chemotherapy received at this facility. Do not record agents administered at other facilities.
- 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
- 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 *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 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 administered in the item *Palliative Care at This Facility* (NAACCR Item #3280)..

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 (ie, comorbid conditions, advanced age, progression of tumor prior to planned administration).
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.

RX Text--Chemo

Item Length: 1000
Allowable Values: Neither carriage return nor line feed characters allowed
Free text
NAACCR Item #2640
NHSCR-Specific

Description
Text area for manual documentation of information regarding chemotherapy treatment of the reported tumor.

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 within 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 reporter independently from the code(s). If 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
• Prioritize entered information in the order of the fields listed below.
• Text automatically generated from coded data is not acceptable.
• NAACCR-approved abbreviations should be utilized.
• 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.

Note: For software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

Suggestions for text:
• Date when chemotherapy began
• Where treatment was given, e.g., at this facility, at another facility
• Type of chemotherapy, e.g., name of agent(s) or protocol
• Other treatment information, e.g., treatment cycle incomplete, unknown if chemotherapy was given

DATE HORMONE THERAPY STARTED

Item Length: 8
NAACCR Item #1230
Revised 01/11, 01/12

Description
Records the date of initiation of hormone therapy that is part of the first course of 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 hormone therapy was administered by any facility. This date corresponds to administration of the agents coded in *Hormone Therapy* (NAACCR Item #1400).
- 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 Hormone Therapy Started* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date Hormone Therapy 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 *RX Date–Hormone Flag* (NAACCR Item #1231) is used to explain why *Date Hormone Therapy Started* is not a known date. See *RX Date–Hormone Flag* for an illustration of the relationships among these items.

RX DATE–HORMONE FLAG

Item Length: 2
NAACCR Item #1231
Valid Codes: 10-12, 15, Blank
New Item: 01/2010

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date Hormone Therapy Started* (NAACCR Item #1230).

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

Coding Instructions
- Leave this item blank if *Date Hormone Therapy Started* (NAACCR Item #1230) has a full or partial date recorded.
- Code 12 if the *Date Hormone Therapy Started* can not 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 Hormone Therapy Started*, and the 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 if this facility did not collect *Date Hormone Therapy Started* at that time.

Code	Description
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 (that is, hormone therapy was given but the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (that is, 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 value is provided in item *Date Hormone Therapy Started* (NAACCR Item #1230). Case was diagnosed between 2003 and 2009 and the facility did not record *Date Hormone Therapy Started* (NAACCR Item #1230) at that time.

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date Hormone Therapy Started* (NAACCR Item #1230) and *Rx Date–Hormone Flag* (NAACCR Item #1231). ***In this table, the lower-case letter "b" is used to represent each blank space.***

Description	Traditional Date Hormone Therapy Started Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999	Interoperable Date Hormone Therapy Started Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown or not applicable.	Rx Date–Chemo Flag
Full date known	MMDDCCYY (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, hormone therapy given	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12
Hormone therapy is planned, not yet begun	88888888 (example: 88888888)	bbbbbbbb (example: bbbbbbbb)	15

HORMONE THERAPY
(HORMONE/STEROID THERAPY)

Item Length: 2
Allowable Values: 00, 01, 82, 85–88, 99
NAACCR Item #1400
Revised 06/05, 09/08, 01/10, 01/13

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.

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 known that it is not usually administered for this type and stage of cancer.
- Code 00 if the treatment plan offered multiple alternative treatment options, and the patient selected treatment that did not include hormone therapy or if the option of "no treatment" was accepted by the patient.
- Code 01 for thyroid replacement therapy which inhibits TSH (thyroid-stimulating hormone). TSH is a product of the pituitary gland that can stimulate tumor growth.
- If it is known that hormone therapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
- Code 87 if the patient refused recommended hormone therapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 88 if it is known that a physician recommended hormone therapy, but no further documentation is available yet to confirm its administration.
- Code 88 to indicate the patient was referred to a medical oncologist and the registry should follow the case for hormone therapy. If follow-up with the specified specialist or facility indicates the patient was never there, code 00.
- Cases coded 88 should be followed to determine whether they received hormone therapy or why not.
- Code 99 if it is not known whether hormone therapy is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered.
- Refer to the *SEER*Rx Interactive Drug Database* (http://seer.cancer.gov/) for a list of hormonal agents.
- If hormone therapy was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the hormone therapy administered in the item *Palliative Care* (NAACCR Item #3270).

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 (ie, 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.

HORMONE THERAPY AT THIS FACILITY (HORMONE/STEROID THERAPY)

Item Length: 2
Allowable Values: 00, 01, 82, 85–88, 99
NAACCR Item #710
Revised 06/05, 09/08, 01/10, 01/13

Description
Records the type of hormone therapy administered as first course treatment at this facility. 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.

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 only hormone therapy received at this facility. Do not record procedures done at other facilities.
- Record prednisone as hormonal therapy when administered in combination with chemotherapy, such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone) or COPP (cyclophosphamide, vincristine, procarbazine, prednisone).
- Do not code prednisone as hormone therapy when it is administered for reasons other than chemotherapeutic treatment.
- Tumor involvement or treatment may destroy hormone-producing tissue. Hormone replacement therapy will be given if the hormone is necessary to maintain normal metabolism and body function. Do not code hormone replacement therapy as part of first course therapy.
- Code 00 if hormone therapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.
- Code 00 if the treatment plan offered multiple alternative treatment options, and the patient selected treatment that did not include hormone therapy or if the option of "no treatment" was accepted by the patient.
- Code 01 for thyroid replacement therapy which inhibits TSH (thyroid-stimulating hormone). TSH is a product of the pituitary gland that can stimulate tumor growth.
- If it is known that hormone therapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
- Code 87 if the patient refused recommended hormone therapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 88 if it is known that a physician recommended hormone therapy, but no further documentation is available yet to confirm its administration.
- 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* (NAACCR Item #3270).

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 (ie, 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.

Code	Definition
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.

RX Text--Hormone

Item Length: 1000
Allowable Values: Neither carriage return nor line feed characters allowed
Free text
NAACCR Item #2650
NHSCR-Specific

Description
Text area for information about hormonal treatment.

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 within 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 reporter independently from the code(s). If 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
• Prioritize entered information in the order of the fields listed below.
• Text automatically generated from coded data is not acceptable.
• NAACCR-approved abbreviations should be utilized.
• 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.

Note: For software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

Suggestions for text:
• Date treatment was started
• Where treatment was given, e.g., at this facility, at another facility
• Type of hormone or antihormone, 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

DATE IMMUNOTHERAPY STARTED

Item Length: 8
NAACCR Item #1240
Valid Codes: 10-12, 15, Blank
Revised 01/11

Description
Records the date of initiation of immunotherapy or a biologic response modifier (BRM) that is part of the first course of 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 immunotherapy or a biologic response modifier was administered by any facility. This date corresponds to administration of the agents coded in *Immunotherapy* (NAACCR Item #1410).
- 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 Immunotherapy Started* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date Immunotherapy 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 *RX Date–BRM Flag* (NAACCR Item #1241) is used to explain why *Date Immunotherapy Started* is not a known date. See *RX Date–BRM Flag* for an illustration of the relationships among these items.

RX DATE–BRM FLAG

Item Length: 2
NAACCR Item #1241
Valid Codes: 10-12, 15, Blank
New Item: 01/2010

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date Immunotherapy Started* (NAACCR Item #1240).

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

Coding Instructions
- Leave this item blank if *Date Immunotherapy Started* (NAACCR Item #1240) has a full or partial date recorded.
- Code 12 if the *Date Immunotherapy Started* can not be determined, but the patient did receive first course immunotherapy or a biologic response modifier.
- Code 10 if it is unknown whether any immunotherapy or a biologic response modifier was given.
- Code 11 if no immunotherapy or 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 Immunotherapy Started*, and the 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 if this facility did not collect *Date Immunotherapy Started* at that time.

Code	Description
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 (that is, immunotherapy was given but the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (that is, 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 value is provided in item *Date Immunotherapy Started* (NAACCR Item #1240). Case was diagnosed between 2003 and 2009 and the facility did not record *Date Immunotherapy Started* (NAACCR Item #1240) at that time.

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date Immunotherapy Started* (NAACCR Item #1240) and *Rx Date–BRM Flag* (NAACCR Item #1241). ***In this table, the lower-case letter "b" is used to represent each blank space.***

Description	Traditional Date Immunotherapy Started	Interoperable Date Immunotherapy Started	Rx Date–BRM Flag
	Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999	Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown or not applicable.	
Full date known	MMDDCCYY (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 immunotherapy 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

IMMUNOTHERAPY

Item Length: 2
Allowable Values: 00, 01, 82, 85–88, 99
NAACCR Item #1410
Revised 06/05, 09/08, 01/10, 01/13, 01/15

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.

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 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 (NAACCR Item #3270).

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
Cetuximab/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 (ie, 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.

IMMUNOTHERAPY AT THIS FACILITY

Item Length: 2
Allowable Values: 00, 01, 82, 85–88, 99
NAACCR Item #720
Revised 06/05, 09/08, 01/10, 01/13, 01/15

Description
Records the type of immunotherapy administered as first course treatment at this facility. 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.

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
- Record only immunotherapy received at this facility. Do not record agents administered at other facilities.
- 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 the patient receive 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 to determine whether they received immunotherapy or why not.
- 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 at This Facility* (NAACCR Item #3280).

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 (ie, comorbid conditions, advanced age).
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.

RX Text--BRM

Item Length: 1000
Allowable Values: Neither carriage return nor line feed characters allowed
Free text
NAACCR Item #2660
NHSCR-Specific

Description
Text area for manual documentation of information regarding the treatment of the tumor being reported with biological response modifiers or immunotherapy.

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 within 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 reporter independently from the code(s). If 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
• Prioritize entered information in the order of the fields listed below.
• Text automatically generated from coded data is not acceptable.
• NAACCR-approved abbreviations should be utilized.
• 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.

Note: For software that allows unlimited text, NAACCR recommends that the software indicate to the reporter the portion of the text that will be transmitted to the central registry.

Suggestions for text:
• Date treatment began
• 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

HEMATOLOGIC TRANSPLANT AND ENDOCRINE PROCEDURES Item Length: 2

Allowable Values: 00, 10–12, 20, 30, 40, 82, 85–88, 99
NAACCR Item #3250
Revised 06/05, 01/10, 01/12, 01/13

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.

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 allogeneic.
- Stem cell harvests involve the collection of immature blood cells from the patient and the reintroduction by transfusion of the harvested cells following chemotherapy or radiation therapy.
- Endocrine irradiation and/or endocrine surgery are procedures which suppress the naturally occurring hormonal activity of the patient and thus alter or affect the long-term control of the cancer's growth. These procedures must be bilateral to qualify as endocrine surgery or endocrine radiation. If only one gland is intact at the start of treatment, surgery and/or radiation to that remaining gland qualifies as endocrine surgery or endocrine radiation.
- Code 00 if a transplant or endocrine procedure was not administered to the patient, and it is known that these procedures are not usually administered for this type and stage of cancer.
- Code 00 if the treatment plan offered multiple alternative treatment options, and the patient selected treatment that did not include a transplant or endocrine procedure or if the option of "no treatment" was accepted by the patient.
- If it is known that a transplant or endocrine procedure is 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.
- Use code 88 if a bone marrow or stem cell harvest was undertaken, but was not followed by a rescue or re-infusion as part of first course treatment.
- Cases coded 88 should be followed to determine whether they were given a hematologic transplant or endocrine procedure or why not.
- Code 99 if it is not known whether a transplant or endocrine procedure is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered.
- If the hematologic transplant or endocrine procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the hematologic transplant or endocrine procedure provided in the items *Palliative Care* (NAACCR Item #3270) and/or *Palliative Care at This Facility* (NAACCR Item #3280), as appropriate.

Code	Definition
00	No transplant procedure or endocrine therapy was administered as part of first course 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, with blood from one or multiple umbilical cords
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 (ie, 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.

SYSTEMIC/SURGERY SEQUENCE

Item Length: 1
Allowable Values: 0, 2–6, 9
NAACCR Item #1639
Revised 01/10, 01/11, 01/12

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 First Surgical Procedure* (NAACCR Item #1200).
- If none of the following surgical procedures was performed: *Surgical Procedure of Primary Site* (NAACCR Item #1290)*, Scope of Regional Lymph Node Surgery* (NAACCR Item #1292), *Surgical Procedure/Other Site* (NAACCR Item #1294), 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: *Surgical Procedure of the Primary Site* (NAACCR Item #1290), *Scope of Regional Lymph Node Surgery* (NAACCR Item # 1292), or *Surgical Procedure/Other Site* (NAACCR Item # 1294), 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 systemic 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 a 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.

DATE OTHER TREATMENT STARTED

Item Length: 8
NAACCR Item #1250
Revised 01/10, 01/11

Description
Records the date on which other treatment began at any facility.

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 *Other Treatment* [NAACCR Item #1420] was initiated.
- If other treatment is the first or only treatment administered to the patient, then the date other treatment started should be the same as the *Date of First Course of Treatment* (NAACCR Item #1270).
- 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 Other Treatment Started* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date Other Treatment 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 *RX Date–Other Flag* (NAACCR Item #1251) is used to explain why *Date Other Treatment Started* is not a known date. See *RX Date–Other Flag* for an illustration of the relationships among these items.

Examples

A patient with metastatic disease was started on an experimental therapy on March 16, 2010.	March 16, 2010
Alcohol was used as an embolizing agent for a patient on August 1, 2009	August 1, 2009
A polycythemia vera patient was given several phlebotomies, the first being on September 17, 2008	September 17, 2008

RX DATE–OTHER FLAG

Item Length: 2
NAACCR Item #1251
Valid Codes: 10-12, Blank
Revised 01/15

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date Other Treatment Started* (NAACCR Item #1250).

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

Coding Instructions
- Leave this item blank if *Date Other Treatment Started* (NAACCR Item #1250) has a full or partial date recorded.
- Code 12 if the *Date Other Treatment Started* can not 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* [NAACCR Item #1420] is 9).
- Code 11 if no other treatment is planned or given (*Other Treatment* [NAACCR Item #1420] is 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	Description
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 (that is, Other Treatment was given but the 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 value is provided in item *Date Other Treatment Started* (NAACCR Item #1250).

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date Other Treatment Started* (NAACCR Item #1250) and *Rx Date–Other Flag* (NAACCR Item #1251). ***In this table, the lower-case letter "b" is used to represent each blank space.***

Description	Traditional Date Other Treatment Started	Interoperable Date Other Treatment Started	Rx Date–Other Flag
	Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999	**Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown or not applicable.**	
Full date known	MMDDCCYY (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

Item Length: 1
Allowable Values: 0–3, 6–9
NAACCR Item #1420
Revised 06/05, 09/08, 01/10, 01/11, 01/12, 01/15

Description
Identifies other treatment that cannot be defined as surgery, radiation, or systemic therapy according to the defined data items in this manual.

Rationale
Information on other therapy 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 in this item
- 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 given for a purpose to shrink the tumor.
- 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* (NAACCR Item #3270).
- 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 was 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 therapy).
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 nonmedical 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.

OTHER TREATMENT AT THIS FACILITY

Item Length: 1
Allowable Values: 0–3, 6–9
NAACCR Item #730
Revised 01/04, 09/08, 01/10, 01/12, 01/15

Description
Identifies other treatment given at this facility that cannot be defined as surgery, radiation, or systemic therapy according to the defined data items in this manual.

Rationale
Information on other therapy 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 in this item
- 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 given for a purpose to shrink the tumor.
- 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 at This Facility* (NAACCR Item #3280).
- Code 8 if it is known that a physician recommended the patient receive treatment coded as Other Treatment, but no further documentation is available yet to confirm its administration.

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 therapy). Use this code for treatment unique to hematopoietic diseases .
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 nonmedical 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.

RX Text--Other

Item Length: 1000
Allowable Values: Neither carriage return nor line feed characters allowed
Free text
NAACCR Item #2670
NHSCR-Specific

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.

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 within 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 reporter independently from the code(s). If 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
• Prioritize entered information in the order of the fields listed below.
• Text automatically generated from coded data is not acceptable.
• NAACCR-approved abbreviations should be utilized.
• 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.

Note: For software that allows unlimited text, NAACCR recommends that the software indicate to the registrar the portion of the text that will be transmitted to the central registry.

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

PALLIATIVE CARE
(PALLIATIVE PROCEDURE)

Item Length: 1
Allowable Values: 0–7, 9
NAACCR Item #3270
Revised 01/04, 01/10

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.

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 metastatic malignant tissue.
- Palliative care is not used to diagnose or stage the primary tumor.
- Do not code 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 the 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 *Surgical Procedure/Other Site* (NAACCR Item #1294)]
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. (Record all chemotherapy items also).
4	A 93-year old patient is diagnosed with multiple myeloma and enters a pain management clinic to treat symptoms. No other therapy 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 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 for unremitting abdominal pain. (Record all radiotherapy items also).
7	A patient enters the facility with a clinical diagnosis of unresectable carcinoma of the pancreas. A stent was inserted into the bile duct to relieve obstruction and improve the bile duct flow.

PALLIATIVE CARE AT THIS FACILITY
(PALLIATIVE PROCEDURE AT THIS FACILITY)

Item Length: 1
Allowable Values: 0–7, 9
NAACCR Item #3280
Revised 01/04, 01/10

Description
Identifies care provided at this facility 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.

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 only the type of palliative care at this facility.
- 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 at this facility should be coded as 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 code 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 the 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.

Outcomes

NOTE: NHSCR is a population-based incidence registry responsible for collecting *all* cancer cases seen and/or treated in NH since June 1986. However, it is not required to conduct annual follow-up of cases reported to NHSCR once initial diagnosis and complete first-course treatment information has been reported.
Refer to p16A when cases are updated after they have been transmitted to NHSCR.

Subsequent RX 2nd Course Date

Item Length: 8
Allowable Values: Valid dates
YYYYMMDD
NAACCR Item #1660
NHSCR-Specific

Description
Date of initiation of second-course treatment. Central registries currently collecting this data item should follow the 1998 ROADS Manual coding instructions. See Chapter X for date format. Use SUBSQ RX 2NDCRS DATE FLAG [1661] if there is no appropriate or known date for this item.

Note: This data item is no longer supported by CoC (as of January 1, 2003).

Subsequent RX 2nd Course Date Flag

Item Length: 2
Allowable Values: 10-20, Blank
NAACCR Item #1661
NHSCR-Specific

Description
This flag explains why no appropriate value is in the field, Subsq RX 2nd Course Date [1660].

Rationale
Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Instructions

Code	Definition
10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if any subsequent therapy)
11	No proper value is applicable in this context (e.g., no subsequent therapy)
Blank	A valid date value is provided in item Subsq RX 2nd Course Date [1660], or the date was not expected to have been transmitted

Comment: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

DATE OF FIRST RECURRENCE

Item Length: 8
NAACCR Item #1860
Revised 06/05, 01/10, 01/11, 01/12

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 *Date of First Recurrence* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of First Recurrence* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *Recurrence Date–1st Flag* (NAACCR Item #1861) is used to explain why *Date of First Recurrence* is not a known date. See *Recurrence Date–1st Flag* for an illustration of the relationships among these items.

RECURRENCE DATE–1st FLAG

Item Length: 2
NAACCR Item #1861
Valid Codes: 10-12, Blank
New Item: 01/2010

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date of First Recurrence* (NAACCR Item #1860).

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 Recurrence* (NAACCR Item #1860) has a full or partial date recorded.
- Code 12 if the *Date of First Recurrence* can not be determined, but the patient did have a recurrence following a disease-free period.
- Code 10 if it is unknown whether the patient had a 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	Description
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 (that is, 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 (that is, there was a recurrence, but the date is unknown
(blank)	A valid date value is provided in item *Date of First Recurrence* (NAACCR Item #1860).

The following table illustrates the use of the date flag and the traditional and interoperable date formats for coding *Date of First Recurrence* (NAACCR Item #1860) and *Recurrence Date–1st Flag* (NAACCR Item #1861). ***In this table, the lower-case letter "b" is used to represent each blank space.***

Description	Traditional Date of First Recurrence	Interoperable Date of First Recurrence	Recurrence Date–1st Flag
	Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999	Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown or not applicable.	
Full date known	MMDDCCYY (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 a 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

TYPE OF FIRST RECURRENCE

Item Length: 2
Allowable Values: 00, 04, 06, 10, 13–17, 20–22, 25–27, 30, 36, 40, 46, 51–59, 60, 62, 70, 88, 99
NAACCR Item #1880
Revised 06/05, 01/10, 01/11, 01/13, 01/15

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 which may occur after subsequent treatment has been completed.
- If the patient is disease-free (code 00), continue to track until a recurrence occurs. First recurrence may occur well after completion of the first course of treatment.
- Once a recurrence has been recorded (code 04-62 or 88), subsequent recurrences are NOT to be recorded.
- Codes 00 through 70 are hierarchical; record the highest-numbered applicable response, with the following limits.. The first time a patient converts from disease status (70) to disease-free, change the code to 00. Then the first time a patient converts from 00 to a recurrence, then record the proper code for the recurrence. No further changes (other than corrections) should be made.
- If the tumor was originally diagnosed as in situ, code recurrence to 06, 16, 17, 26, 27, 36, or 46 only. Do not use those codes for any other tumors. Codes 00, 88, or 99 may apply to any tumor.
- Codes 51–59 (organ or organ system of distant recurrence) apply only if all first occurrences were in a single category. There may be multiple metastases (or "seeding") within the distant location.
- Code lymphomas or leukemias that are in remission 00. If the patient relapses, then code recurrence as 59. If one of these is controlled by drugs (for example, Gleevec for CML), the patient is in remission.
- If there is more than one primary tumor and the physician is unable to decide which has recurred, code the recurrent disease for each tumor. If the recurrent primary is identified later, revise the codes appropriately.

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 to 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

Code	Definition
17	Both local and trocar recurrence of an in situ tumor.
20	Regional recurrence, and there is insufficient information available to code to 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.
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 organs(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 to 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

DATE OF LAST CONTACT OR DEATH

Item Length: 8
NAACCR #1750
Revised 06/05, 01/10, 01/11,01/15

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 outcomes 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.
- As of January 1, 2006, the CoC does not require *Class of Case* 00 cases to be followed.
- 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* (NAACCR Item #1751) 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

Item Length: 2
NAACCR #1751
Valid Codes: 12, Blank
New Item: 01/2010

Description
This flag explains why there is no appropriate value in the corresponding date field, *Date of Last Contact or Death* (NAACCR Item #1750).

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* (NAACCR Item #1750) has a full or partial date recorded.
- Code 12 if the *Date of Last Contact or Death* can not 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	Description
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, the date of last contact is unknown).
(blank)	A valid date value is provided in item *Date of Last Contact or Death* (NAACCR Item #1750).

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* (NAACCR Item #1750) and *Date of Last Contact Flag* (NAACCR Item #1751). ***In this table, the lower-case letter "b" is used to represent each blank space.***

Description	Traditional Date of Last Contact or Death	Interoperable Date of Last Contact or Death	Date of Last Contact Flag
	Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999	**Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces); omit the date if the date is completely unknown or not applicable.**	
Full date known	MMDDCCYY (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

Item Length: 1
Allowable Values: 0, 1
NAACCR Item #1760
Revised 01/15

Description
Records the vital status of the patient as of the date entered in *Date of Last Contact or Death* (NAACCR Item #1750).

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

Instructions for Coding
- This item is collected during the follow-up process with *Date of Last Contact or Death* (NAACCR Item #1750).
- 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

Example

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 a patient's following physician, it is learned the patient is alive.

Cause of Death

Alternate Name: Underlying Cause of Death (SEER)

Item Length: 4
Allowable Values: Valid ICD-7, ICD-8, ICD-9, and ICD-10 codes; also 0000, 7777, 7797
4 digits (for ICD-7, 8, 9); for ICD-10, upper case letter followed by 3 digits or upper case followed by 2 digits plus blank
NAACCR Item #1910
NHSCR-Specific

Description
Official cause of death as coded from the death certificate in valid ICD-7, ICD-8, ICD-9, and ICD-10 codes.

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

Special codes in addition to ICD-7, ICD-8, ICD-9, and ICD-10 (refer to *SEER Program Code Manual* for additional instructions):

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

Note: This data item is no longer supported by COC (as of January 1, 2003).

Autopsy

Item Length: 1
Allowable Values: 0-2, 9
NAACCR Item #1930
NHSCR-Specific

Description
Code indicating whether or not an autopsy was performed.

Instructions for Coding

Code	Definition
0	Not applicable; patient alive
1	Autopsy performed
2	No autopsy performed
9	Patient expired, unknown if autopsy performed

Note: This data item is no longer supported by COC (as of January 1, 2003).

Place of Death--Country

Item Length: 3
Allowable Values: Reference NAACCR Data Dictionary
Upper Case
NAACCR Item #1944
NHSCR-Specific

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 [1942]. It replaces the use of Place of Death [1940].

Rationale
Place of death is helpful for carrying out death clearance. When a reporting facility 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
Use the International Standards Organization (ISO) 3166-1 Country Three Character Codes, whenever possible, augmented by custom codes. See Appendix B in the *NAACCR v16 Data Dictionary* for complete list of country names and corresponding three character alpha codes.

Codes

Code	Definition
ZZN	North America NOS
ZZC	Central America NOS
ZZS	South America NOS
ZZP	Pacific NOS
ZZE	Europe NOS
ZZF	Africa NOS
ZZA	Asia NOS
ZZX	Non-US NOS
ZZU	Unknown
Custom codes for historic use only	
XNI	North American Islands
ZCB	Other Caribbean Islands
XEN	England, Channel Islands, Isle of Man
XSC	Scandinavia
XGR	Germanic Countries
XSL	Slavic Countries
CSK	Czechoslovakia (former)
YUG	Yugoslavia (former)
XUM	Ukraine and Moldova
XNF	North Africa

XSD	Sudanese Countries
XWF	West Africa
XSF	South Africa
XEF	East Africa
XIF	African Islands
XET	Ethiopia and Eritrea
XAP	Arabian Peninsula
XIS	Israel and Palestine
XCR	Caucasian Republics of former USSR
XOR	Other Asian Republics of former USSR
XSE	Southeast Asia
XMS	Malaysia, Singapore, Brunei
XCH	China, NOS
XML	Melanesian Islands
XMC	Micronesian Islands
XPL	Polynesian Islands
Blank	Not applicable, patient alive

Place of Death—State

Item Length: 2
Allowable Values: Reference NAACCR Data Dictionary
Upper Case
NAACCR Item #1942
NHSCR-Specific

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 [1944]. It replaces the use of PLACE OF DEATH [1940].

Rationale
This field also helps carry out death clearance. When a reporting facility 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

Code	Definition
Blank	Not applicable, patient alive

Note: See Appendix B in the NAACCR v16 *Data Dictionary* for numeric and alphabetic lists of places and codes (also see Appendix B of the *SEER Program Code Manual* at seer.cancer.gov/tools/codingmanuals/index.html).

CANCER STATUS

Item Length: 1
Allowable Values: 1, 2, 9
NAACCR Item #1770
Revised 01/04

Description
Records the presence or absence of clinical evidence of the patient's malignant or non-malignant tumor as of the *Date of Last Contact or Death* (NAACCR Item #1750).

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 nonphysician, 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

Example

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* (NAACCR Item #1750) 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.

NPI–FOLLOWING REGISTRY

Item Length: 10
Allowable Value: Ten digits
NAACCR Item #2445
Revised 04/07, 09/08, 01/11

Description
Records the registry responsible for following the patient.

Rationale
This data item is useful when the same patient is recorded in multiple registries.

Instructions for Coding
- Record the 10-digit NPI for the facility of the registry responsible for following the patient.
- 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 of the following registry is unknown or not available.

Following Registry

Item Length: 10
Allowable Values: 10-digit number
Right justified, zero filled
NAACCR Item #2440
NHSCR-Specific

Description
Records the FIN of the registry responsible for following the patient.

Rationale
The number is essential to NCDB [and NHSCR] for monitoring data submissions, ensuring the accuracy of data, and identifying areas for special studies.

Instructions for Coding
CoC maintains the codes, including those for non-hospital sources of reporting.

For facilities with 7-digit FINs, consisting of a constant "6" followed by 6-digit facility-specific codes in the range of 6020009-6953290 that were assigned by CoC before January 1, 2001: Enter all FIN codes of this type as 3 zeroes, followed by the constant "6" and the 6-digit facility-specific codes.

For facilities with FINs greater than or equal to 10000000 that were assigned by CoC after January 1, 2001: Enter FIN codes of this type as 2 zeroes followed by the full 8-digit code. These sometimes are called CoC FIN 10-digit codes.

Codes

Code	Definition
0000000000	Case not reported by a facility
0099999999	Case reported, but facility number is unknown

Note: This item is not supported by CoC as of January 1, 2010, (the respective NPI item is required).

FOLLOW-UP SOURCE

Item Length: 1
Allowable Values: 0–5, 7–9
NAACCR Item #1790

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	Department 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
(NEXT FOLLOW-UP METHOD)

Item Length: 1
Allowable Values: 0–5, 8, 9
NAACCR Item #1800
Revised 01/10

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 in CoC-accredited cancer programs 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.

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.

Case Administration

ABSTRACTED BY

Item Length: 3
Left Justified Alphanumeric
NAACCR Item #570

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 multistaffed registries.

Instructions for Coding
Code the initials of the abstractor.

In a registry with more than one abstractor, *Abstracted By* should reflect the abstractor who completed the case.

Code	Definition
(fill spaces)	Initials or code of abstractor.

FACILITY IDENTIFICATION NUMBER (FIN)

Item Length: 10
Right Justified, Zero-filled
NAACCR Item #540
Revised 09/08, 01/12

Description
Identifies the facility reporting the case.

Rationale
Each facility's identification number (FIN) is unique. The number is essential to the National Cancer Data Base (NCDB) for monitoring data submissions, ensuring the accuracy of data, and for identifying areas for special studies.

Instructions for Coding
- *Facility Identification Number* is automatically coded by the software provider.
- 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 zeros followed by the full eight-digit number.
- Facilities that are part of an Integrated Network Cancer Program (INCP) *must* use the hospital-specific FIN in their data for submission to the National Cancer Data Base.
- Facilities that merge are legally a single hospital. Consult NCDB for instructions for recording the FIN for newly-merged programs.

Examples

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

Note: A complete list of FINs is available on the American College of Surgeons Web site at *https://www.facs.org/quality-programs/cancer/accredited/info/fin*.

NPI–REPORTING FACILITY

Item Length: 10
Allowable Value: Ten digits
NAACCR Item #545
Revised 04/07, 09/08, 01/10, 01/12

Description
Identifies the facility whose data are in the record.

Rationale
Each facility's NPI is unique. The number is essential to the National Cancer Data Base (NCDB) for monitoring data submissions, ensuring the accuracy of data, and for identifying areas for special studies.

NPI–Reporting Facility is the NPI equivalent of *Facility Identification Number* (NAACCR Item #540). Both are required during a period of transition.

Instructions for Coding
- *NPI–Reporting Facility* is automatically coded by the software provider.
- 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.
- The facility's NPI can be obtained from the billing or accounting department, or searched at *https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do*.
- If the facility has more than one NPI number assigned, use the "umbrella" number that applies to the entire facility.
- Facilities that are part of an Integrated Network Cancer Program (INCP) must use the hospital-specific NPI number in their data for submission to the National Cancer Data Base.
- Facilities that merge are legally a single hospital. Use the NPI number for the merged hospital.
- NPI may be blank for cases diagnosed on or before December 31, 2006.

Code	Definitions
(fill spaces)	10-digit NPI number for the facility.
(leave blank)	NPI for the facility is unknown or not available.

ARCHIVE FIN

Item Length: 10
Right Justified, Zero-filled
NAACCR Item #3100
Revised 01/10, 01/12

Description
Identifies the facility that originally abstracted the case.

Rationale
It is essential for hospital registries to have the ability to distinguish cases originally accessioned by each registry of the merged unit. This enables the CoC to manage the receipt of historical data and to appropriately attribute these data.

Instructions for Coding
- *Archive FIN* is automatically coded by the software provider.
- This data item never changes and must be included as part of the patient record when data are submitted to the NCDB.
- For facilities that have not merged, the *Archive FIN* and *FIN* (NAACCR Item #540) will be the same.
- If facilities merged after January 1, 2003, a new FIN was assigned to represent the merged facility. This new FIN was assigned to all cases in the *merged* registry, but the *Archive FIN* for cases from each registry prior to the merger **does not** change.
- If a merged program continues to operate multiple campuses, the Archive FIN is the historic FIN for the respective facilities that are now separate campuses of the same hospital.
- Facilities that are part of an Integrated Network Cancer Program (INCP) *must* use the hospital-specific FIN for the Archive FIN in their data for submission to the National Cancer Data Base.
- Programs that are not part of a merged facility or an INCP will use their hospital's FIN as the Archive FIN.
- 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. The Archive FIN must be recorded similarly.
- 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 zeros followed by the full eight-digit number. The Archive FIN must be recorded similarly.

Examples

Code	Reason
0006439999	General Hospital, Anytown, Illinois (FIN: 6439999). Original diagnosis was made at this facility; both the FIN and the Archive FIN are the same.
0006439999 or 0006430000	General Hospital (FIN: 6439999) and Anytown Medical Center (FIN: 6430000) in Anytown IL merged; the two cancer registries were combined and now report as Anytown Medical Center. The new FIN for this reporting facility is 10000099. All cases from the merged General Hospital and Anytown Medical Center registry have the new FIN (0010000099) assigned to them. In addition, either the General Hospital Archive FIN (0006439999) or the Anytown Medical Center Archive FIN (0006430000) is retained in each record depending on which registry originally accessioned the case.

NPI–ARCHIVE FIN

Item Length: 10
Allowable Value: Ten digits
NAACCR Item #3105
Revised 01/10, 01/12

Description
Identifies the facility that originally abstracted the case.

Rationale
It is essential for hospital registries to have the ability to distinguish cases originally accessioned by each registry of the merged unit. This enables the CoC to manage the receipt of historical data and to appropriately attribute these data.

NPI–Archive FIN is the NPI equivalent of *Archive FIN* (NAACCR Item #3100). Both are required during a period of transition.

Instructions for Coding
- *NPI–Archive FIN* is automatically coded by the software provider.
- This data item never changes and must be included as part of the patient record when data are submitted to the NCDB.
- For facilities that have not merged, the *NPI–Archive FIN* and the *NPI–Reporting Facility* (NAACCR Item #545) will be the same. Facilities that are part of an Integrated Network Cancer Program (INCP) must use the hospital-specific NPI number for the NPI-Archive FIN in their data for submission to the National Cancer Data Base.
- If the facility has more than one NPI number assigned, use the "umbrella" number that applies to the entire 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.

Code	Definition
(fill spaces)	10-digit NPI number for the facility.
(leave blank)	NPI for the facility is unknown or not available.

DATE CASE COMPLETED – COC

Item Length: 8
NAACCR Item #2092
Revised 01/12

Description
This data item identifies the date that specified items are completed, based on the *Class of Case*, and those items pass the relevant edits. Follow-up information, including delayed treatment received elsewhere, may be coded after the *Date Case Completed–CoC*. This item should be autocoded by the registry software. The CoC specifications will not necessarily be the same as those used for *Date Case Completed* [NAACCR Item #2090], which CoC does not require.

Rationale
This item was created to measure abstracting timeliness of information that should be available when the facility's main involvement in the patient's first course care is completed, based on *Class of Case*. CoC Standard 3.3 requires that 90% of all cases be abstracted within 6 months of the patient's first contact with the facility in CoC accredited programs. It is assumed that for all except some unusual cases, all required items, not just those used to determine *Date Case Completed – CoC*, will have been completed for all analytic cases by the time the NCDB annual Call for Data begins.

Instructions
- This item may be left blank for cases diagnosed prior to 2010.
- Follow-up information, information about delayed treatment received elsewhere, and information about multiple tumors diagnosed later may be coded after the *Date Case Completed – CoC*.
- Corrections and updates may be made after the *Date Case Completed – CoC*.
- Appendix D provides a list of items in each broad completion category below.
- After all required items identified below for the patient's *Class of Case* have been abstracted, the registrar should run the standard NAACCR edit set "Hosp: vs 12 CoC Required - All" using the registry software. The registry software will record the *Date Case Completed – CoC* when those items are abstracted and the case passes all edits in that set.

Class of Case	Description	Items that Must Be Completed by Date Case Completed - CoC
00-22	All analytic cases	Identification, demographic, diagnostic
10-22	Patient received part or all first course treatment from facility	Staging, hospital-specific treatment
10, 12, 14, 20, 22	Patient received all first course treatment from facility, or unspecified whether all or part	Summary treatment (treatment at any facility)
00	Patient diagnosed at facility, received all treatment elsewhere	NPI number for the facility the patient was referred to or a treating physician
20-22	Patient diagnosed elsewhere, received part or all of treatment from facility	NPI number for the facility the patient was referred to or from OR the physician who diagnosed or treated the patient

OVERRIDE ACSN/CLASS/SEQ

Item Length: 1
Allowable Values: 1
NAACCR Item #1985
Revised 09/06, 09/08, 01/10

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–Hospital* = 00, 01, 60 or 61, and *Class of Case* = 00, 10, 12, 13, or14), then the first 4 characters of the *Accession Number* (NAACCR Item #550) must equal the year of the *Date of First Contact* (NAACCR Item #580).
- 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–Hospital* = 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* (NAACCR Item #1750) 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–Hospital* 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–Hospital* = 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*, *Sequence 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

Item Length: 1
Allowable Values: 1
NAACCR Item #1986
Revised 09/06, 09/08

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)*, does 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–Hospital* > 00 (more than one primary), review is required.
- If *Primary Site* (NAACCR Item #400) specifies an ill-defined or unknown primary (C76.0–C76.8, C80.9), no further checking is done. If *Sequence Number–Hospital* 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 is 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

Item Length: 1
Allowable Values: 1
NAACCR Item #1987
Revised 09/06, 09/08

Description
Used with the EDITS software to override the edits *Primary Site*, *Morphology-Type ICDO2 (CoC)*, *Primary Site*, *Morphology-Type ICDO3 (CoC)*, and/or *Primary Site, Morphology-Type, Behavior 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 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 Web site) contains those histologies commonly found in the specified primary site. Histologies that occur only rarely or never are not be 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* (NAACCR Item #400) 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 (See *Cancer Identification* in Section I). 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 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

Item Length: 1
Allowable Values: 1
NAACCR Item #1988
Revised 09/06 09/08, 02/10

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 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–Hospital* 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 diseases. (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 an edit of the type *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 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

Item Length: 1
Allowable Values: 1
NAACCR Item #1989
Revised 09/04, 09/08, 01/10, 01/12

Description
Used with the EDITS software to override the edits of the type *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 the type, *Primary Site, AJCC Stage Group*, check 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* (NAACCR Item #970) and *Pathologic Stage Group* (NAACCR Item #910). 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 cancers whose sites and histologies have an AJCC scheme may be coded according to a pediatric scheme instead, use *Override Site/TNM-Stage Group* to indicate the case was coded according to a pediatric staging system if it was not also 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 component 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 edits of the type, *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

Item Length: 1
Allowable Values: 1
NAACCR Item #1990
Revised 04/07, 09/08, 01/10

Description
Used with the EDITS software to override edits of the type *Age, Primary Site, Morphology; Age, Primary Site, Morph 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, Morph 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, Morph 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

Item Length: 1
Allowable Values: 1
NAACCR Item #2020
Revised 09/06, 09/08

Description
Used with the EDITS software to override the edits *RX Summ–Surg Prim Site, Diag Conf (SEER IF76); RX Summ–Surgery Type, Diag Conf (SEER IF46);* and/or the edit *RX Summ–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, *RX Summ–Surg Prim 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 edits of the type, *RX Summ–Surg Prim Site*, *Diag Conf*.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if 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, confirmed as reported.

OVERRIDE SITE/TYPE

Item Length: 1
Allowable Values: 1
NAACCR Item #2030
Revised 09/06, 09/08, 01/10

Description
Used with the EDITS software to override 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 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 be 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* (NAACCR Item #400) is in the range C440-C449 (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 (See *Cancer Identification* in Section I). 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 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 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, confirmed as reported.

OVERRIDE HISTOLOGY

Item Length: 1
Allowable Values: 1, 2, 3
NAACCR Item #2040
Revised 04/07, 09/08

Description
Used with the EDITS software to override any of five edits: *Diagnostic Confirmation*, *Behavior ICDO2 (SEER IF31); Diagnostic Confirmation*, *Behavior ICDO3* (SEER IF31); *Morphology–Type/Behavior ICDO2 (SEER MORPH)*; *Morphology–Type/Behavior ICDO3 (SEER MORPH);* and/or the edit *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. Very rarely, a physician will 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* (NAACCR Item #523) and *Diagnostic Confirmation* (NAACCR Item #490) 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-Type/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 or 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 in problem cases.

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 edits of the types *Diagnostic Confirmation* or *Morph* or *Morphology–Type/Behavior.*
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1, 2 or 3 as indicated if 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, confirmed as reported for edits of the type *Morphology–Type/Behavior*.
2	Reviewed, confirmed as reported for edits of the type *Diagnostic Confirmation, Behavior Code*.
3	Reviewed: conditions 1 and 2 above both apply.

OVERRIDE LEUK, LYMPHOMA

Item Length: 1
Allowable Values: 1
NAACCR Item #2070
Revised 09/06, 09/08, 01/10

Description
Used with the EDITS software to override edits of the type *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 (NAACCR Item #420) or ICD-O-3 (NAACCR Item #522) 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* (NAACCR Item #490) 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* items 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 edits of the type *Diagnostic Confirmation*, *Histology*.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if 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, confirmed as reported.

OVERRIDE SITE/BEHAVIOR

Item Length: 1
Allowable Values: 1
NAACCR Item #2071
Revised 09/06, 09/08

Description
Used with the EDITS software to override the edits of the type *Primary Site, Behavior Code.*

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*, 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
C39.9	Ill-defined sites within respiratory system
C55.9	Uterus, NOS
C57.9	Female genital tract, NOS
C63.9	Male genital organs, NOS
C68.9	Urinary system, NOS
C72.9	Nervous system, NOS
C75.9	Endocrine gland, NOS
C76.0-C76.8	Ill-defined sites
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 *Primary Site, Behavior* edits.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if 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, confirmed as reported.

OVERRIDE SITE/LAT/MORPH

Item Length: 1
Allowable Values: 1
NAACCR Item #2074
Revised 09/06, 09/08

Description
Used with the EDITS software to override edits of the type *Laterality, Primary Site, 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
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 and do the following:

- If the *Primary Site* (NAACCR Item #400) is a paired organ and *Behavior Code* (NAACCR Item #523) is in situ (2), then *Laterality* (NAACCR Item #410) must be 1, 2, 3 or 5.
- If diagnosis year is less than 1988 and *Histology* (NAACCR Item #522) 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 and the case was diagnosed prior to 2010 (when midline was coded 9), either change the *Laterality* code to 5 and leave the override blank, or enter code 1 for *Override Site/Lat/Morph.* For cases diagnosed in 2010 or later, *Laterality* must be coded 5 for midline tumors.
- If the rare 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, confirmed as reported.

COC CODING SYSTEM–CURRENT

Item Length: 2
Allowable Values: 00–08, 99
NAACCR Item #2140
Revised 01/10

Description
Indicates the Commission on Cancer coding system currently used in the record.

Rationale
Knowledge of the coding system that describes the meaning of the codes currently stored for each case is necessary for interpretation of the coded data. It is also necessary for correct conversion of the record to a different coding system or to a different registry software system. This item differs from *CoC Coding System–Original* (NAACCR Item #2150) if the record has been converted to a more recent coding system.

Instructions for Coding
- All fields in a case record should be coded according to the same Commission on Cancer coding system following record conversion.
- This code does not apply to patient race, primary site, histology, TNM stage and its components, Collaborative Stage, comorbidities and complications, or cause of death. The original coding systems for these items are recorded in other fields.
- This item should be updated every time the record is converted to another coding system.

Code	Label	Definition
00	None	No CoC coding system used.
01	Pre-1988	Pre-1988 version (Cancer Program Manual Supplement)
02	1988	1988 *Data Acquisition Manual*
03	1989	1989 *Data Acquisition Manual*
04	1990	1990 *Data Acquisition Manual*
05	1994	1994 *Data Acquisition Manual*
06	1996	*Standards of the Commission on Cancer Volume II: Registry Operations and Data Standards (ROADS)*
07	1998	*Standards of the Commission on Cancer, Volume II: Registry Operations and Data Standards (ROADS)* 1998 Revisions
08	2003	*Facility Oncology Registry Data Standards (FORDS)*
99	Unknown	Unknown coding system.

Examples

Code	Reason
00	A case accessioned in 1980 was coded according to codes developed locally by the hospital before it became involved in the Commission on Cancer Approvals Program and no conversion of the record has occurred since its accession into the registry.
08	A case accessioned in 1980 was coded according to codes developed locally by the hospital before it became involved in the Commission on Cancer Approvals Program. In 1989, the registry records were converted to conform to the codes defined in the 1989 *Data Acquisition Manual*. The registry data were subsequently converted in 1996, 1998, and 2003 with the publication of each manual.

Code	Reason
08	A case accessioned in 1997 was coded according to 1996 *Standards of the Commission on Cancer, Volume II: Registry Operations and Data Standards (ROADS)*, and subsequently converted to correspond to the coding system expressed in *Facility Oncology Registry Data Standards (FORDS).*
08	A new case was abstracted in 2010 using *Facility Oncology Registry Data Standards* (*FORDS) Revised for 2010.*
99	A case was accessioned in 1989, but it is unknown whether the 1988 or 1989 version of the *Data Acquisition Manual* was used to code the case. The conversion of this record to a more recent coding system is not possible due the uncertainty of its original coding system.

COC CODING SYSTEM–ORIGINAL

Item Length: 2
Allowable Values: 00–08, 99
NAACCR Item #2150
Revised 01/10

Description
Indicates the Commission on Cancer coding system used to originally code the items.

Rationale
The coding system used when a case is originally coded limits the possible categories that could have been applied to code the case. Because code categories may change over time as new coding systems are developed, this item is used to assist interpretation when cases that may have been coded originally according to multiple coding systems are analyzed.

Instructions for Coding
- All fields in a case record should be coded according to the same Commission on Cancer coding system.
- This code does not apply to patient race, primary site, histology, TNM stage and its components, Collaborative Stage, comorbidities or complications, or cause of death. The original coding systems for these items are recorded in other fields.
- This item must not be changed when the record is converted to another coding system. That information is reflected in the data item *CoC Coding System–Current* (NAACCR Item #2140).
- Code 99 for cases coded prior to 2003 if the correct CoC coding system is not known, or if multiple coding systems were used to code a single case. Ordinarily, it will not be necessary to use code 99 for cases accessioned in 2003 or later.

Code	Label	Definition
00	None	No CoC coding system used.
01	Pre-1988	Pre-1988 version (Cancer Program Manual Supplement)
02	1988	1988 *Data Acquisition Manual*
03	1989	1989 *Data Acquisition Manual*
04	1990	1990 *Data Acquisition Manual*
05	1994	1994 *Data Acquisition Manual*
06	1996	*Standards of the Commission on Cancer, Volume II: Registry Operations and Data Standards (ROADS)*
07	1998	*Standards of the Commission on Cancer Volume II: Registry Operations and Data Standards (ROADS)* 1998 Revisions
08	2003	*Facility Oncology Registry Data Standards (FORDS)*
99	Unknown	Original CoC coding system used is not known.

Examples

Code	Reason
00	A case accessioned in 1980 was coded according to codes developed locally by the hospital before it became involved in the Commission on Cancer Approvals Program.
00	A case accessioned in 1980 was coded according to codes developed locally by the hospital before it became involved in the Commission on Cancer Approvals Program. In 1989, the registry records were converted to conform to the codes defined in the 1989 *Data Acquisition Manual*. The registry data were subsequently converted in 1996, 1998, and 2003 with the publication of each manual.
06	A case accessioned in 1997 was coded according to *1996 Standards of the Commission on Cancer, Volume II: Registry Operations and Data Standards* (ROADS), and subsequently converted to correspond to the coding rules expressed in *Facility Oncology Registry Data Standards (FORDS)*.
99	A case was accessioned in 1989, but it is unknown whether the 1988 or 1989 version of the *Data Acquisition Manual* was used to code the case.

RACE CODING SYSTEM–CURRENT

Item Length: 1
Allowable Values: 1–6, 9
NAACCR Item #170
Revised 01/04, 01/10

Description
Describes how race is currently coded. If converted, this field shows the system to which it was converted.

Rationale
Race codes (NAACCR Items #160–164) have changed over time. To accurately group and analyze data, it is necessary to record the system used to record the race codes.

Instructions for Coding
This item is autocoded by the software provider.

Code	Definition
1	4-value coding: 1 = White, 2 = Black, 3 = Other, 9 = Unknown
2	<1988 (1-digit)
3	1988 + (2-digit)
4	1991 + (added codes 20–97)
5	1994 + (added code 14)
6	2000 + (no new codes added, new items *Race #2–Race #5* added)
7	2010 + (added codes 15, 16, and 17; removed 09)
9	Other

RACE CODING SYSTEM–ORIGINAL

Item Length: 1
Allowable Values: 1–6, 9
NAACCR Item #180
Revised 01/04, 01/10

Description
Describes how race was originally coded.

Rationale
Race #1–#5 codes (NAACCR Items #160–164) have changed over time. Identifying both the original and current coding systems used to code race promotes accurate data grouping and analysis.

Instructions for Coding
- This item is autocoded by the software provider.
- For cases diagnosed on or after January 1, 2010, this data item must be coded 7.

Code	Definition
1	4-value coding: 1 = White, 2 = Black, 3 = Other, 9 = Unknown
2	<1988 (1-digit)
3	1988 + (2-digit)
4	1991 + (added codes 20–97)
5	1994 + (added code 14)
6	2000 + (no new codes added, new items *Race #2–Race #5* added)
7	2010 + (added codes 15, 16, and 17; removed 09)
9	Other

SITE CODING SYSTEM–CURRENT

Item Length: 1
Allowable Values: 1–6, 9
NAACCR Item #450

Description
Describes how the primary site is currently coded. If converted, this field shows the system to which it was converted.

Rationale
This information is used for some data analysis and for further item conversions.

Instructions for Coding
This item is autocoded by the software provider.

Code	Definition
1	ICD-8 and Manual of Tumor Nomenclature and Coding (MOTNAC)
2	ICD-9
3	ICD-O, First Edition
4	ICD-O, Second Edition
5	ICD-O, Third Edition
6	ICD-10
9	Other

SITE CODING SYSTEM–ORIGINAL

Item Length: 1
Allowable Values: 1–6, 9
NAACCR Item #460

Description
Describes how the primary site was originally coded.

Rationale
This information is used for some data analysis. Converted codes have a slightly different distribution and meaning than codes entered directly. Cancer registries record case histories over many years, so not all cases will originally be assigned according to the same code version.

Instructions for Coding
This item is autocoded by the software provider.

Code	Definition
1	ICD-8 and Manual of Tumor Nomenclature and Coding (MOTNAC)
2	ICD-9
3	ICD-O, First Edition
4	ICD-O, Second Edition
5	ICD-O, Third Edition
6	ICD-10
9	Other

MORPHOLOGY CODING SYSTEM–CURRENT

Item Length: 1
Allowable Values: 1–7, 9
NAACCR Item #470
Revised 01/10

Description
Describes how morphology is currently coded. If converted, this field shows the system to which it was converted.

Rationale
This information is used for some data analysis and for further item conversions. New versions of the codes used for recording histology and behavior reflect advances in medical and pathologic knowledge, and converted codes have a slightly different distribution and meaning than codes entered directly. Cancer registries record case histories over many years, so not all cases will originally be assigned according to the same code version.

Instructions for Coding
This item is autocoded by the software provider.

Code	Definition
1	ICD-O, First Edition
2	ICD-O, 1986 Field Trial
3	ICD-O, 1988 Field Trial
4	ICD-O, Second Edition
5	ICD-O, Second Edition, plus REAL lymphoma codes effective 1/1/95
6	ICD-O, Second Edition, plus FAB codes effective 1/1/98
7	ICD-O, Third Edition
8	ICD-O, Third Edition, plus 2008 WHO hematopoietic/lymphoid new terms effective 1/1/2010
9	Other

MORPHOLOGY CODING SYSTEM–ORIGINAL

Item Length: 1
Allowable Values: 1–7, 9
NAACCR Item #480
Revised 01/04, 01/10, 01/11

Description
Describes how morphology was originally coded. If later converted, this field shows the original codes used.

Rationale
This information is used for some data analysis and for further item conversions. New versions of the codes used for recording histology and behavior reflect advances in medical and pathologic knowledge, and converted codes have a slightly different distribution and meaning than codes entered directly. Cancer registries record case histories over many years, so not all cases will originally be assigned according to the same code version.

Instructions for Coding
- This item is autocoded by the software provider.
- For cases diagnosed on or after January 1, 2010, this data item must be coded 8.

Code	Definition
1	ICD-O, First Edition
2	ICD-O, 1986 Field Trial
3	ICD-O, 1988 Field Trial
4	ICD-O, Second Edition
5	ICD-O, Second Edition, plus REAL lymphoma codes effective 1/1/95
6	ICD-O, Second Edition, plus FAB codes effective 1/1/98
7	ICD-O, Third Edition
8	ICD-O, Third Edition, plus 2008 WHO hematopoietic/lymphoid new terms effective 1/1/2010
9	Other

ICD-O-2 CONVERSION FLAG

Item Length: 1
Allowable Values: 0–6, blank
NAACCR Item #1980
Revised 01/04

Description
Specifies whether or how site and morphology codes were converted to ICD-O-2.

Rationale
This information is used for some data analysis and for further item conversions.

Instructions for Coding
- Codes 0, 1, and 2 are autocoded by the software provider.
- Codes 3 and 4 are manually entered following a review of the automated morphology conversion from ICD-O-1 or ICD-O-3 to ICD-O-2.

Code	Definition
(leave blank)	Not converted.
0	Primary site and morphology originally coded in ICD-O-2.
1	Primary site and morphology converted without review.
2	Primary site and morphology converted with review; morphology machine-converted without review.
3	Primary site machine-converted without review; morphology converted with review.
4	Primary site and morphology converted with review.
5	Morphology converted from ICD-O-3 without review.
6	Morphology converted from ICD-O-3 with review.

ICD-O-3 CONVERSION FLAG

Item Length: 1
Allowable Values: 0, 1, 3, blank
NAACCR Item #2116
Revised 01/04

Description
Identifies how the conversion of morphology codes from ICD-O-2 to ICD-O-3 was accomplished.

Rationale
This information is used for some data analysis and for further item conversions. New versions of the codes used for recording histology and behavior reflect advances in medical and pathologic knowledge, and converted codes have a slightly different distribution and meaning than codes entered directly. Cancer registries record case histories over many years, so not all cases will originally be assigned according to the same code version.

Instructions for Coding
- Codes 0 and 1 are autocoded by the software provider.
- Code 3 is manually entered following review of the automated morphology conversion from ICD-O-2 to ICD-O-3.

Code	Definition
(leave blank)	Not converted.
0	Morphology (Morph–Type&Behav ICD-O-3, NAACCR Item #521) originally coded in ICD-O-3.
1	Morphology (Morph–Type&Behav ICD-O-3, NAACCR Item #521) converted from (Morph–Type&Behav ICD-O-2, NAACCR Item #419) without review.
3	Morphology (Morph–Type&Behav ICD-O-3, NAACCR Item #521) converted from (Morph–Type&Behav ICD-O-2, NAACCR Item #419) with review.

TNM EDITION NUMBER

Item Length: 2
Allowable Values: 00–06, 88, 99
NAACCR Item #1060
Revised 01/04, 01/10

Description
Identifies the edition of the *AJCC Cancer Staging Manual* used to stage the case.

Rationale
AJCC stage and component T, N, and M codes and rules have changed over time. This item enables the analysis of cases grouped by edition number.

Instructions for Coding
This item is autocoded by the software provider.

Code	Label
00	Not staged (cases that have an AJCC staging scheme and staging was not done).
01	First Edition
02	Second Edition
03	Third Edition
04	Fourth Edition
05	Fifth Edition
06	Sixth Edition
07	Seventh Edition
88	Not applicable (cases that do not have an AJCC staging scheme).
99	Staged, but the edition is unknown.

RX CODING SYSTEM–CURRENT

Item Length: 2
Allowable Values: 00–06, 99
NAACCR Item #1460

Description
Describes how treatment for this case is now coded.

Rationale
This information is used for some data analysis and for further item conversions.

Instructions for Coding
- This item is autocoded by the software provider.
- The *FORDS* manual **must** be used to record treatment for all cases diagnosed January 1, 2003, or later and this item **must** be coded 06.

Code	Definition
00	Treatment data not coded/transmitted, i.e., all treatment fields blank.
01	Treatment data coded using 1-digit surgery codes.
02	Treatment data coded according to 1983–1992 SEER manuals and CoC manuals 1983–1995.
03	Treatment data coded according to 1996 ROADS manual.
04	Treatment data coded according to 1998 ROADS supplement.
05	Treatment data coded according to 1998 SEER manual.
06	Treatment data coded according to FORDS.
07	Treatment data coded according to 2010 SEER manual.
99	Other coding, including partial or nonstandard coding.

DERIVED AJCC–FLAG

Item Length: 1
Allowable Values: 1, 2
NAACCR Item #3030
Revised 01/10

Description
Indicates the source data items used to derive AJCC Stage descriptors and Stage Group. It also indicates the target AJCC edition described by the derived AJCC Stage descriptors and Stage Group.

Rationale
AJCC Stage and component T, N, and M codes and rules change over time as does the method of deriving them. This item enables the analysis of cases grouped by coding and derivation version.

Effective for cases diagnosed January 1, 2016 and later this data item is no longer required by CoC for accredited cancer program cancer registries, and should no longer be derived and recorded in the hospital registry database.

Instructions for Coding

Code	Description
(leave blank)	Not derived.
1	AJCC fields derived from Collaborative Stage.
2	AJCC fields derived from EOD (prior to 2004).

DERIVED SS1977–FLAG

Item Length: 1
Allowable Values: 1, 2
NAACCR Item #3040
Revised 01/10

Description
Indicates the source data items used to derive SEER Summary Stage 1997.

Rationale
The derivation of SS1977 varies over time with the coding rules and codes in use when the components were coded. This item enables the analysis of cases grouped by coding and derivation version.

Effective for cases diagnosed January 1, 2016 and later this data item is no longer required by CoC for accredited cancer program cancer registries, and should no longer be derived and recorded in the hospital registry database.

Instructions for Coding

Code	Description
(leave blank)	Not derived.
1	SS1977 derived from Collaborative Stage.
2	SS1977 derived from EOD (prior to 2004).

DERIVED SS2000–FLAG

Item Length: 1
Allowable Values: 1, 2
NAACCR Item #3050
Revised 01/10

Description
Indicates the source data items used to derive SEER Summary Stage 2000.

Rationale
The derivation of SS2000 varies over time with the coding rules and codes in use when the components were coded. This item enables the analysis of cases grouped by coding and derivation version.

Effective for cases diagnosed January 1, 2016 and later this data item is no longer required by CoC for accredited cancer program cancer registries, and should no longer be derived and recorded in the hospital registry database.

Instructions for Coding

Code	Description
(leave blank)	Not derived.
1	SS2000 derived from Collaborative Stage.
2	SS2000 derived from EOD (prior to 2004).

CS VERSION INPUT ORIGINAL
(CS VERSION FIRST)

Item Length: 6
Numeric
NAACCR Item #2935
Revised 01/10

Description
This item indicates the number of the version initially used to code Collaborative Staging (CS) fields. The CS version number is returned as part of the output of the CS algorithm.

Rationale
Over time, the input codes and instructions for CS items may change. This item identifies the correct interpretation of input CS items.

Instructions for Coding
This item is autocoded by the software provider.

Codes
CS Version Input Original is a 6-digit code. The first two digits represent the major version number; the second two digits represent minor version changes; and, the last two digits represent even less significant changes, such as corrections of typographical errors that do not affect coding or derivation of results (e.g., 010100).

CS VERSION INPUT CURRENT

Item Length: 6
Numeric
NAACCR Item #2937
New Item 01/2010

Description
This item indicates the version of CS input fields after they have been updated or recoded. This data item is recorded the first time the CS input fields are entered and should be updated each time the CS input fields are modified.

Rationale
Over time, the input codes and instructions for CS items may change. This item identifies the correct interpretation of input CS items.

Instructions for Coding
This item is autocoded by the software provider.

Codes
CS Version Input Current is a 6-digit code. The first two digits represent the major version number; the second two digits represent minor version changes; and, the last two digits represent even less significant changes, such as corrections of typographical errors that do not affect coding or derivation of results (e.g., 010100).

CS VERSION DERIVED
(CS VERSION LATEST)

Item Length: 6
Numeric
NAACCR Item #2936
Revised 01/10

Description
This data item is recorded the first time the CS output fields are derived and should be updated each time the CS Derived items are recomputed. The CS version number is returned as part of the output of the CS algorithm.

Rationale
The CS algorithm may be re-applied to compute the CS Derived items; for example, when the data are to be used for a special study, transmitted, or when an updated CS algorithm is produced. This item identifies the specific algorithm used to obtain the CS Derived values in the data record.

Effective for cases diagnosed January 1, 2016 and later this data item is no longer required by CoC for accredited cancer program cancer registries, and should no longer be derived and recorded in the hospital registry database.

Instructions for Coding
This item is autocoded by the software provider.

Codes
CS Version Derived is a 6-digit code. The first two digits represent the major version number; the second two digits represent minor version changes; and, the last two digits represent even less significant changes, such as corrections of typographical errors that do not affect coding or derivation of results (e.g., 010100).

OVER-RIDE CS 1-19

Numeric
NAACCR Item #3750-3768
New 01/2013

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 and error message and review of the case indicates that the codes are correct for the case, then the over-ride flag is used to skip the edit in the future.

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

Over-ride CS 20 is defined, but is not to be used by CoC accredited programs for analytic cases.

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

APPENDIX A

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

Appendix A: Definitions of Single and Subsequent Primaries for Hematologic Malignancies

Based on ICD-O-3 reportable malignancies, for use 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 diagnosis into another.

The following chart, provided to aid the registrar in determining single versus subsequent primaries, employs the following guidelines:

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.

We gratefully acknowledge the assistance of Drs. Charles Lynch, Charles Platz, and Fred Dick of the University of Iowa. Dr. Tim Cote of the SEER Program, Jennifer Seiffert, MLIS, CTR, and Annette Hurlbut, RHIT, CTR for their assistance with this project.

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 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 1: 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 2: The table "Single versus Subsequent Primaries of Lymphatic and Hematopoietic Diseases" (pages X-X) and the "Complete Diagnostic Terms for Table (based on ICD-O-3)" (page X) display only the ICD-O-3 primary (boldfaced) term associated with the code. Refer to the *International Classification of Disease, Third Edition* (ICDO-3) for a complete list of related terms and synonyms.

Source: SEER Program, NCI E-mail: seerweb@ims.nci.nih.gov

February 28, 2001 PAGE 354 SECOND DX ACROSS FIRST DX DOWN		1. 9590 Malig lymphoma, NOS	2. 9591 NHL, NOS	3. 9596Compos 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. 9687Burkitt 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

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APPENDIX A: Definitions of Single and Subsequent Primaries for Hematologic Malignancies p. 355 February 28, 2001 SECOND DX ACROSS FIRST DX DOWN		11. 9700-9701 MF, Sezary disease	12. 9702-9719 T/NK-cell lymphoma	13. 9727 Precursl ym'blas lymph NOS	14. 9728 Precurs lym'blas lymph B-cl	15. 9729 Precursl ym'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

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SINGLE VERSUS SUBSEQUENT PRIMARIES OF LYMPHATIC AND HEMATOPOIETIC DISEASES

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

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SINGLE VERSUS SUBSEQUENT PRIMARIES OF LYMPHATIC AND HEMATOPOIETIC DISEASES

February 28, 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

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SINGLE VERSUS SUBSEQUENT PRIMARIES OF LYMPHATIC AND HEMATOPOIETIC DISEASES

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							

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

Version 1.01. Codes corrected for terms in rows 7 and 9 on pages 2-5.

APPENDIX B:
Site-Specific Surgery Codes

Note: The histologies specified in this section apply only to cases diagnosed in 2010 or later. Please consult *FORDS: Revised for 2009* for applicable histologies for cases diagnosed prior to that date.

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

(Revised 12/4/02, 01/10, 02/10, 01/16)

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

(Revised 01/10, 02/10, 01/16)

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 WITHOUT laryngectomy
- 52 WITH laryngectomy

Specimen sent to pathology from surgical events 20–52.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 01/10, 02/10, 01/16)

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

(Revised 01/10, 02/10, 01/16)

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

A 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* (NAACCR Item #1294).

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 data item *Surgical Procedure/Other Site* (NAACCR Item #1294).

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 data item *Surgical Procedure/Other Site* (NAACCR Item #1294).

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's 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* (NAACCR Item #1292) or *Scope of Regional Lymph Node Surgery at This Facility* (NAACCR Item #672).

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

(Revised 01/10, 02/10, 01/11, 01/16)

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

(Revised 01/10, 02/10, 01/16)

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, 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

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* (NAACCR Item #1292) or *Scope of Regional Lymph Node Surgery at This Facility* (NAACCR Item #672).

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* (NAACCR Item #1292) or *Scope of Regional Lymph Node Surgery at This Facility* (NAACCR Item #672).

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* (NAACCR Item #1292) or *Scope of Regional Lymph Node Surgery at This Facility* (NAACCR Item #672).

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

(Revised 01/04, 01/10, 02/10, 01/16)

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* (NAACCR Item #1294) or *Surgical Procedure/Other Site at This Facility* (NAACCR Item #674).

BONES, JOINTS, AND ARTICULAR CARTILAGE C40.0–C41.9
PERIPHERAL NERVES AND AUTONOMIC NERVOUS SYSTEM C47.0–C47.9
CONNECTIVE, SUBCUTANEOUS, AND OTHER SOFT TISSUES 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 events 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

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 for surgical events 21-80.

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 reexcision of lesion or minor (local) amputation with 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 reexcision 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

(Revised 01/04, 01/10, 02/10, 01/15, 01/16)

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 events 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 With reconstruction NOS
    - 44 Tissue
    - 45 Implant
    - 46 Combined (Tissue and Implant)
- 42 WITH removal of uninvolved contralateral breast
  - 47 With 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 the involved contralateral breast under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294) and/or *Surgical Procedure/Other Site at This Facility* (NAACCR Item #674).

If the 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* (NAACCR Item #1294) or *Surgical Procedure/Other Site at This Facility* (NAACCR Item #674).

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

(Revised 01/04, 01/10, 02/10, 05/10, 01/11, 01/13, 01/16)

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 *Surgical Diagnostic and Staging Procedure* (NAACCR Item #1350).

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 *Surgical Diagnostic and Staging Procedure* (NAACCR Item #1350).

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 Electocautery 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 followed by another treatment modality such as chemotherapy.

70 Pelvic exenteration, NOS
- 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.

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 *Hematologic Transplant and Endocrine Procedures* (NAACCR Item #3250).

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

(Revised 12/4/02, 01/10, 02/10, 1/11, 01/16)

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 9975-99922)

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 this surgical event 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, simple, 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

(Revised 01/10, 02/10, 01/16)

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 removed 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 tumor destruction. All of these modalities are recorded in the radiation treatment fields.

20 Local excision of tumor, lesion or mass; excisional biopsy

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 can not 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 M9727, 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 20–80.

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–C 30.1, 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* (NAACCR Item #1294) or *Surgical Procedure/Other Site at This Facility* (NAACCR Item #674).

(Revised 01/04, 01/10, 02/10, 01/16)

APPENDIX C:
FORDS Page Revisions

FORDS: An Evolving Data Manual

Following the initial release of ***FORDS*** in July 2002, the manual has undergone a series of modifications and revisions. All revisions have been made to the online edition of the manual and have been available to registries effective the date of revision.

This edition contains all the necessary documentation to support changes in case reporting to accommodate the standard data item changes implemented in 2013. The changes in the January 2010 release involved so much of this document that they are not itemized here. See ***FORDS: Revised for 2009*** for documentation of changes from 2003 through 2009 (see *http://www.facs.org/cancer/coc/fordsmanual.html* for a link). This appendix now contains changes introduced since the initial January 2010 release of ***FORDS: Revised for 2010***. Spelling and grammar corrections are generally not cited below.

Specific questions regarding these revisions may be directed to the editor of ***FORDS: Revised for 2016***, Kathleen K. Thoburn, BA, CTR (kthoburn@facs.org). All other *FORDS*-related coding questions should be directed to the CAnswer Forum at http://cancerbulletin.facs.org/forums/.

CHANGES TO *FORDS* SECTION ONE

2010

CANCER IDENTIFICATION: Primary Site
02/01/2010

Instructions for assigning primary site and morphology codes to hematopoietic and lymphoid tumors now specify "and lymphoid" and designate the applicable histology range as M-9590-9992.

CANCER IDENTIFICATION: Morphology
02/01/2010

Instructions for assigning histology codes now specify they apply to "solid tumors".

CANCER IDENTIFICATION: Morphology - Grade/Differention
05/01/2010

Deleted breast, prostate and kidney from the 3-grade conversion instructions, because separate instructions exist for them.

FIRST COURSE OF TREATMENT: Surgery
02/01/2010

Second of duplicated "Reason for No Surgery of the Primary Site" deleted from list.

2011

AMBIGUOUS TERMS AT DIAGNOSIS
01/01/2011

Added sentence: Words or phrases that appear to be synonyms of these terms do not constitute a diagnosis. For example, "likely" alone does not constitute a diagnosis.
Exception clarified: If a cytology is identified only with an ambiguous term, do not interpret it as a diagnosis of cancer.

CANCER IDENTIFICATION
01/01/2011

Section coverage clarified: The following instructions apply to Primary Site (NAACCR Item #400), Laterality (NAACCR Item #410), Histology (NAACCR Item #522), Behavior Code (NAACCR Item #523), Grade/Differentiation (NAACCR Item #440), Grade Path Value (NAACCR Item #441) and Grade Path System (NAACCR Item #449).

CANCER IDENTIFICATION: Laterality
01/01/2011

Added sentences: ”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 can not develop midline tumors. For example, skin of the trunk can have a midline tumor, but the breasts can not.

CANCER IDENTIFICATION: Morphology - Grade/Differention, Grade Path Value, Grade Path System
01/01/2011

Section largely reworded.

CANCER IDENTIFICATION: Revising the Original Diagnosis
01/01/2011

Section clarified by adding the word “grade” to the sentence: Change the primary site, laterality, histology, grade and stage as the information becomes more complete. Also sentence added to first example: If first course surgery was performed, the surgery codes should be reviewed.

FIRST COURSE OF TREATMENT: Radiation
01/01/2011

Added sentence to *Treatment Volume* description: 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.

TREATMENT, PALLIATIVE, AND PROPHYLACTIC CARE
01/01/2011

Clarified palliative care description: This treatment qualifies the patient as analytic if it is given as part of planned first course treatment.

COMORBIDITIES AND COMPLICATIONS
01/01/2011

Revised section to reflect the fact that ICD-10-CM will be adopted by most United States hospitals during 2011.

2012

AMBIGUOUS TERMS AT DIAGNOSIS
01/01/2012

Changed first sentence to read “As part of the registry case-finding activities, all diagnostic reports should be reviewed to confirm whether a particular case should be included”. Replaced “pathology” with “diagnostic.”

CLASS OF CASE
01/01/2012

Third paragraph under “Analytic Cases” changed to present tense for grammatical consistency.

Second sentence in "Nonanalytic Cases" was modified to read, "The CoC does not require registries in accredited programs to accession, abstract, or follow these cases, but the program or central registry may require them."

Dropped "considered" from the following sentence: "A network clinic or outpatient center belonging to the facility is part of the facility."

Explanation added to "Modifications to Class of Case in 2010": "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."

CANCER IDENTIFICATION

01/01/2012

Replaced the entire "Morphology: Grade" section with rules to determine when to code grade information in CS special grades, *Grade Path System* and *Grade Path Value* or *Grade/Differentiation*.

Removed redundant reference to the ***SEER Multiple Primary and Histology Coding Rules*** in the "Multiple Primaries" section.

AJCC TNM STAGING

01/01/2012

Added to first paragraph: "Use the rules in the current ***AJCC Cancer Staging Manual*** to assign AJCC T, N, M and Stage Group values".

Added to the second non-bulleted paragraph: "CoC rules for recording AJCC staging changed in 2008".

COLLABORATIVE STAGE DATA COLLECTION SYSTEM

01/01/2012

Changed section label to the current name of the system.

Removed extended description of the system, and changed the first paragraph to read: "The current ***Collaborative Stage Data Collection System*** (CS) is to be used for cases diagnosed on or after January 1, 2004. It is not to be used for cases diagnosed prior to that date. All CS items identified in FORDS are required to be completed for ***Class of Case*** 10-22".

Reworded first paragraph under "Using CS Derived Values": "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."

04/09/2012

Corrected ***Class of Case*** range for CS code requirements to 00-22.

AMBIGUOUS TERMS AT DIAGNOSIS
01/01/2012

Dropped "considered" from the following sentence: "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."

FIRST COURSE OF TREATMENT
01/01/2012

Added the following sentence to the first paragraph: "Maintenance treatment given as part of the first course of planned treatment (for example, for leukemia) is first course treatment, and cases receiving that treatment are analytic."

In the section "Relationships among Surgical Items", added: "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." (This was previously written under the primary site section, though it should apply to all surgery items.

Moved the third bullet under that statement from paragraph to bullet form.

In the section "Relationships among Radiation Items", removed bullets that described relationships between *Regional Treatment Modalilty* and the former *Radiation* item (the latter item does not appear in **FORDS**).

In the paragraph following the table "Clarification of Systemic Therapy Terms," removed a parenthetic phrase that described one way of grouping chemotherapeutic items; that list did not match the grouping in the *SEER*Rx Interactive Drug Database*.

Added the following sentence under "Other Treatment": "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."

COMORBIDITIES AND COMPLICATIONS
01/01/2012

Dropped "considered" from the following sentence: "All are secondary diagnoses."

Changed wording of sentence referring to the timing of ICD-10-CM implementation to "Most hospitals in the United States are expected to implement use of ICD-10-CM in the near future."

OUTCOMES
01/01/2012

Removed the sentence: "Reappearance of a tumor of the same histology in the same primary site during the time period defined by the *SEER Multiple Primary and Histology Coding Rules* does not constitute a recurrence." That statement was incorrect.

2013

CASE ELIGIBILITY
01/01/2013

Added phrase to the first title so it now reads: "Tumors Required by the CoC to be Accessioned, Abstracted, Followed and Submitted to the National Cancer Data Base (NCDB)".

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

Under "Examples of Diagnostic Terms", in the second bullet the word "mammogram" was replaced with "pathology".

CANCER IDENTIFICATION
01/01/2013

"Soft Tissue" was added to the table "Special Grades Coded in the Collaborative Stage Data Collection System".

Added instructions and a table of CS schema that require Grade/Differentiation to be coded.

PATIENT ADDRESS AND RESIDENCY RULES
01//01/2013

Added at new section, "Coding Country and State".

COMORBIDITIES AND COMPLICATIONS / SECONDARY DIAGNOSES
01/01/2013

Section expanded to include new Secondary Diagnosis #1-10 items.

FIRST COURSE OF TREATMENT
01/01/2013

In radiation section, the word "volume" in the definition of boost treatment was changed to "field".

CASE ADMINISTRATION
01/01/2013

Added Over-ride CS 1-19 to list of override items that must be in the facility's database.

Added CS Versions to the list of code versions used.

2015

CASE ELIGIBILITY
01/01/2015

Added Exception 2, and renumbered the remaining exceptions. Now carcinoid tumors of the appendix (C18.1) formerly coded 8240/1 must be coded 8240/3.

CLASS OF CASE
01/01/2015

Sentence changed to indicate no Class of Case 00 cases need to be followed: "Analytic cases *Class of Case* 00 are not required to be staged or followed, regardless of the year of diagnosis."

CANCER IDENTIFICATION
01/01/2015

Removed introductory reference *to Grade Path Value* and *Grade Path System*, which are no longer required.

01/01/2015

Under *Morphology: Histology Code*, updated reference to the SEER *2007 Multiple Primary and Histology Coding Rules*, and added reference to the SEER *Hematopoietic and Lymphatic Neoplasm Coding Manual*.

01/01/2015

Replaced entire *Morphology: Grade* section.

PATIENT ADDRESS AND RESIDENCY RULES

01/01/2015

Under *Coding Country and State*, modified grammar in "**S**tate and country codes also include some custom codes**,** which are included in Appendix E."

AJCC TNM STAGING

01/01/2015

Revised statements identifying AJCC registry staging requirements: "Clinical and pathologic staging components and stage groups should be recorded to the extent they are available." Pathologic staging is required as well as clinical.

01/01/2015

Modified grammar in "If either clinical or pathologic staging was applied for a pediatric tumor, enter the appropriate codes and do not code 88."

FIRST COURSE OF TREATMENT

01/01/2015

In *Relationships among Surgical Items* corrected the code range in "Codes 10 through 19 are site-specific descriptions of tumor-destruction procedures that do not produce a pathologic specimen."

01/01/2015

In *Systemic Therapy* added clarification that six drugs were reclassified in 2013 from chemotherapy to BRM/immunotherapy; no code change is applied for pre-2013 diagnoses.

01/01/2015

Updated the paragraph following the section described above to apply both to chemotherapy and hormone therapy: "Chemotherapy and hormone therapy agents are administered in treatment cycles, either singly or in a combination regimen of two or more drugs…. Refer to the *SEER*Rx Interactive Drug Database* (*http://seer.cancer.gov/)* for a list of systemic therapy agents."

OUTCOMES

01/01/2015

Clarified that *Class of Case* 00 cases no longer need to be followed.

01/01/2015

Added definitions of local, trocar, regional and distant recurrence.

2016

CASE ELIGIBILITY

01/01/2016

Added larynx (LIN III), and squamous intraepithelial neoplasia excluding cervix (SIN III) to Exception 4.

UNIQUE PATIENT IDENTIFIERS CODES

01/01/2016

Added sentence to emphasize that Accession number should never be changed:
"Once cases are submitted to RQRS or the NCDB, accession numbers are not to be changed for any reason. Even if there is a clerical error, of if cases are found in an out-of-order fashion when case

finding (i.e., find an old case after abstraction of a newer one), the accession number serves as a permanent identifier for a patient at your facility. NCDB does not accommodate any requests for accession number changes for cases already submitted."

AJCC TNM STAGING

01/01/2016

Added new coding rules for use of 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."

Added verbiage to introduce the new T, N, M categories:
"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 and will be expanded with the implementation of the AJCC 8th Edition Manual. For example, the new category of cN0 for the TNM Path N [890] data item is limited to in situ tumors only in 2016.

COLLABORATIVE STAGE DATA COLLECTION SYSTEM

01/01/2016

Added statement about retirement of Collaborative Stage and delineated diagnosis year-specific requirement of Collaborative Stage data items:
"For cases diagnosed beginning January 1, 2016, the Collaborative Stage Data Collection System (CS) has been retired. CS The current Collaborative Stage Data Collection System (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 that dates. For cases diagnosed from 2004-2015 all CS items identified in FORDS are required to be completed for Class of Case 00-22. See the interactive application at http://seer.cancer.gov/csreqstatus/application.html for the specific Site-Specific Factors required by CoC 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 are continued to be required for AJCC staffing and research purposes. They are required for all cases diagnosed in 2004 and later:

- Regional Nodes Positive [820]
- Regional Nodes Examined [830]
- Lymph-vascular Invasion [1182]
- CS Site-specific Factors [2861-2880, 2890-2930]
- CS Version Input Original [2935]
- CS Version Input Current [2937]

Note: CoC's requirements for the 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 SSFs."

CASE ADMINISTRATION
01/01/2016

Under Administrative Tracking, updated URL for complete list of FINs on ACoS website: https://www.facs.org/quality-programs/cancer/accredited/info/fin

Under Code Versions Used, specified that CS Version Derived (NAACCR Item # 2936 is required "for cases diagnosed 2004 through 2015".

CHANGES TO *FORDS* SECTION TWO: PATIENT IDENTIFICATION

2011

Military Record Number Suffix (NAACCR Item #2310)
01/01/2011

Item deleted from **FORDS**

First Name (NAACCR Item #2240)
01/01/2011

Modified instructions: Blanks, spaces, hyphens, and apostrophes are allowed. Do not use other punctuation. This field may be updated if the name changes.

Middle Name (NAACCR Item #2250)
01/01/2011

Modified instructions: Blanks, spaces, hyphens, and apostrophes are allowed. Do not use other punctuation. This field may be updated if the name changes.

State at Diagnosis (NAACCR Item #80)
01/01/2011

Code for Canada corrected: CD

State -- Current (NAACCR Item #1820)
01/01/2011

Code for Canada corrected: CD

Following Physician (NAACCR Item #2470)
01/01/2011

Item deleted from **FORDS**

Primary Surgeon (NAACCR Item #2480)
01/01/2011

Item deleted from **FORDS**

Physician #3 (NAACCR Item #2490)
01/01/2011

Item deleted from **FORDS**

Physician #4 (NAACCR Item #2500)
01/01/2011

Item deleted from **FORDS**

2012

Patient Address at Diagnosis (Number and Street)
01/01/2012
Added label “Examples” to example grid.

Patient Address at Diagnosis–Supplemental
01/01/2012
Added label “Examples” to example grid.

State at Diagnosis
01/01/2012
Relabeled United States and Canadian abbreviations list for consistency.

Patient Address–Current (Number and Street)
01/01/2012
Added label “Examples” to example grid.

Patient Address Current– Supplemental
01/01/2012
Added label “Examples” to example grid.

State–Current
01/01/2012
Added label “Examples” to example grid.

Place of Birth
01/01/2012
Added label “Examples” to example grid.

Added example (000 , Place of birth in United States, no other detail known).

Race 1-5
01/01/2012
Redefined code 21, Chamorro/Chamoru

Comorbidities and Complications (1-10)
01/01/2012
Removed code range Z23001-Z2493 from allowable code range.

Added “or ICD-10-CM” to the code definition instructions.

NPI—Physician #4
01/01/2012
Third bullet: changed “radiation” to “medical” oncologist.

2013

Sequence Number
01/01/2013
Word “malignant” in first, second and fourth bullets corrected to “invasive”.

Address at DX – Country
01/01/2013

New item. Corresponds to other Addr at DX items (state, postal code). Pre-2013 cases should be converted by the registry's software.

Address Current – Country
01/01/2013

New item. Corresponds to Address Current – State. Pre-2013 cases should be converted by the registry's software.

Place of Birth
01/01/2013

Deleted item. Replaced by Birthplace-State and Birthplace-Country, which should be converted from it. Codes are not the same.

Birthplace-State
01/01/2013

New item. Along with Birthplace-Country, replaced Place of Birth. Historic data should be converted by software.

Birthplace-Country
01/01/2013

New item. Along with Birthplace-State, replaced Place of Birth. Historic data should be converted by software.

Comorbidities and Complications #1
Comorbidities and Complications #2
Comorbidities and Complications #3
Comorbidities and Complications #4
Comorbidities and Complications #5
Comorbidities and Complications #6
Comorbidities and Complications #7
Comorbidities and Complications #8
Comorbidities and Complications #9
Comorbidities and Complications #10
01/01/2013

In the past, these items were updated to permit coding of ICD-10-CM values in addition to ICD-9-CM values. Because those values have more characters than are available in these items (7 compared to 5), new Secondary Diagnosis #1-10 items have been introduced for use. All references to ICD-10-CM were removed from these items; however, already-coded ICD-10-CM data will be accepted for cases diagnosed prior to 2013.

Secondary Diagnosis #1
Secondary Diagnosis #2
Secondary Diagnosis #3
Secondary Diagnosis #4
Secondary Diagnosis #5
Secondary Diagnosis #6
Secondary Diagnosis #7
Secondary Diagnosis #8
Secondary Diagnosis #9
Secondary Diagnosis #10

01/01/2013

These items are used to record secondary diagnoses when they are recorded in ICD-10-CM, rather than using Comorbidities and Complications #1-10.

2015

County at Diagnosis (NAACCR Item #90)
01/01/2015
Changed instruction: If the patient is a non-U.S. resident, use code 999. Also changed the example for 999.

01/01/2015
Removed instruction for coding country in this field.

Birthplace—State (NAACCR Item #252)
01/01/2015
Corrected header to indicate the item was added (not revised) in 2013.

Spanish Origin—All Sources (NAACCR #190)
01/01/2015
Corrected bullet by adding the word "not": 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.

Sex (NAACCR Item #220)
01/01/2015
Updated code 4 to Transsexual, NOS; Added code 5 Transsexual, natal male; Added code 6 Transsexual, natal female.
Added instruction: Natality for transsexuals was added for use in 2015, but may be applied for earlier diagnoses.

Comorbidities and Complications #2 (NAACCR Item #3120)
Comorbidities and Complications #3 (NAACCR Item #3130)
Comorbidities and Complications #4 (NAACCR Item #3140)
Comorbidities and Complications #5 (NAACCR Item #3150)
Comorbidities and Complications #6 (NAACCR Item #3160)
Comorbidities and Complications #7 (NAACCR Item #3161)
Comorbidities and Complications #8 (NAACCR Item #3162)
Comorbidities and Complications #9 (NAACCR Item #3163)
Comorbidities and Complications #10 (NAACCR Item #3164)
01/01/2015
Updated coding instructions.

Secondary Diagnosis #2 (NAACCR Item #3782)
Secondary Diagnosis #3 (NAACCR Item #3784)
Secondary Diagnosis #4 (NAACCR Item #3786)
Secondary Diagnosis #5 (NAACCR Item #3788)
Secondary Diagnosis #6 (NAACCR Item #3790)
Secondary Diagnosis #7 (NAACCR Item #3792)
Secondary Diagnosis #8 (NAACCR Item #3794)
Secondary Diagnosis #9 (NAACCR Item #3796)
Secondary Diagnosis #10 (NAACCR Item #3798)
01/01/2015
Deleted bullet that belonged only to **Secondary Diagnosis #1** (NAACCR Item #3780): 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.

2016

Sex (NAACCR Item #220)
01/01/2016

Updated Label for code 3 from "Other (hermaphrodite)" to "Other (intersex, disorders of sexual development/DSD)"
Added instruction: "The definition of code 3 was updated to "Other (intersex, disorders of sexual development/DSD)" in 2016".

CHANGES TO *FORDS* SECTION TWO: CANCER IDENTIFICATION

2010

Class of Case (NAACCR Item #610)
05/01/2010

Second sentence in description modified to read: "Analytic cases are grouped according to the location of diagnosis and first course of treatment."
Added "or a decision not to treat" to description of code 22.

Date of Initial Diagnosis (NAACCR Item #390)
02/01/2010

Deleted two sentences from final paragraph: "The *Date of Diagnosis Flag* (NAACCR Item #391) is used to explain why *Date of Diagnosis* is not a known date. See *Date of Diagnosis Flag* for an illustration of the relationships among these items."

Date of Diagnosis Flag (NAACCR Item #391)
02/01/2010

Item deleted. Because *Date of Initial Diagnosis* must always have a year estimated if the exact date is not known, this item will never be used.

Laterality (NAACCR Item #410)
05/01/2010

Changed third bullet to read: "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)."

Histology (NAACCR Item #522)
03/10/2010

Deleted exception to sixth bullet for consistency with Multiple Primary and Histology rules.

Date Conclusive DX Flag (NAACCR Item #448)
05/01/2010

Corrected item name (from Date of Conclusive DX Flag).

2011

Class of Case (NAACCR Item #610)
01/01/2011

Added instruction: If the hospital has purchased 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 are staff physicians or not, as with any other physician.
Added clarification to codes 13 and 21: "part of first course treatment was done elsewhere".
Added "treatment plan only" to code 30 examples.
Added to definition of code 31: or hospital provided care that facilitated treatment elsewhere (for example, stent placement)
Added to code 32: (active disease)
Added to code 33: (disease not active)

Facility Referred From (NAACCR Item #2410)
01/01/2011

Item deleted from **FORDS**

Facility Referred To (NAACCR Item #2420)
01/01/2011

Item deleted from **FORDS**

Date of First Contact (NAACCR Item #580)
01/01/2011

Clarified first instruction (added "first course"): 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.
Added instruction: 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.

Date of Initial Diagnosis (NAACCR Item #390)
01/01/2011

Clarified instruction: 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.
Modified examples

Grade/Differentiation (NAACCR Item #440)
01/01/2011

Added instruction: Code the grade or differentiation from the pathology report prior to any neoadjuvant treatment. If there is no pathology report prior to neoadjuvant treatment, assign code 9.

Grade Path System (NAACCR Item #449)
01/01/2011

Replaced detailed instructions with: Refer to the current *CS Manual* for coding instructions.

Grade Path Value (NAACCR Item #441)
01/01/2011

Replaced detailed instructions with: Refer to the current *CS Manual* for coding instructions.

Lymph-Vascular Invasion (NAACCR Item #1182)
01/01/2011

Replaced detailed instructions with: Refer to the current *CS Manual* for coding instructions.

Diagnostic Confirmation (NAACCR Item #490)
01/01/2011

Added new first instruction to Solid Tumor instructions: See the section following this one for Coding Hematopoietic or Lymphoid Tumors (9590-9992).
Added sentence to cytology coding instruction: CoC does not require programs to abstract cases that contain ambiguous terminology regarding a cytologic diagnosis.

Ambiguous Terminology Diagnosis (NAACCR Item #442)
01/01/2011

Added instruction: Leave blank for cases diagnosed prior to January 1, 2007.

Date Conclusive DX Flag (NAACCR Item #448)
01/01/2011

Replaced detailed instructions with: Apply the instructions in the current version of *Multiple Primary Histology and Coding Rules* to code this item.

Date of Mult Tumors Flag (NAACCR Item #439)
01/01/2011

Replaced detailed instructions with: Apply the instructions in the current version of *Multiple Primary Histology and Coding Rules* to code this item.

2012

Class of Case
01/01/2012

Modified second sentence of third bullet: "If it is not known that the patient actually went somewhere else, code *Class of Case* 10".

Added to eighth bullet: "Treatment provided in a staff physician's office is provided 'elsewhere'. That is because care given in a physician's office is not within the hospital's realm of responsibility."

Added bullet: "'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. 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)".

Modified label for analytic codes: "Initial diagnosis at reporting facility or in a staff physician's office."

Added more examples.

Behavior Code
01/01/2012

Added "malignant" to first bullet.

Added new bullet (second): "Code 3 if any *malignant* metastasis to nodes or tissue beyond the primary is present."

In table, modified descriptions of terminologies for "in situ", and added "carcinoma" specification for several.

Grade/Differention
01/01/2012

Added new bullet: "See "Morphology: Grade" in the "Cancer Identification" of *Section I* for determining whether a particular grade is coded as *Grade/Differentiation* NAACCR Item #440), *Grade Path System* (NAACCR Item #449) and *Grade Path Value* (NAACCR Item #441), or as a site-specific special grade in the **Collaborative Stage Data Collection System**".

Added bullet: "Do not code 'high grade dysplasia' as *Grade/Differentiation*; the term 'grade' has a different meaning in that context."

Modified a bullet to read: "Codes 5–8 define T-cell or B-cell origin for leukemias and lymphomas. Do not use codes 1-4 for these cases."

Deleted bullet that said: "See Section I to convert other solid tumor grade systems to *Grade/Differentiation"*.

Deleted bullet that said: "If *Grade Path System* (NAACCR Item #449) and *Grade Path Value* (NAACCR Item #441) are coded, *Grade/Differentiation* (NAACCR Item #440) must not be 9". That rule no longer holds.

Grade Path System
01/01/2012

Added bullet: "See 'Morphology: Grade' in the 'Cancer Identification' of *Section I* for determining whether a particular grade is coded as *Grade/Differentiation* NAACCR Item #440), *Grade Path System* (NAACCR Item #449) and *Grade Path Value* (NAACCR Item #441), or as a site-specific special grade in the **Collaborative Stage Data Collection System**.

Grade Path Value
01/01/2012

Added the word "value" to the description: "Describes the grade value assigned according to the grading system in *Grade Path System* (NAACCR Item #449)".

Added bullet: "See 'Morphology: Grade' in the 'Cancer Identification' of *Section I* for determining whether a particular grade is coded as *Grade/Differentiation* NAACCR Item #440), *Grade Path System* (NAACCR Item #449) and *Grade Path Value* (NAACCR Item #441), or as a site-specific special grade in the **Collaborative Stage Data Collection System**.

Diagnostic Confirmation
01/01/2012

Removed reference to multiple myeloma in definition of code 5 for solid tumors.

Ambiguous Terminology Diagnosis
01/01/2012

This item should now be coded according to FORDS, rather than the *SEER Multiple Primary and Histology Coding Rules*. Instructions for distinguishing between "60 or fewer days" and "more than 60 days" clarified from that source.

Date of Conclusive Diagnosis
01/01/2012

This item should now be coded according to FORDS, rather than the *SEER Multiple Primary and*

Histology Coding Rules.

Date of Conclusive DX Flag
01/01/2012

This item should now be coded according to FORDS, rather than the *SEER Multiple Primary and Histology Coding Rules*.

Date of Multiple Primary Tumors
01/01/2012

This item should now be coded according to FORDS, rather than the *SEER Multiple Primary and Histology Coding Rules*.

Date of Mult Tumors Flag
01/01/2012

This item should now be coded according to FORDS, rather than the *SEER Multiple Primary and Histology Coding Rules*.

Type of Multiple Tumors Reported as One Primary
01/01/2012

This item should now be coded according to FORDS, rather than the *SEER Multiple Primary and Histology Coding Rules*.

Multiplicity Counter
01/01/2012

This item should now be coded according to FORDS, rather than the *SEER Multiple Primary and Histology Coding Rules*. Codes 00 and 89 were added. Note also that some site- and histology-specific instructions have changed since that manual was produced.

2013

Laterality
01/01/2013

Added as 3rd bullet: "If both lungs have nodules or tumors and the lung of origin is not known, assign code 4."

Behavior Code
01/01/21013

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

Grade/Differentiation
01/01/2013

Deleted 4 bullets that were instances of other bullets.

Diagnostic Confirmation
01/01/2013

Reworded the Rationale to better apply to CoC programs: "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."

Reordered instructions so tables do not span pages.

Reworded bullet for code 8 in the hematopoietic instructions so first sentence reads "Assign code 8 when the case was diagnosed by any clinical method not mentioned in preceding codes." Copied entire bullet to solid tumor instructions.

Ambiguous Terminology Diagnosis
01/01/2013
Item deleted. Use older codes for cases diagnosed prior to 2013.

Date of Conclusive Diagnosis
01/01/2013
Item deleted. Use older codes for cases diagnosed prior to 2013.

Date Conclusive DX Flag
01/01/2013
Item deleted. Use older codes for cases diagnosed prior to 2013.

Date of Multiple Tumors
01/01/2013
Item deleted. Use older codes for cases diagnosed prior to 2013.

Date of Mult Tumors Flag
01/01/2013
Item deleted. Use older codes for cases diagnosed prior to 2013.

Type of Multiple Tumors Reported As One Primary
01/01/2013
Item deleted. Use older codes for cases diagnosed prior to 2013.

Multiplicity Counter
01/01/2013
Item deleted. Use older codes for cases diagnosed prior to 2013.

2015

Class of Case (NAACCR Item #610)
01/01/2015
New bullet: Physicians who are not employed by the hospital 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.

01/01/2015
Modified wording in bullet: If the hospital purchases a physician practice …

01/01/2015
Added wording to last bullet: "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 **infusion** elsewhere and continues at the reporting facility, and the care is not in-transit, then the case is analytic (*Class of Case* 21).

01/01/2015
Modified wording for *Class of Case* codes 10, 11, 12, and 41.

01/01/2015
Changes to examples for 00, 13, 11, 42 and 31.

Behavior Code (NAACCR Item #523)
01/01/2015
Added "only" to this definition of code 2: Noninvasive (carcinoma **only**)

Grade/Differentiation (NAACCR Item #440)
01/01/2015
New instruction: See "Morphology: Grade" in the "Cancer Identification" of *Section I* for instructions for coding this item for cases diagnosed in 2014 or subsequently. Consult the applicable version of **FORDS** for cases for instructions for cases diagnosed prior to 2014.

Diagnostic Confirmation (NAACCR Item #490)
01/01/15
Corrected header to show that changes to the item were made in 2013.

2016

Regional Lymph Nodes Examined (NAACCR Item #830)
01/01/2016
Added sentence to Description:
"In 2016 use of CS was discontinued, however this data item continued to be required."

Added sentence to Instructions:
"When 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 Positive (NAACCR Item #820)
01/01/2016
Added sentence to Description:
"In 2016 use of CS was discontinued, however this data item continued to be required."

Added sentence to Instructions:
"When definition of regional nodes differs between the AJCC Cancer Staging Manual and the SEER Program Coding and Staging Manual use the AJCC definition."

CHANGES TO *FORDS* SECTION TWO: STAGE OF DISEASE AT DIAGNOSIS

2010

Clinical Stage (Prefix/Suffix) Descriptor (NAACCR Item #980)
02/01/2010
Code 4 removed and the following instruction added: "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".

05/01/2010
Code 6 removed; it was a combination of code 4 (removed 02/10/2010) and another code.

Site-Specific Factor 1 (NAACCR Item #2880)
02/01/2010
BileDuctsIntrahepatic schema added to table.
Site C30.1 (middle ear) added to Head and Neck site codes in table footnote.
03/01/2010
Kaposi Sarcoma schema added to table.
Added "abstracted in CSv2" to SSF requirements in the table.

Site-Specific Factor 2 (NAACCR Item #2890)
02/01/2010
BileDuctsIntrahepatic schema added to table.
03/01/2010
Added "abstracted in CSv2" to SSF requirements in the table.

Site-Specific Factor 3 (NAACCR Item #2900)
02/01/2010
SkinEyelid SSF3 name changed to "Clinical Status of Lymph Nodes".
Site C30.1 (middle ear) added to Head and Neck site codes in table footnote.
03/01/2010
Added "abstracted in CSv2" to SSF requirements in the table.

Site-Specific Factor 4 (NAACCR Item #2910)
02/01/2010
Added instruction: Prostate SSF4 (Prostate Apex Involvement) does not show on this table, because it is considered obsolete in 2010. However, it is required for cases diagnosed through 2009, as it was required in CSv1, even if it is abstracted in CSv2.
Site C30.1 (middle ear) added to Head and Neck site codes in table footnote.
03/01/2010
Added "abstracted in CSv2" to SSF requirements in the table.

Site-Specific Factor 5 (NAACCR Item #2920)
02/01/2010
Melanoma Choroid and MelanomaCiliaryBody schema added to table.
Site C30.1 (middle ear) added to Head and Neck site codes in table footnote.
03/01/2010
Added "abstracted in CSv2" to SSF requirements in the table.

Site-Specific Factor 6 (NAACCR Item #2930)
02/01/2010
SkinEyelid, MelanomaChoroid, and MelanomaCiliaryBody schema added to table.
Site C30.1 (middle ear) added to Head and Neck site codes in table footnote.
03/01/2010
Added "abstracted in CSv2" to SSF requirements in the table.

Site-Specific Factor 7 (NAACCR Item #2861)
02/01/2010
MelanomaChoroid and MelanomaCiliaryBody schema added to table.
03/01/2010
Added "abstracted in CSv2" to SSF requirements in the table.

Site-Specific Factor 8 (NAACCR Item #2862)
02/01/2010
SkinEyelid schema added to table.
03/01/2010
Added “abstracted in CSv2” to SSF requirements in the table.

Site-Specific Factor 9 (NAACCR Item #2863)
02/01/2010
SkinEyelid schema deleted from table.
MelanomaChoroid and MelanomaCiliaryBody schema added to table.
Site C30.1 (middle ear) added to Head and Neck site codes in table footnote.
03/01/2010
Added “abstracted in CSv2” to SSF requirements in the table.

Site-Specific Factor 10 (NAACCR Item #2864)
02/01/2010
TongueBase, PalateSoft, SkinEyelid, GISTPeritoneum, MelanomaChoroid, and MelanomaCiliaryBody schema added to table.
03/01/2010
Added “abstracted in CSv2” to SSF requirements in the table.

Site-Specific Factor 11 (NAACCR Item #2865)
02/01/2010
MelanomaChoroid, MelanomaCiliaryBody and MerkelCellVulva schema added to table.
Site C03.1 (Gum, Lower) added to Head and Neck site codes in table footnote.
03/01/2010
Added “abstracted in CSv2” to SSF requirements in the table.

Site-Specific Factor 12 (NAACCR Item #2866)
02/01/2010
MelanomaChoroid and MelanomaCiliaryBody schema added to table.
03/01/2010
Added “abstracted in CSv2” to SSF requirements in the table.

Site-Specific Factor 13 (NAACCR Item #2867)
02/01/2010
MelanomaChoroid and MelanomaCiliaryBody schema added to table.
03/01/2010
Added “abstracted in CSv2” to SSF requirements in the table.

Site-Specific Factor 14 (NAACCR Item #2868)
02/01/2010
SkinEyelid schema deleted from table.
03/01/2010
Added “abstracted in CSv2” to SSF requirements in the table.

Site-Specific Factor 15 (NAACCR Item #2869)
03/01/2010
Added “abstracted in CSv2” to SSF requirements in the table.

Site-Specific Factor 16 (NAACCR Item #2870)
03/01/2010
Added “abstracted in CSv2” to SSF requirements in the table.

Site-Specific Factor 17 (NAACCR Item #2871)
03/01/2010
Added "abstracted in CSv2" to SSF requirements in the table.

Site-Specific Factor 18 (NAACCR Item #2872)
03/01/2010
Added "abstracted in CSv2" to SSF requirements in the table.

Site-Specific Factor 19 (NAACCR Item #2873)
03/01/2010
Added "abstracted in CSv2" to SSF requirements in the table.

Site-Specific Factor 20 (NAACCR Item #2874)
03/01/2010
Added "abstracted in CSv2" to SSF requirements in the table.

Site-Specific Factor 21 (NAACCR Item #2875)
03/01/2010
Added "abstracted in CSv2" to SSF requirements in the table.

Site-Specific Factor 22 (NAACCR Item #2876)
03/01/2010
Added "abstracted in CSv2" to SSF requirements in the table.

Site-Specific Factor 23 (NAACCR Item #2877)
03/01/2010
Added "abstracted in CSv2" to SSF requirements in the table.

Site-Specific Factor 24 (NAACCR Item #2878)
03/01/2010
Added "abstracted in CSv2" to SSF requirements in the table.

Site-Specific Factor 25 (NAACCR Item #2879)
02/01/2010
GISTPeritoneum schema deleted from table.

2011

Clinical M (NAACCR Item #960)
01/01/2011
Added sentence to Rationale: Effective January 1, 2008 the CoC requires that AJCC clinical TNM staging be recorded in its accredited cancer program cancer registries.
Corrected code: 0I+ (was I+), represents M0(i+)

Clinical Stage Group (NAACCR Item #970)
01/01/2011
Revised fourth bullet: If the value does not fill all 4 characters, then record the value to the left and leave the remaining spaces blank.

Clinical Stage (Prefix/Suffix) Descriptor (NAACCR Item #980)
01/01/2011
Corrected Allowable Values: 0-3, 5, 9

Pathologic Stage Group (NAACCR Item #910)
01/01/2011
Revised fifth bullet: If the value does not fill all 4 characters, then record the value to the left and leave the remaining spaces blank.

All CS items
01/01/2011
Changed references from "Collaborative Staging" to "Collaborative Stage"

CS Lymph Nodes Eval (NAACCR Item #2840)
01/01/2011
Changed item name from *CS Reg Nodes Eval* for consistency with Collaborative Stage.

CS Site-Specific Factor 2 (NAACCR Item #2890)
01/01/2011
Added new schema and SSF: MyelomaPlasmaCellDisorder, Durie-Salmon Staging System

CS Site-Specific Factor 3 (NAACCR Item #2900)
01/01/2011
Added new schema and SSF: MyelomaPlasmaCellDisorder, Multiple Myeloma Terminology

CS Site-Specific Factor 10 (NAACCR Item #2864)
01/01/2011
Added new SSF for BileDuctsIntrahep schema: Tumor Growth Pattern

CS Site-Specific Factor 13 (NAACCR Item #2867)
01/01/2011
Added new SSF for Testis: Postorchiectomy Alpha Fetoprotein (AFP) Range

CS Site-Specific Factor 15 (NAACCR Item #2869)
01/01/2011
Added new SSF for Breast: HER2: Summary result of testing
Added new SSF for Testis: Postorchiectomy Human Chorionic Gonadotropin (hCG) Range

CS Site-Specific Factor 16 (NAACCR Item #2870)
01/01/2011
Added new SSF for Testis: Postorchiectomy Lactate Dehydrogenase (LDH) Range

Site-Specific Factor (SSF) 1-25
01/01/2011
Updated 2010 reference in table instructions: For tumors abstracted in CS v02.03 or diagnosed in 2011 …
Corrected histology and/or primary site for applicable schema as shown in the following table. Neither schema names nor the associated SSF names are affected. Only the changed sites and histologies are listed below.

Schema Name	Site	Histology
Head and Neck (all)		8000-8713, 8800-9136, 9141-9582, 9700-9701
Esophagus		8000-8934, 8940-9136, 9141-9582, 9700-9701
EsophagusGEJunction		8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8934, 8940-9136, 9141-9582, 9700-9701
Stomach		8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8934, 8940-9136, 9141-9582, 9700-9701
SmallIntestine		8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8934, 8940-9136, 9141-9582, 9700-9701

Colon		8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8934, 8940-9136, 9141-9582, 9700-9701
Appendix		8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8934, 8940-9136, 9141-9582, 9700-9701
Rectum		8000-8152, 8154-8231, 8243-8245, 8247-8248, 8250-8934, 8940-9136, 9141-9582, 9700-9701
Liver	C22.1	8170-8175
	C22.0	8000-8157, 8162-8175, 8190-9136, 9141-9582, 9700-9701
CysticDuct		8000-9136, 9141-9582,9700-9701
BileDuctsIntrahepat	C22.0	8160-8161, 8180
	C22.1	8000-8162, 8180-9136, 9141-9582, 9700-9701
BileDuctsPerihilar		8000-9136, 9141-9582, 9700-9701
Lung		8000-9136, 9141-9582, 9700-9701
HeartMediastinum		8000-9136, 9141-9582, 9700-9701
Pleura		8000-9136, 9141-9582, 9700-9701
Bone		8000-9136, 9141-9582, 9700-9701
Skin		8000-8246, 8248-8713, 8800-9136, 9141-9582
SkinEyelid		8000-8713, 8800-9136, 9141-9508, 9510-9514, 9520-9582
SoftTissue		8000-9136, 9141-9582, 9700-9701
Retroperitoneum		8000-8934, 8940-9136, 9141-9582, 9700-9701
Peritoneum	C48.1-2,8	Male: 8800-8921, 8940-9055, 9120-9136, 9141-9582
		Female: 8580-8589, 8680-8921, 9120-9136, 9141-9582, 9700-9701
Breast		8000-9136, 9141-9582, 9700-9701
Vagina		8000-9136, 9141-9582, 9700-9701
Cervix		8000-9136, 9141-9582, 9700-9701
CorpusAdenosarcoma		8933
CorpusSarcoma		8800-8932, 8934-8974, 8982-9136, 9141-9582
Ovary		8000-9136, 9141-9582, 9700-9701
FallopianTube		8000-9136, 9141-9582, 9700-9701
Placenta		8000-9136, 9141-9582, 9700-9701
Prostate		8000-9136, 9141-9582, 9700-9701
Testis		8000-9136, 9141-9582, 9700-9701
Scrotum		8000-8246, 8248-8713, 8800-9136, 9141-9582
Penis		8000-8246, 8248-8713, 8800-9136, 9141-9582
KidneyParenchema		8000-9136, 9141-9582, 9700-9701
KidneyRenalPelvis		8000-9136, 9141-9582, 9700-9701
Bladder		8000-9136, 9141-9582, 9700-9701
Urethra		8000-9136, 9141-9582, 9700-9701
Conjunctiva		8000-8713, 8800-9136, 9141-9508, 9510-9514, 9520-9582
LacrimalGland		8000-8713, 8800-9136, 9141-9508, 9520-9582, 9700-9701
LacrimalSac		8000-8713, 8800-9136, 9141-9508, 9520-9582, 9700-9701
Brain		8000-9136, 9141-9582, 9700-9701
CNSOther		8000-9136, 9141-9582, 9700-9701
Thyroid		8000-9136, 9141-9582, 9700-9701
IntracranialGland		8000-9136, 9141-9582, 9700-9701
Lymphoma	C00.0-44.0; C44.2-68.9; C69.1-4,8-C80.9	9590-9699, 9702-9729, 9735, 9737-9738
	C00.0-41.9; C42.2-3,5-44.0; C44.2-68.9; C69.1-4,8-C80.9	9811-9818, 9823, 9827, 9837
HemeRetic	C00.0-80.9	9740-9809, 9840-9992
	C42.0,1,4	9811-9818, 9823, 9827, 9837

	C00.0-44.0; C44.2-68.9; C69.1-4,8-C80.9	9733, 9820, 9826, 9231-9836

Derived AJCC-6 Stage Group (NAACCR Item #3000)
01/01/2011
Replaced "M" in final instruction with "Stage Group"

Derived AJCC-7 Stage Group (NAACCR Item #3430)
01/01/2011
Replaced "M" in final instruction with "Stage Group"

2012

RX Date—DX/Stg Proc Flag
01/01/2012
Corrected NAACCR Item #1281.

Surgical Diagnostic and Staging Procedure
01/01/2012
Reworded description: "Identifies the positive surgical procedure(s) performed to diagnose and/or stage disease."

Added new bullet (second): "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".

Surgical Diagnostic and Staging Procedure
01/01/2012
Reworded description: "Identifies the positive surgical procedure(s) performed to diagnose and/or stage disease."

Added new bullet (second): "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".

CS Site-Specific Factor 1-25
01/01/2012
Removed detailed list of SSFs required to be coded, and replaced it with the following bullet: "Refer to the CS coding instructions on the Collaborative Stage web site at http://www.cancerstaging.org for the current list of CS Site Specific Factors *required* to be abstracted by CoC. Registries are *encouraged* to code other prognostic site specific factors used by the facility.

2015

Surgical Diagnostic and Staging Procedure (NAACCR #1350)
Surgical Diagnostic and Staging Procedure at This Facility (NAACCR #740)
01/01/2015
Added clarifying instruction: If a needle biopsy preceded an excisional biopsy or more extensive surgery, even if no tumor remained at the time of surgery, both the needle biopsy (*Surgical Diagnostic and Staging Procedure*) and the *Surgical Procedure of the Primary Site* are to be reported. Surgical margins must be examined to determine whether a biopsy intended as incisional is excisional instead, and margins cannot be evaluated for a needle biopsy.
Pathologic T (NAACCR Item #880)

Pathologic N (NAACCR Item #890)
Pathologic M (NAACCR Item #900)
Pathologic Stage Group (NAACCR Item #910)
01/01/2015

Removed bullet: these items are required, not "recommended", in 2015.
Added bullet: items are required for Class of Case 10-22.

2016

Surgical Diagnostic and Staging Procedure (NAACCR #1350)
01/01/2016
Reworded 8th bullet for clarity

- 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 as such in the *Surgical Diagnostic and Staging Procedure* (NAACCR Item #1350) data item and the excisional biopsy or more extensive surgery in the *Surgical Procedure of the Primary Site* data item (NAACCR Item #1290).

Surgical Diagnostic and Staging Procedure at this Facility (NAACCR #740)
01/01/2016
Reworded 8th bullet for clarity

- 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 as such in the *Surgical Diagnostic and Staging Procedure* (NAACCR Item #1350) data item and the excisional biopsy or more extensive surgery in the *Surgical Procedure of the Primary Site* data item (NAACCR Item #1290).

Tumor Size Summary (NAACCR #756)
Mets at Diagnosis – Bone (NAACCR #1112)
Mets at Diagnosis – Brain (NAACCR #1113)
Mets at Diagnosis – Distant Lymph Nodes (NAACCR #1114)
Mets at Diagnosis – Liver (NAACCR #1115)
Mets at Diagnosis – Lung (NAACCR #1116)
Mets at Diagnosis – Other (NAACCR #1117)
01/01/2016
Added new data items to FORDS

Clinical T (NAACCR #940)
01/01/2016
Added the following to rationale:
Beginning in 2016, new T, N, and M categories were implemented the AJCC T, N, and M data items [940, 950, 960, 880, 890, and 900]. 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 and will be expanded with the implementation of the AJCC 8th Edition Manual.

Added the following bullets to Instructions:

- 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.

Replaced Code Table:

Code	Definition
(blank)	Not recorded
cX	cTX
c0	cT0
pA	pTa
pIS	pTis
pISU	pTispu
pISD	pTispd
c1MI	cT1mi, cT1mic
c1	cT1
c1A	cT1a
c1A1	cT1a1
c1A2	cT1a2

Code	Definition
c1B	cT1b
c1B1	cT1b1
c1B2	cT1b2
c1C	cT1c
c1D	cT1d
c2	cT2
c2A	cT2a
c2A1	cT2a1
c2A2	cT2a2
c2B	cT2b
c2C	cT2c
c2D	cT2d

Code	Definition
c3	cT3
c3A	cT3a
c3B	cT3b
c3C	cT3c
c3D	cT3d
c4	cT4
c4A	cT4a
c4B	cT4b
c4C	cT4c
c4D	cT4d
c4E	cT4e
88	Not applicable

Clinical N (NAACCR #950)

01/01/2016

Added the following to rationale:

Beginning in 2016, new T, N, and M categories were implemented the AJCC T, N, and M data items [940, 950, 960, 880, 890, and 900]. 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 and will be expanded with the implementation of the AJCC 8th Edition Manual.

Added the following bullets to Instructions:

- 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.

Replaced Code Table:

Code	Definition
(blank)	Not recorded
cX	cNX
c0	cN0
c0A	cN0a

Code	Definition
c1B	cN1b
c1C	cN1c
c2	cN2
c2A	cN2a

Code	Definition
c3A	cN3a
c3B	cN3b
c3C	cN3c
c4	cN4

Code	Definition
c0B	cN0b
c1	cN1
c1A	cNla

Code	Definition
c2B	cN2b
c2C	cN2c
c3	cN3

Code	Definition
88	Not applicable

Clinical M (NAACCR #960)
01/01/2016
Added the following to rationale:
Beginning in 2016, new T, N, and M categories were implemented the AJCC T, N, and M data items [940, 950, 960, 880, 890, and 900]. 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 and will be expanded with the implementation of the AJCC 8th Edition Manual.

Added the following bullets to Instructions:
- 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.

Replaced Code Table:

Code	Definition
(blank)	Not recorded
c0	cM0
c0I+	cM0(i+)
c1	cM1
c1A	cM1a
c1B	cM1b
c1C	cM1c
c1D	cM1d
c1E	cM1e

Code	Definition
p1	pM1
p1A	pM1a
p1B	pM1b
p1C	pM1c
p1D	pM1d
p1E	pM1e
88	Not applicable

Clinical Stage Group (NAACCR #970)
01/01/2016
Added the following bullets to Instructions:
- 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.

Clinical Stage (Prefix/Suffix) Descriptor (NAACCR #980)
01/01/2016
Added the following bullets to Instructions:
If the tumor is not staged according to the AJCC manual, leave this data item blank.

Staged By (Clinical Stage) (NAACCR #990)
01/01/2016
Added expanded version of data item to FORDS

Pathologic T (NAACCR #880)
01/01/2016
Revised rationale:
The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2015 the CoC requires that AJCC pathologic TNM staging be recorded in its accredited cancer program cancer registries. 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 the AJCC T, N, and M data items [940, 950, 960, 880, 890, and 900]. 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 and will be expanded with the implementation of the AJCC 8th Edition Manual.

Revised 3rd bullet under Instructions:
- 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.

Added the following bullets to Instructions:
- 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.

Replaced Code Table:

Code	Definition
(blank)	Not recorded
pX	pTX
p0	pT0
pA	pTa
pIS	pTis
pISU	pTispu
pISD	pTispd
p1MI	pT1mi, pT1 mic
p1	pT1
p1A	pT1a

Code	Definition
p1B	pT1b
p1B1	pT1b1
p1B2	pT1b2
p1C	pT1c
p1D	pT1d
p2	pT2
p2A	pT2a
p2A1	pT2a1
p2A2	pT2a2
p2B	pT2b

Code	Definition
p3	pT3
p3A	pT3a
p3B	pT3b
p3C	pT3c
p3D	pT3d
p4	pT4
p4A	pT4a
p4B	pT4b
p4C	pT4c
p4D	pT4d

p1A1	pT1a1
p1A2	pT1a2

p2C	pT2c
p2D	pT2d

p4E	pT4e
88	Not applicable

Pathologic N (NAACCR #890)
01/01/2016
Revised rationale:
The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2015 the CoC requires that AJCC pathologic TNM staging be recorded in its accredited cancer program cancer registries. 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 the AJCC T, N, and M data items [940, 950, 960, 880, 890, and 900]. 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 and will be expanded with the implementation of the AJCC 8th Edition Manual.

Revised 3rd bullet under Instructions:
- 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.

Added the following bullets to Instructions:
- 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.

Replaced Code Table:

Code	Definition
(blank)	Not recorded
pX	pNX
c0	cN0
p0	pN0
p0I-	pN0i-
p0I+	pN0i+
p0M-	pN0m-
p0M+	pN0m+
p1MI	pN1mi

Code	Definition
p0A	pN0a
p0B	pN0b
p1	pN1
p1A	pNla
p1B	pN1b
p1C	pN1c
p2	pN2
p2A	pN2a
p2B	pN2b

Code	Definition
p2C	pN2c
p3	pN3
p3A	pN3a
p3B	pN3b
p3C	pN3c
p4	pN4
88	Not applicable

Pathologic M (NAACCR #900)
01/01/2016
Revised rationale:
The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2015 the CoC requires that AJCC pathologic TNM staging be recorded in its accredited cancer program cancer registries. 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 the AJCC T, N, and M data items [940, 950, 960, 880, 890, and 900]. 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 and will be expanded with the implementation of the AJCC 8th Edition Manual.

Revised 3rd bullet under Instructions:
- 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.

Added the following bullets to Instructions:
- 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.

Replaced Code Table:

Code	Definition
(blank)	Not recorded
c0	cM0
c0I+	cM0(i+)
p1	pM1
p1A	pM1a
p1B	pM1b

Code	Definition
p1C	pM1c
p1D	pM1d
p1E	pM1e
c1	cM1
c1A	cM1a
c1B	cM1b

Code	Definition
c1C	cM1c
c1D	cM1d
c1E	cM1e
88	Not applicable

Pathologic Stage Group (NAACCR #910)
01/01/2016
Revised Rationale
The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2015 the CoC requires that AJCC pathologic TNM staging be recorded in its accredited cancer program cancer registries. 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.

Added the following bullets to Instructions:

- 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.

Pathologic Stage (Prefix/Suffix) Descriptor (NAACCR #920)
01/01/2016
Revised 2nd bullet under Instructions:

- 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(s).

Added the following bullet to Instructions:

- If the tumor is not staged using AJCC rules, leave this data item blank.

Staged By (Pathologic Stage) (NAACCR #930)
01/01/2016
Added expanded version of data item to FORDS

SEER Summary Stage 2000 (NAACCR #759)
01/01/2016
Added data item to FORDS

CS Tumor Size (NAACCR #2800)
CS Extension (NAACCR #2810)
CS Tumor Size/Ext Eval (NAACCR #2820)
CS Lymph Nodes (NAACCR #2830)
CS Lymph Nodes Eval (NAACCR #2840)
CS Mets at Dx (NAACCR #2850)
CS Mets at Dx - Bone (NAACCR #2851)
CS Mets at Dx - Brain (NAACCR #2852)
CS Mets at Dx - Liver (NAACCR #2853)
CS Mets at Dx - Lung (NAACCR #2854)
CS Mets Eval (NAACCR #2860)
01/01/2016
Added the following to Rationale:
Effective for cases diagnosed January 1, 2016 and later, this data item is no longer required by CoC for accredited cancer program cancer registries.

CS Site-Specific Factor 1-24 (NAACCR #2880-2878)
01/01/2016
Revised 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 prognostic factors of clinical significance, and for research purposes. This data item is required by CoC for accredited cancer program cancer registries on a sites-specific basis for cases diagnosed January 1, 2016 and later.

CS Site-Specific Factor 25 (NAACCR #2879)
01/01/2016
Revised Rationale:
CS Site-Specific Factor25 is used to discriminate between CS staging schema (for cases 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 as shown below.

Derived AJCC-6 T (NAACCR #2940)
Derived AJCC-6 T Descript (NAACCR #2950)
Derived AJCC-6 N (NAACCR #2960)
Derived AJCC-6 N Descript (NAACCR #2970)
Derived AJCC-6 M (NAACCR #2980)
Derived AJCC-6 M Descript (NAACCR #2990)
Derived AJCC-6 Stage Group (NAACCR #3000)
Derived AJCC-7 T (NAACCR #3400)
Derived AJCC-7 T Descript (NAACCR #3402)
Derived AJCC-7 N (NAACCR #3410)
Derived AJCC-7 N Descript (NAACCR #3412)
Derived AJCC-7 M (NAACCR #3420)
Derived AJCC-7 M Descript (NAACCR #3422)
Derived AJCC-7 Stage Group (NAACCR #3430)
Derived SS1977 (NAACCR #3010)
Derived SS2000 (NAACCR #3020)
01/01/2016
Added following sentence to Rationale:
Effective for cases diagnosed January 1, 2016 and later this data item is no longer required by CoC for accredited cancer program cancer registries, and should no longer be derived and recorded in the hospital registry database.

CHANGES TO *FORDS* SECTION TWO: FIRST COURSE OF TREATMENT

2010

Approach - Surgery of the Primary Site at This Facility (NAACCR Item #668)
05/01/2010

Changed term “laparoscopic” to “endoscopic” in instructions and codes.
Added new bullet: “If both robotic and endoscopic surgery were used, code to robotic (codes 1 or 2).”

Surgical Margins of the Primary Site (NAACCR Item #1320)
02/01/2010

Changed list of lymphoma histologies to be coded 9 when sited to lymph nodes to “9590-9726, 9728-9732, 9734-9740, 9750-9762, 9811-9831, 9940, 9948 and 9971.”
Changed list of hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease histologies that are coded 9 to “9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992.”

Scope of Regional Lymph Node Surgery (NAACCR Item #1292)

02/01/2010

Changed list of lymphoma histologies to be coded 9 when sited to lymph nodes to "9590-9726, 9728-9732, 9734-9740, 9750-9762, 9811-9831, 9940, 9948 and 9971."
Changed list of hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease histologies that are coded 9 to "9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992."

Scope of Regional Lymph Node Surgery at This Facility (NAACCR Item #672)
02/01/2010

Changed list of lymphoma histologies to be coded 9 when sited to lymph nodes to "9590-9726, 9728-9732, 9734-9740, 9750-9762, 9811-9831, 9940, 9948 and 9971."
Changed list of hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease histologies that are coded 9 to "9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992."

Surgical Procedure/Other Site (NAACCR Item #1294)
02/01/2010

Changed list of hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease histologies that are coded 1 if treated surgically to "9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992."

Surgical Procedure/Other Site at This Facility (NAACCR Item #674)
02/01/2010

Changed list of hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease histologies that are coded 1 if treated surgically to "9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992."

Number of Treatments to this Volume (NAACCR Item #1520)
05/01/2010

Changed code range for number of treatments to 001-998 (from 091-998).
Changed examples to 3-digit codes (from 2).

Rx Date Rad Ended Flag (NAACCR Item #3221)
02/01/2010

Modified fourth bullet to read "Code 11 if no radiation is planned or given, or if it is not yet completed."
Modified definition of code 11 to read "No proper value is applicable in this context (for example, radiation has not been completed)."
03/01/2010

Above changes were incorrect (NCDB apologizes).
Modified fourth bullet by removing "if it is not yet completed"
Modified definition of code 11 to read "No proper value is applicable in this context (for example, no radiation was administered)."

2011

RX Summ -- Treatment Status (NAACCR Item #1285)
01/01/2011

Added instruction: Use code 0 when treatment is refused or the physician decides not to treat for any reason such as the presence of comorbidities.

Approach - Surgery of the Primary Site at This Facility (NAACCR Item #668)
01/01/2011

Changed term “endoscopic” to “endoscopic or laparoscopic” in instructions and codes.

Radiation Treatment Volume (NAACCR Item #1540)
01/01/2011

Added bullet: If two discrete volumes are treated and one of those includes the primary site, record the treatment to the primary site.
Added example for TBI (total body irradiation).

Regional Treatment Modality (NAACCR Item #1570)
01/01/2011

Added examples for PUVA and I-125

Number of Treatments to This Volume (NAACCR Item #1520)
01/01/2011

Added example for Mammosite®

Radiation/Surgery Sequence (NAACCR Item #1380)
01/01/2011

Clarified that at least two courses of radiation must be given to assign code 4.

Systemic/Surgery Sequence (NAACCR Item #1639)
01/01/2011

Clarified that at least two courses of systemic therapy must be given to assign code 4.

Other Treatment (NAACCR Item #1420)
01/01/2011

Added instruction: Code 1 for PUVA (psoralen and long-wave ultraviolet radiation)

2012

Date 1st Crs Fx Flag
01/01/2012

Clarified definition of code 11: “No proper value is applicable in this context (that is, no treatment was given or autopsy only)”.

Surgical Procedure of Primary Site
01/01/2012

Added sentence to seventh bullet: “Do not rely on registry software to perform this task for you.”

Surgical Procedure of Primary Site at This Facility
01/01/2012

Added sentence to seventh bullet: “Do not rely on registry software to perform this task for you.”

Scope of Regional Lymph Node Surgery
01/01/2012

Added bullet: “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.”

Revised code-specific instructions to capture sentinel lymph node biopsies and regional lymph node biopsies in a clinically-relevant manner based on surgical notes.

Scope of Regional Lymph Node Surgery at This Facility
01/01/2012

Added bullet: "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."

Revised code-specific instructions to capture sentinel lymph node biopsies and regional lymph node biopsies in a clinically-relevant manner based on surgical notes.

04/09/2012

Corrected and clarified examples for codes 0, 2 and 9.

Surgical Procedure/Other Site
01/01/2012

Added bullet: "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."

Surgical Procedure/Other Site at This Facility
01/01/2012

Added bullet: "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."

Corrected item name and NAACCR number in the last bullet: "*Palliative Care at This Facility* (NAACCR Item #3280)".

Reason for No Surgery of Primary Site
01/01/2012

Added NAACCR item number (1340).

Radiation/Surgery Sequence
01/01/2012

Added bullet: "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".

Definition of code 4 clarified: "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)."

Added code 7: "Surgery both before and after radiation", defined as "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)".

Location of Radiation Treatment
01/01/2012

Added sentence: "In this context, 'regional' is used to distinguish from 'boost'; it does not refer to 'regional' as used to identify stage or disease spread."

Radiation Treatment Volume
01/01/2012

Deleted the word "regional" from description.

Added "whole-body" to first example for code 33.

Number of Treatments to This Volume
01/01/2012

Added example of prostate primary treated with a single administration of seeds.

Date Radiation Ended
01/01/2012

Corrected item name in final sentence: "*RX Date–Rad Ended Flag*."

Rx Date Systemic Flag
01/01/2012

Corrected NAACCR item number in final sentence (3231).

Chemotherapy at This Facility
01/01/2102

Corrected item name and number in last bullet: "*Palliative Care at This Facility* (NAACCR Item #3280)."

Date Hormone Therapy Started
01/01/2012

Corrected NAACCR item number (1230).

Corrected NAACCR item number for Hormone Therapy (1400) in first bullet.

Hematologic Transplant and Endocrine Procedures
01/01/2012

Added bullet: "Use 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."

Systemic/Surgery Sequence
01/01/2012

Added bullet: "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".

Definition of code 4 clarified: "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."

Added code 7: "Systemic therapy both before and after radiation", defined as "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)".

Other Treatment
01/01/2012

Added "certain" to the following sentence in the first bullet: "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."

Added the following sentence to the first bullet: "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."

Other Treatment at This Facility
01/01/2012

Corrected item name and NAACCR item number in sixth bullet: "*Palliative Care at This Facility* (NAACCR Item #3280)."

Added "certain" to the following sentence in the first bullet: "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."

Added the following sentence to the first bullet: "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."

2013

Approach-Surgery of the Primary Site at This Facility
01/01/2013

Changed wording of 3rd bullet to read "For ablation procedures, assign code 3". Formerly, specified ablation of skin tumors.

Surgical Margins of the Primary Site
01/01/2013

Added wording to the 5th bullet so it reads "code 9 if the pathology report makes no mention of margins or no tissue was sent to pathology."

Scope of Regional Lymph Node Surgery
01/01/2013

Corrected site code reference in second example (previous omitted the "C" for "C50.1".

Surgical Procedure/Other Site
01/01/2013

Reversed sequence of first two bullets.

Reason for No Surgery of Primary Site
01/01/2013

Second bullet: Added wording to the 2nd bullet so it now reads "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."

Moved "diagnosed at autopsy" from code 9 to code 1.

Reason for No Radiation
01/01/2013

Added modifier "alternative treatment" to "options" in the 2nd and 7th bullets.

Moved "diagnosed at autopsy" from code 9 to code 1.

Chemotherapy

01/01/2013

Second bullet: Added wording to the 2nd bullet so it now reads "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."

Chemotherapy at This Facility

01/01/2013

Third bullet: Added wording to the 3rd bullet so it now reads "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."

Hormone Therapy

01/01/2013

Fifth bullet: Added wording to the 5th bullet so it now reads "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."

Hormone Therapy at This Facility

01/01/2013

Sixth bullet: Added wording to the 6th bullet so it now reads "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."

Immunotherapy

01/01/2013

Second bullet: Added wording to the 2nd bullet so it now reads "Code00 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."

Immunotherapy at This Facility

01/01/2013

Third bullet: Added wording to the 2nd bullet so it now reads "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."

Hematologic Transplant and Endocrine Procedures

01/01/2013

Fifth bullet: Added wording to the 2nd bullet so it now reads "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."

2015

Date 1st Crs Rx Flag (NAACCR Item #1271)

01/01/2015

Added "at all" to instruction: Code 12 if the *Date of First Course of Treatment* can not be determined at all, but the patient did receive first course treatment.

New instruction: Code 12 if a decision not to treat was made, but the date is totally unknown.

New instruction: Code 12 if a decision to use active surveillance was made, but the date is totally unknown.

Removed "no treatment was given or" for definition of code 11.

Surgical Procedure of Primary Site (NAACCR #1290)
Surgical Procedure of Primary Site at This Facility (NAACCR # 670)
01/01/2015

Added clarifying instruction: If a needle biopsy preceded an excisional biopsy or more extensive surgery, even if no tumor remained at the time of surgery, both the needle biopsy (*Surgical Diagnostic and Staging Procedure*) and the *Surgical Procedure of the Primary Site* are to be reported. Surg;ical margins must be examined to determine whether a biopsy intended as incisional is excisional instead, and margins cannot be evaluated for a needle biopsy.

Approach—Surgery of the Primary Site at This Facility (NAACCR Item #668)
01/01/2015

Revised instructions and code definitions to emphasize "minimally invasive" terminology.

Scope of Regional Lymph Node Surgery (NAACCR Item #1292)
01/01/2015

Corrected typo in definition of code 1: 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.

Radiation Treatment Volume (NAACCR Item #1540)
01/01/2015

Corrected grammar in definition of code 08: 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.

Regional TreatmentModality (NAACCR Item #1570)
01/01/2015

Added advisory bullet: Note: do not confuse a radioiodine *scan* with treatment. Only treatment is recorded in this item.

Regional Dose: cGy (NAACCR Item #1510)
Boost Dose: cGy (NAACCR Item #3210)
01/01/2015

Added instruction: 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).

Chemotherapy (NAACCR Item #1390)
Chemotherapy at This Facility (NAACCR Item #700)
Immunotherapy (NAACCR Item #1410)
Immunotherapy at This Facility (NAACCR Item #720)
01/01/2015

Added information about six drugs that changed category in 2013 from Chemotherapy to BRM/Immunotherapy.

Other Treatment at This Facility (NAACCR Item # 730)
01/01/2015

Added instruction: Code 1 for PUVA (psoralen and long-wave ultraviolet radiation)

Rx Date—Other Flag (NAACCR Item #1251)
01/01/2015
Added code 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.

2016

Surgical Procedure of Primary Site (NAACCR #1290)
Surgical Procedure of Primary Site at This Facility (NAACCR # 670)
01/01/2016
Revised 6th bullet under Instructions:
- 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 as such in the *Surgical Diagnostic and Staging Procedure* (NAACCR Item #1350) data item and the excisional biopsy or more extensive surgery in the *Surgical Procedure of the Primary Site* data item (NAACCR Item #1290).

Regional Dose: cGy (NAACCR #1510)
Boost Dose: cGy (NAACCR #3210)
01/01/2016
Revised 3rd bullet under Instructions (revised "photon" to "proton"):
- 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).

Chemotherapy (NAACCR #1390)
Chemotherapy at this Facility (NAACCR #700)
01/01/2016
Added bullet under Instructions:
- 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.

CHANGES TO *FORDS* SECTION TWO: OUTCOMES

2011

Following Registry
01/01/2011
Item deleted from **FORDS.**

2012

Date of First Recurrence
01/01/2012
Deleted second bullet.

2013

Type of First Recurrence
01/01/2013
Added to ninth bullet: "If one of these is controlled by drugs (for example, Gleevec for CML), the patient is in remission"

2015

Type of First Recurrence (NAACCR Item #1880)
01/01/2015

Clarified bullet: Codes 00 through 70 are hierarchical; record the highest-numbered applicable response, with the following limits.. The first time a patient converts from disease status (70) to disease-free, change the code to 00. Then the first time a patient converts from 00 to a recurrence, then record the proper code for the recurrence. No further changes (other than corrections) should be made.

Date of Last Contact or Death (NAACCR #1750)
Vital Status (NAACCR Item #1760)
01/01/2015

Added bullet: 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.

CHANGES TO *FORDS* SECTION TWO: CASE ADMINISTRATION

2010

Override Hospseq/Site (NAACCR Item #1988)
02/01/2010

Changed the wording of the second bullet to read "Lymph node primary sites (C77.0-C77.9) for histologies other than lymphomas, or hematopoietic primary sites (C42.0-C42.4) for histologies not in range for hematopoietic diseases. (That combination is most likely a metastatic lesion. Check whether the lesion could be a manifestation of one of the patient's other cancers.)"

2011

Morphology Coding System Original (NAACCR Item #480)
01/01/2011

Corrected instruction: For cases diagnosed on or after January 1, 2010, this data item must be coded 8. [Formerly, it said 2000].

2012

Facility Identification Number (FIN)
01/01/2012

Added bullet: "Facilities that are part of an Integrated Network Cancer Program (INCP) must use the hospital-specific FIN in their data for submission to the National Cancer Data Base."

Added bullet: "Facilities that merge are legally a single hospital. Consult NCDB for instructions for recording the FIN for newly-merged programs."

NPI-Reporting Facility
01/01/2012

Added bullet: "Facilities that are part of an Integrated Network Cancer Program (INCP) must use the hospital-specific NPI number in their data for submission to the National Cancer Data Base."

Added bullet: "Facilities that merge are legally a single hospital. Use the NPI number for the merged hospital."

Archive FIN
01/01/2012

Added bullet: "Facilities that are part of an Integrated Network Cancer Program (INCP) *must* use the hospital-specific FIN for the Archive FIN in their data for submission to the National Cancer Data Base."

Added bullet: "Programs that are not part of a merged facility or an INCP will use their hospital's FIN as the Archive FIN."

NPI-Archive FIN
01/01/2012

Added bullet: "Facilities that are part of an Integrated Network Cancer Program (INCP) must use the hospital-specific NPI number for the NPI-Archive FIN in their data for submission to the National Cancer Data Base."

Date Case Completed-CoC
01/01/2012

For Class of Case 00, the items that must be completed were reworded to "NPI number for the facility the patient was referred to OR a treating physician".

For Class of Case 20-22, the items that must be completed were reworded to "NPI number for the facility the patient was referred to or from OR the physician who diagnosed or treated the patient".

Override Site/TNM Stage Group
01/01/2012

Under "EDITS Use", changed reference to AJCC Staging Manual to specify the "applicable" version.

ICD Revision Comorbidities and Complications
01/01/2012

Changed "Rationale" to read "This item is necessary to interpret the meaning of particular codes for *Comorbidities and Complications* (secondary diagnoses); there is some overlap between specific codes."

Added "-CM" to edition labels in the "Definitions".

ICD-O-2 Conversion Flag
01/01/2012

Corrected Allowable Codes to 0-6 or blank

ICD Revision Cormorbidities and Complications
01/01/2012

Revised Rationale: "This item is necessary to interpret the meaning of particular codes for *Comorbidities and Complications* (secondary diagnoses); there is some overlap between specific codes".

Corrected labels for codes to specify that they indicate ICD-9-**CM** and ICD-10-**CM**.

2013

ICD Revision Secondary Diagnosis
01/01/2013

Changed name from *ICD Revision Comorbidities and Complications*

Expanded instructions to handle movement from use of ICD-9-CM *Comorbidities and Complications* to ICD-10-CM *Secondary Diagnoses*. CMS requires implementation of ICD-10-CM during 2014, but some programs are testing the system before that.

Over-ride CS 1-19
01/01/2013

New items. These 19 items were introduced for the Collaborative Stage Data Coding System (CS) for use with rare but not impossible code combinations if they fail an edit. Definitions will be provided as edits are released that use them. (Over-ride CS 20 is defined but not to be used by CoC accredited programs).

2016

Derived AJCC–Flag (NAACCR #3030)
Derived SS1977–Flag (NAACCR #3040)
Derived SS2000–Flag (NAACCR #3050)
CS Version Derived (NAACCR #2936)
01/01/2016
Added following sentence to Rationale:
Effective for cases diagnosed January 1, 2016 and later this data item is no longer required by CoC for accredited cancer program cancer registries, and should no longer be derived and recorded in the hospital registry database.

CHANGES TO *FORDS*: APPENDIX B

2010

Section cover page
02/01/2010

Added the following note: "The February 2010 updates changed the histologies that apply to these site-specific surgery codes. Those changes apply only to cases diagnosed in 2010 or later. Please consult *FORDS: Revised for 2009* for applicable histologies for cases diagnosed prior to that date".

Rectum
05/01/2010

Corrected notation to indicate that codes 20-80 (rather than 20-28) send material to pathology.

Lung
02/01/2010

Corrected notation to indicate that codes 20-80 (rather than 20-25) send material to pathology.

Breast
05/01/2010

Changed explanatory note for code 30 to read: "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."

Corrected indentation of subcodes under codes 40, 50 and 60.

Hematopoietic/Reticuloendothelial/Immunoproliferative/Myeloproliferative Disease
02/01/2010

Changed list of included histologies to "9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992."

Every site other than Hematopoietic/Reticuloendothelial/Immunoproliferative/Myeloproliferative Disease
02/01/2010

Changed list of excluded histologies to "9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992."

2011

Liver and Intrahepatic Bile Ducts
01/01/2011

Reworded description of code 66: Excision of an intrahepatic bile duct PLUS partial hepatectomy
Reworded description of code 75: Extrahepatic bile duct and hepatectomy WITH transplant

Breast
01/01/2011

Added phrase to mastectomy description: 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.

Added new code 76: Bilateral mastectomy for a single tumor involving both breasts, as for bilateral inflammatory carcinoma.

Added "41 or" to this sentence about contralateral primaries: The surgical procedure is coded 41 or 51 for the first primary.

Prostate

01/01/2011

Clarified code 19: Transurethral resection (TURP), NOS, and no specimen sent to pathology or unknown if sent
Clarified code 21: Transurethral resection (TURP), NOS, with specimen sent to pathology

2012

Bladder

01/01/2012

Added note to code 16: "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 in the immunotherapy items."

Please note: Changes made in 2010 to the bladder instructions were omitted in Appendix C at that time, and were noted only in the *Preface*. These changes provided instructions for coding pelvic exenteration differentially based on the sex of the patient.

Code 71 note reads: "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)." A companion note for codes 60-64 reads: "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)."

Code 72 note reads: "For females, also includes removal of vagina, rectum and anus. For males, also includes prostate, rectum and anus."

Code 73 note reads: "Includes all tissue and organs removed for an anterior and posterior exenteration."

Code 74 note reads: "Includes pelvic blood vessels or bony pelvis."

2013

Breast
01/01/2013

Deleted sentence from instruction after code 63: "If only sentinel lymph nodes are removed, the procedure should be coded as a simple mastectomy." The purpose is to avoid possible conflict with the instructions for coding Scope of Regional Lymph Node Surgery.

Removed irrelevant "41 or" from second instruction following code 63.

2015

Skin
01/01/2015

Modified explanation about margins (codes 45-47): If the excision does not have microscopically clinically negative margins during surgery greater than 1 cm, use the appropriate code, 20–36.

2016

All Sites
Revised Histology Exceptions to reflect 2015 Heme conversion
Skin
01/01/2016

Revised explanation about margins (codes 45-47) for further clarification:
If the excision or reexcision 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.

CHANGES TO *FORDS*: APPENDIX D

2011
The "referred to" and "referred from" sections of the table were modified as follows:

Referred To Class of Case 00 [Must have a facility or at least one Physician]	NPI-Inst Referred To	2425
	NPI-Primary Surgeon	2485
	NPI-Physician #3	2495
	NPI-Physician #4	2505
Referred From	NPI-Inst Referred From	2415

Class of Case 20-22 [Must have a facility or at least one Physician]	NPI-Primary Surgeon	2485
	NPI-Physician #3	2495
	NPI-Physician #4	2505

2012

The final section of the table was modified such that all cases that received first course care "elsewhere" have at least one entry for the NPI of the facility or physician elsewhere. *Class of Case* 11 through 13 are affected in this modification. Also, *NPI-Inst Referred To* and *NPI-Managing Physician* were added to the list of equivalent options for representing that information.

Referred To or From Class of Case 11-13, 20-22 [Must have at least one facility or at least one Physician]	NPI-Inst Referred From	2415
	NPI-Inst Referred To	2425
	NPI-Managing Physician (if that person diagnosed the patient and the other options do not apply)	2465
	NPI-Primary Surgeon	2485
	NPI-Physician #3	2495
	NPI-Physician #4	2505

2013

The following items for Diagnostic information are required only for cases diagnosed in 2010-2012: Ambiguous Terminology, Date Conclusive DX, Date Conclusive DX Flag, Mult Tum Rpt as One Prim, Date of Multiple Tumors, Date of Mult Tumors Flag, and Multiplicity Counter.

2015

Deleted from the table:
- ICD Revision Comorbidities and Complications
- Birth Place
- Date of Diagnosis Flag
- Grade Path Value
- Grade Path System
- Ambiguous Terminology DX
- Date of Conclusive DX
- Date Conclusive DX Flag
- Mult Tum Rpt as One Prim
- Date of Multiple Tumors
- Date of Mult Tumors Flag
- Multiplicity Counter

Added to the table:
- Addr at DX—Country
- Secondary Diagnosis #1-10
- Address Current – Country
- Birthplace—State
- Birthplace--Country

Changed explanation for "Referred To": Class of Case 00 [Must have a facility **OR** at least one Physician]
Changed explanation for "Referred To or From: Class of Case 11-13, 20-22 [Must have at least one facility **OR** at least one Physician]

CHANGES TO *FORDS*: APPENDIX E

2013

New Appendix. Tables of state and country for coding the following items: Birthplace-State, Birthplace-Country, Address at DX-State, Address at DX-Country, Address Current-State, Address Current-Country. Three tables are included for Preferred (detailed) codes, General codes (when no preferred code applies), and Obsolete codes (codes that may have been generated in conversion, not to be used for cases coded beginning in 2013).

2015

The country codes for Czechoslovakia and Yugoslavia were changed from XCZ and XYG, respectively, to CSK and YUG, and moved from Obsolete to General codes. These codes were updated in historic data by the conversion to NAACCR v15 layout and codes.

2016

Country and State label and code revisions:
01/01/2016
Brunei Darussalam, BND, XX to Brunei, BRN, XX
Central America, ZZC, XX to Central America, ZZC, YY
Czechoslovakia, CSK, XX to Czechoslovakia, CSK, YY
Yugoslavia, YUG, XX to Yugoslavia, YUG, YY
St. Martin, MAF, XX added
Congo, COG, XX added
Slovakia, SWK, XX to Slovakia, SVK, XX
Vanuatu, VLT, XX to Vanuatu, VUT, XX
Palestine Territory, Occupied, PSE, XX to Palestine, PSE, XX
Zaire (Congo-Leopoldville, Belgian Congo, Congo/Kinshasa), COD, XX to
Congo, Democratic Republic of, COD, XX
Indonesia (Dutch East Indies), IDN, XX to Indonesia, IDN, XX
Northern Ireland (Ulster), NIR, XX to Northern Ireland, NIR, XX
Palau (Trust Territory of Pacific Islands), PLW, PW to Palau, PLW, PW
Tokelau Islands (New Zealand), TKL, XX TO Tokelau, TKL, XX

APPENDIX D:

FORDS Items Required to Be Complete to Enter *Date Case Completed – CoC* for Cases Diagnosed in 2016

See *Date Case Completed–CoC* (NAACCR Item #2092) for instructions.

Category	FORDS Items	NAACCR Item #
Identification Class of Case 00-22	Addr at DX–City	70
	Addr at DX–State	80
	Addr at DX–Postal Code	100
	County at DX	90
	Addr at DX--Country	102
	Date of 1st Contact	580
	Date of 1st Contact Flag	581
	Class of Case	610
	Primary Payer at DX	630
	NPI Archive FIN	3105
	Archive FIN	3100
	Accession Number	500
	Sequence Number	560
	Abstracted By	570
	Comorbidities and Complications #1	3110
	Comorbidities and Complications #2	3120
	Comorbidities and Complications #3	3130
	Comorbidities and Complications #4	3140
	Comorbidities and Complications #5	3150
	Comorbidities and Complications #6	3160
	Comorbidities and Complications #7	3161
	Comorbidities and Complications #8	3162
	Comorbidities and Complications #9	3163
	Comorbidities and Complications #10	3164
	Secondary Diagnosis #1	3780
	Secondary Diagnosis #2	3782
	Secondary Diagnosis #3	3784
	Secondary Diagnosis #4	3786
	Secondary Diagnosis #5	3788
	Secondary Diagnosis #6	3790
	Secondary Diagnosis #7	3792
	Secondary Diagnosis #8	3794
	Secondary Diagnosis #9	3796
	Secondary Diagnosis #10	3798
	Override Acsn/Class/Seq	1985
	CoC Coding System - Current	2140
	CoC Coding System - Original	2150
	Vendor Name	2170
	ICD-O-3 Conversion Flag	2116
	Date of Last Contact or Death	1750
	Date of Last Contact Flag	1751
	City/Town – Current	1810
	State – Current	1820
	Postal Code – Current	1830
	Address Current--Country	1832
	Last Name	2230
	First Name	2240
	Middle Name	2250

	Medical Record Number	2300
	Social Security Number	2320
	Patient Address (Number and Street) at Diagnosis	2330
	Patient Address at Diagnosis – Supplemental	2335
	Patient Address (Number and Street) – Current	2350
	Patient Address–Current - Supplemental	2335
	Telephone	2360
Demographic Class of Case 00-22	Race 1	160
	Race 2	161
	Race 3	162
	Race 4	163
	Race 5	164
	Spanish/Hispanic Origin	190
	Sex	220
	Age at Diagnosis	230
	Date of Birth	240
	Date of Birth Flag	241
	Birthplace--State	252
	Birthplace--Country	254
	Race Coding System – Current	170
	Race Coding System – Original	180
Diagnostic Class of Case 00-22	Date of Diagnosis	390
	Primary Site	400
	Laterality	410
	Histologic Type ICD-O-3	522
	Behavior Code ICD-O-3	523
	Grade	440
	Diagnostic Confirmation	490
	Sequence Number - Hosp	560
	RX Hosp–DX/Stg Proc	740
	Regional Nodes Positive	820
	Regional Nodes Examined	830
	Site Coding System – Current	450
	Site Coding System – Original	460
	Morph Coding System – Current	470
	Morph Coding System – Original	480
	Override HospSeq/DxConf	1986
	Override CoC Site/Type	1987
	Override HospSeq/Site	1988
	Override Site/TNM-StgGrp	1989
	Override Age/Site/Morph	1990
	Override SeqNo/DxConf	2000
	Override Site/Lat/SeqNo	2010
	Override Surg/DxConf	2020
	Override Site/Type	2030
	Override Histology	2040
	Override Leuk, Lymphoma	2070
	Override Site/Behavior	2071
	Override Site/Lat/Morph	2074
Staging Class of Case 10-22	TNM Edition Number	1060
	TNM Path T	880
	TNM Path N	890

	TNM Path M	900
	TNM Path Stage Group	910
	TNM Path Descriptor	920
	TNM Path Staged By	930
	TNM Clin T	940
	TNM Clin N	950
	TNM Clin M	960
	TNM Clin Stage Group	970
	TNM Clin Descriptor	980
	TNM Clin Staged By	990
	Lymph-vascular Invasion	1182
	CS Tumor Size	2800
	CS Extension	2810
	CS Tumor Size/Ext Eval	2820
	CS Lymph Nodes	2830
	CS Lymph Nodes Eval	2840
	CS Mets at DX	2850
	CS Mets Eval	2860
	CS Mets at Dx-Bone	2851
	CS Mets at Dx-Brain	2852
	CS Mets at Dx-Liver	2853
	CS Mets at Dx-Lung	2854
	Site-Specific Factors 1-25 – if required for case	
	Derived SS1977	3010
	Derived SS2000	3020
	Derived AJCC–Flag	3030
	Derived SS1977–Flag	3040
	Derived SS2000–Flag	3050
	CS Version Input Current	2937
	CS Version Original	2935
	CS Version Derived	2936
	Derived AJCC 6 T	2940
	Derived AJCC 6 T Descript	2950
	Derived AJCC 6 N	2960
	Derived AJCC 6 N Descript	2970
	Derived AJCC 6 M	2980
	Derived AJCC 6 M Descript	2990
	Derived AJCC 6 Stage Grp	3000
	Derived AJCC 7 T	3400
	Derived AJCC 7 T Descript	3402
	Derived AJCC 7 N	3410
	Derived AJCC 7 N Descript	3412
	Derived AJCC 7 M	3420
	Derived AJCC 7 M Descript	3422
	Derived AJCC 7 Stage Grp	3430
Hospital-Specific Treatment Class of Case 10-22	RX Hosp–Surg App 2010	668
	Surgical Procedure of Primary Site at This Facility	670
	Scope of Regional Lymph Node Surgery at This Facility	672
	Surgical Procedure / Other Site at This Facility	674
	Chemotherapy at This Facility	700
	Hormone Therapy at This Facility	710
	Immunotherapy at This Facility	720
	Other Treatment at This Facility	730

	Palliative Care at This Facility	3280
	Date of First Course of Treatment	1270
	Date of 1st Crs Flag	1271
	Date of First Surgical Procedure	1200
	RX Date–Surgery Flag	1201
	Date of the Most Definitive Resection of the Primary Site	3170
	RX Date–Mst Defin Srg Flag	3171
	Date of Surgical Discharge	3180
	RX Date–Surg Disch Flag	3181
	Date Radiation Started	1210
	RX Date–Radiation Flag	1211
	Date Radiation Ended	3220
	RX Date–Rad Ended Flag	3221
	Date Systemic Therapy Started	3230
	Date Chemotherapy Started	1220
	RX Date–Chemo Flag	1221
	Date Hormone Therapy Started	1230
	RX Date–Hormone Flag	1231
	Date Immunotherapy Started	1240
	RX Date–BRM Flag	1241
	Date Other Treatment Started	1250
	RX Date–Other Flag	1251
	RX Summ–Treatment Status	1285
	NPI- Managing Physician	2465
	NPI-Following Physician	2475
	NPI-Primary Surgeon	2485
	NPI-Physician #3	2495
	NPI-Physician #4	2505
Summary Treatment Class of Case 10, 12, 14, 20, 22	Surgical Procedure of Primary Site	1290
	Scope of Regional Lymph Node Surgery	1292
	Surgical Procedure / Other Site	1294
	Surgical Margins of the Primary Site	1320
	Reason for No Surgery of Primary Site	1340
	Surgical Diagnostic and Staging Procedure	1350
	Palliative Care	3270
	Radiation / Surgery Sequence	1380
	Hematological Transplant and Endocrine Procedures	3250
	Chemotherapy	1390
	Hormone Therapy	1400
	Immunotherapy	1410
	Other Treatment	1420
	Reason for No Radiation	1430
	Rx Coding System–Current	1460
	Regional Dose: cGy	1510
	Number of Treatments to This Volume	1520
	Radiation Treatment Volume	1540
	Location of Radiation Treatment	1550
	Regional Treatment Modality	1570
	Boost Treatment Modality	3200
	Boost Dose: cGy	3210
	Systemic / Surgery Sequence	1639
Referred To Class of Case 00	NPI-Inst Referred To	2425
	NPI-Primary Surgeon	2485

[Must have a facility OR at least one Physician]	NPI-Physician #3	2495
	NPI-Physician #4	2505
Referred To or From Class of Case 11-13, 20-22 [Must have at least one facility OR at least one Physician]	NPI-Inst Referred From	2415
	NPI-Inst Referred To	2425
	NPI-Managing Physician (if that person diagnosed the patient and the other options do not apply)	2465
	NPI-Primary Surgeon	2485
	NPI-Physician #3	2495
	NPI-Physician #4	2505

(Revised 01/12, 01/14, 01/15)

APPENDIX E:
Country and State Codes

Geographic Area	Country Code	State or Province Code
Preferred: Specific Codes for Use Where the 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

Geographic Area	Country Code	State or Province Code
Preferred: Specific Codes for Use Where the Detail is Known		
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
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

Geographic Area	Country Code	State or Province Code
Preferred: Specific Codes for Use Where the Detail is Known		
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
Virgin Islands, British	VGB	XX
Brunei	BRN	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
Congo, Democratic Republic of	COD	XX
Cook Islands	COK	XX
Costa Rica	CRI	XX

Geographic Area	Country Code	State or Province Code
Preferred: Specific Codes for Use Where the Detail is Known		
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
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

Geographic Area	Country Code	State or Province Code
Preferred: Specific Codes for Use Where the Detail is Known		
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
Mariana Islands (Trust Territory of Pacific Islands)	MNP	MP
Marshall Islands (Trust Territory Pacific Islands)	MHL	MH
Martinique	MTQ	XX
Mauritania	MRT	XX

Geographic Area	Country Code	State or Province Code
Preferred: Specific Codes for Use Where the Detail is Known		
Mauritius	MUS	XX
Mayotte	MYT	XX
Mexico	MEX	XX
Micronesia (Fed States of) (Caroline, Trust Terr 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	NIR	XX
Norway (Svalbard, Jan Mayen)	NOR	XX
Oman	OMN	XX
Pakistan (West Pakistan)	PAK	XX
Palau	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

Geographic Area	Country Code	State or Province Code
Preferred: Specific Codes for Use Where the Detail is Known		
Réunion	REU	XX
Romania	ROU	XX
Russian SFSR (Russia)	RUS	XX
Rwanda (Ruanda)	RWA	XX
Ryukyu Islands (Japan)	JPN	XX
Samoa	ASM	XX
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	SVK	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. Martin	MAF	XX
St. Vincent and the Grenadines	VCT	XX
Sudan	SDN	XX
Suriname (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

Geographic Area	Country Code	State or Province Code
Preferred: Specific Codes for Use Where the Detail is Known		
Timor-Leste	TLS	XX
Togo	TGO	XX
Tokelau	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	VUT	XX
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
Zambia (Northern Rhodesia)	ZMB	XX
Zimbabwe (Rhodesia, Southern Rhodesia)	ZWE	XX

Geographic Area	Country Code	State or Province Code
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	YY
Czechoslovakia	CSK	YY
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	YY
Not U.S., but no other information	ZZX	YY
Unknown, no mention in patient record	ZZU	ZZ

Geographic Area	Country Code	State or Province Code
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
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
Sudanese Countries	XSD	YY
Ukraine and Moldavia	XUM	YY
West Africa, NOS (French Africa, NOS)	XWF	YY

Geographic Area	Country Code	State or Province Code
Preferred: Specific Codes for Use Where the 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

Geographic Area	Country Code	State or Province Code
Preferred: Specific Codes for Use Where the Detail is Known		
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
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

Geographic Area	Country Code	State or Province Code
Preferred: Specific Codes for Use Where the Detail is Known		
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
Virgin Islands, British	VGB	XX
Brunei	BRN	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
Congo, Democratic Republic of	COD	XX
Cook Islands	COK	XX
Costa Rica	CRI	XX

Geographic Area	Country Code	State or Province Code
Preferred: Specific Codes for Use Where the Detail is Known		
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
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

Geographic Area	Country Code	State or Province Code
Preferred: Specific Codes for Use Where the Detail is Known		
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
Mariana Islands (Trust Territory of Pacific Islands)	MNP	MP
Marshall Islands (Trust Territory Pacific Islands)	MHL	MH
Martinique	MTQ	XX
Mauritania	MRT	XX

Geographic Area	Country Code	State or Province Code
Preferred: Specific Codes for Use Where the Detail is Known		
Mauritius	MUS	XX
Mayotte	MYT	XX
Mexico	MEX	XX
Micronesia (Fed States of) (Caroline, Trust Terr 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	NIR	XX
Norway (Svalbard, Jan Mayen)	NOR	XX
Oman	OMN	XX
Pakistan (West Pakistan)	PAK	XX
Palau	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

Geographic Area	Country Code	State or Province Code
Preferred: Specific Codes for Use Where the Detail is Known		
Réunion	REU	XX
Romania	ROU	XX
Russian SFSR (Russia)	RUS	XX
Rwanda (Ruanda)	RWA	XX
Ryukyu Islands (Japan)	JPN	XX
Samoa	ASM	XX
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	SVK	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. Martin	MAF	XX
St. Vincent and the Grenadines	VCT	XX
Sudan	SDN	XX
Suriname (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

Geographic Area	Country Code	State or Province Code
Preferred: Specific Codes for Use Where the Detail is Known		
Timor-Leste	TLS	XX
Togo	TGO	XX
Tokelau	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	VUT	XX
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
Zambia (Northern Rhodesia)	ZMB	XX
Zimbabwe (Rhodesia, Southern Rhodesia)	ZWE	XX

Geographic Area	Country Code	State or Province Code
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	YY
Czechoslovakia	CSK	YY
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	YY
Not U.S., but no other information	ZZX	YY
Unknown, no mention in patient record	ZZU	ZZ

Geographic Area	Country Code	State or Province Code
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
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
Sudanese Countries	XSD	YY
Ukraine and Moldavia	XUM	YY
West Africa, NOS (French Africa, NOS)	XWF	YY

APPENDIX F:
NEW HAMPSHIRE RULES & REGULATIONS

PART He-P 304 CANCER REGISTRY RULES

He-P 304.01 Definitions.

(a) "Clinic" means a health care facility licensed by the state of New Hampshire, where a physician, nurse practitioner, or other health care professional provides cancer diagnosis and treatment or both, and that is not an operational entity of and not affiliated with a hospital. Such facilities include urology clinics, dermatology clinics, out-patient surgical centers, ambulatory oncology treatment centers, ambulatory radiation treatment centers, and physician group practices devoted to oncology.

(b) "Commissioner" means the commissioner of the department of health and human services.

(c) "Confidence interval" means an estimated range of values, which is likely to include an unknown population parameter, the estimated range being calculated from a given set of sample data.

(d) "Courier service" means a mail delivery service that provides guaranteed delivery of documents or packages by using a reliable tracking system.

(e) "Definitive report" means information or data in the format of an electronic or paper document, or report, describing a reportable cancer, including the information described in He-P 304.02(e), that is submitted to the state cancer registry (SCR) as follows:

(1) No sooner than 90 days and no later than 180 days of an initial diagnosis or treatment; or

(2) In cases where the patient has died, or is transferred to hospice care, within 90 days of death and transfer.

(f) "Department" means the New Hampshire department of health and human services.

(g) "Facility" means "facility" as defined in RSA 141-B:3, VI, namely, "a governmental or private agency, department, institution, clinic, laboratory, hospital, health maintenance organization, association, physician, or other similar unit diagnosing or providing treatment for cancer."

(h) "Medical laboratory" means a facility performing tests or analyses of human samples from patients suspected to have cancer.

(i) "Mutual agreement" means an understanding, arrangement, or stipulation which establishes the responsible reporter to the SCR as made between 2 facilities, clinics, or physicians, which can be confirmed in writing, but for which written documentation is not required.

(j) "Pathology report" means electronic or paper report(s) prepared by a pathologist providing a description of laboratory test results, and an evaluation of cells, tissues, and organs based on evidence from a sample of body tissue, which is used to diagnose and characterize disease.

(k) "Protected health information" means protected health information as defined in 45 CFR 160.103.

(l) "Rapid report" means information or data in an electronic or paper document or report, describing a reportable cancer, including the information described in He-P 304.02(d), that is submitted to the SCR within 45 days of diagnosis.

(m) "Reportable cancer" means any syndrome, condition, or disease listed in "Table 2 "NAACCR Layout Version 15: Comparison of Reportable Cancers" (Thornton ML, (ed.)) "Standards and Registry Operations/Volume II/Data Standards and Data Dictionary," Version 15, 19th ed. (Posted October 2014, Revised February 27, 2015)/Chapter III, "Standards for Tumor Inclusion and Reportability" "Table 2 NPCR

Requirements", Springfield, Ill., North American Association of Central Cancer Registries. As listed in Appendix A and available as a free electronic document at http://www.naaccr.org.

(n) "State cancer registry (SCR)" means the department or, if the department meets its statutory obligations by contract, an organization, system, or individual contracted by the department to collect, manage and store information on cases of reportable cancer pursuant to RSA 141:B:5 and RSA 141-B:10.

Source. #4055, eff 5-27-86; amd by #4869, eff 7-24-90; ss by #5601, eff 3-24-93; amd by #6075, eff 8-5-95; ss by #7406, eff 11-21-00; ss by #9046, eff 12-5-07; ss by #11054, eff 3-15-16

He-P 304.02 Reporting Requirements.

(a) In accordance with RSA 141-B:7, all facilities shall report diagnosis or treatment of a reportable cancer to the SCR in accordance with the rules specified below, and using the means described in He-P 304.02(f), (g) and (h). SCR may be contacted through http://geiselmed.dartmouth.edu/nhscr/contact.

(b) Pursuant to (a) above, all facilities shall include information and data in each report describing cancer diagnosis or treatment according to one of the following standards, as applicable:

(1) The North American Association of Central Cancer Registries (NAACCR), "Standards for Cancer Registries, Volume II/Data Standards and Data Dictionary, 19th Edition, Record Layout Version 15," (January 1, 2015) Edited by Monica Thornton, Revised (February, 27, 2015.), as listed in Appendix A and available as a free document at www.naaccr.org;

(2) The North American Association of Central Cancer Registries (NAACCR), "Standards for Cancer Registries/Volume V: "Pathology Laboratory Electronic Reporting, Version 4.0." Klein Wt., Havener L (eds.), Springfield (IL); North American Association of Central Cancer Registries, Inc., April, 2011, as listed in Appendix A and available as a free electronic document at www.naaccr.org; or

(3) The National Center for Chronic Disease Prevention and Health Promotion Division of Cancer Prevention and Control, "Implementation Guide for Ambulatory Healthcare Provider Reporting to Central Cancer Registries HL7 Clinical Document Architecture (CDA) Release 1.1" (March, 2014), as listed in Appendix A and available as a free electronic document in PDF format at http://cdc.gov/cancer/npcr/ehrmeaningfuluse/cancer.htm.

(c) Each report shall contain information or data required by the appropriate standard in (b) above, as listed in elements (1)-(10) below, and include any supporting information, as follows:

(1) Item numbers defining demographics;

(2) Item numbers defining cancer identification;

(3) Item numbers defining hospital-specific information;

(4) Item numbers defining stage prognostic factors;

(5) Item numbers defining the first course of treatment;

(6) Item numbers defining follow-up, recurrence, and death;

(7) Item numbers defining confidential patient information;

(8) Item numbers defining confidential hospital information;

(9) Item numbers defining other confidential information; and

(10) Item numbers defining diagnosis.

(d) Of the item numbers specified in (b) and (c) above, the following shall require rapid reporting as defined in He-P 304.01(l) and described in He-P 304.03(b) and (c):

(1) Item numbers defining demographics;

(2) Item numbers defining cancer identification;

(3) Item numbers defining hospital-specific information;

(4) Item numbers defining confidential patient information; and

(5) Item numbers defining other confidential information.

(e) The items listed in (c) above shall require definitive reporting as defined in He-P 304.01(e), and described in He-P 304.03(a), He-P 304.03(d), He-P 304.04(a), and He-P 304.06(a) and (b).

(f) All facilities making an electronic report to the SCR in accordance with (a) above, shall submit through a secure internet-based encrypted mechanism, such as a direct file transfer, or a web-based reporting form supported by the SCR.

(g) All facilities reporting electronically shall format reports as specified by one of the following standards, as applicable:

(1) The North American Association of Central Cancer Registries (NAACCR), "Standards for Cancer Registries, Volume II/Data Standards and Data Dictionary, 19th Edition, Record Layout Version 15." (January 1, 2015) Edited by Monica Thornton, Revised (February, 27, 2015), as listed in Appendix A and available as a free document at http://www.naaccr.org;

(2) The North American Association of Central Cancer Registries (NAACCR), "Standards for Cancer Registries/Volume V: Pathology Laboratory Electronic Reporting, Version 4.0." Klein Wt., Havener L. (eds.) Springfield (IL); North American Association of Central Cancer Registries, Inc., (April, 2011), as listed in Appendix a and available as a free electronic document at http://www.naaccr.org; or

(3) The National Center for Chronic Disease Prevention and Health Promotion Division of Cancer Prevention and Control, "Implementation Guide for Ambulatory Healthcare Provider Reporting to Central Cancer Registries HL7 Clinical Document Architecture (CDA) Release 1.1" (March, 2014), as listed in Appendix A and available as a free electronic document in PDF format at http://cdc.gov/cancer/npcr/ehrmeaningfuluse/cancer.htm.

(h) Where electronic reporting is not feasible, facilities shall complete and file the New Hampshire State Cancer Registry (NHSCR) "Cancer Report Form" (July, 2015) provided by the SCR and faxed or mailed by the facilities to the SCR, via regular mail or a courier service.

Source. #4055, eff 5-27-86, EXPIRED: 5-27-92

New. #5601, eff 3-24-93; amd by #6075, eff 8-5-95; ss by #7406, eff 11-21-00; ss by #9046, eff 12-5-07; ss by #11054, eff 3-15-16

He-P 304.03 Reporting of Information by Hospitals Licensed by the State of New Hampshire.

(a) Hospitals licensed by the state of New Hampshire that diagnose or treat at least 105 new reportable cancer cases per year shall employ a cancer registrar to abstract the definitive report.

(b) Hospitals licensed by the state of New Hampshire that diagnose or treat at least 105 new reportable cancer cases per year shall provide a rapid report to SCR in accordance with He-P 304.01(l) and a definitive report in accordance with He-P 304.01(e).

(c) Hospitals licensed by the state of New Hampshire that diagnose or treat fewer than 105 reportable cancer cases per year shall provide a rapid report to SCR in accordance with He-P 304.01(l), and a paper or electronic report to SCR in accordance with He-P 304.02.

(d) Hospitals licensed by the state of New Hampshire that diagnose or treat fewer than 105 reportable cancer cases per year shall make available to SCR the medical records of all patients with a reportable cancer for the creation of the definitive report in accordance with He-P 304.01(e).

(e) Facilities owned by a hospital licensed by the state of New Hampshire shall have met the reporting requirements of this rule if reports are submitted to SCR on their behalf by the hospital.

Source. #4055, eff 5-27-86, EXPIRED: 5-27-92

New. #5601, eff 3-24-93, EXPIRED: 3-24-99

New. #7406, eff 11-21-00; ss by #9046, eff 12-5-07; ss by #11054, eff 3-15-16

He-P 304.04 Reporting of Information by a Physician Licensed by the State of New Hampshire.

(a) A physician, surgeon, or other licensed health care practitioner who diagnoses or treats cancer patients shall complete and provide a definitive report in accordance with He-P 304.01(d) for each newly diagnosed cancer case when that patient will not be immediately referred to a hospital or other treatment center for additional diagnosis or treatment.

(b) A physician, surgeon, or other licensed health care practitioner shall provide additional information to SCR regarding a patient as is considered necessary for abstraction of required cancer incidence data in accordance with He-P 304.07(a).

(c) A physician, surgeon, or other licensed health care practitioner may fulfill his or her responsibility for cancer reporting for a cancer patient through a mutual agreement allowing cases to be reported by a hospice or other facility that provided medical or nursing care to that cancer patient.

(d) A physician, surgeon or other licensed health care practitioner shall make available to the SCR the medical records of all patients with a reportable cancer for creation of the definitive report in accordance with He-P 304.01(e).

Source. #4055, eff 5-27-86, EXPIRED: 5-27-92

New. #5601, eff 3-24-93, EXPIRED: 3-24-99

New. #7406, eff 11-21-00; ss by #9046, eff 12-5-07; ss by #11054, eff 3-15-16

He-P 304.05 Reporting of Information by a Medical Laboratory Licensed by the State of New Hampshire.

(a) A medical laboratory licensed by the state of New Hampshire that obtains a specimen of human tissue which, upon examination, shows evidence of cancer, shall:

(1) Within 180 days after that pathology report is complete, provide information concerning its findings to the SCR; and

(2) Fax, mail, or electronically transmit a copy of the pathology report using procedures described in this section.

(b) A medical laboratory may fulfill its responsibility for cancer reporting through a mutual agreement allowing cases to be submitted by the cancer registrar at an affiliated hospital or other facility.

(c) The SCR shall be granted access to pathology reports used to confirm or rule out a diagnosis of cancer by medical laboratories for the purpose of case finding and quality assurance.

(d) The SCR shall be authorized to identify cancer cases from the pathology reports and request information about missing cancer reports from the reporting facility.

Source. #4055, eff 5-27-86; amd by #4869, eff 7-24-90; ss by #5601, eff 3-24-93, EXPIRED: 3-24-99

New. #7406, eff 11-21-00; ss by #9046, eff 12-5-07; ss by #11054, eff 3-15-16

He-P 304.06 Reporting of Information by Clinics that Diagnose or Treat Patients With Cancer.

(a) A clinic shall provide a definitive report for each case in accordance with He-P 304.01(e).

(b) A clinic licensed by the state of New Hampshire shall:

(1) Be responsible for the submission of all definitive reports to the SCR; or

(2) Develop a mutual agreement with a cancer registrar at a hospital or other affiliated facility for the submission of a definitive report to the SCR.

(c) A clinic shall provide additional information to SCR regarding a cancer patient as necessary for abstraction of required cancer incidence data in accordance with He-P 304.07(a).

Source. #4055, eff 5-27-86; ss by #4377, eff 3-1-88; ss by #5601, eff 3-24-93, EXPIRED: 3-24-99

New. #7406, eff 11-21-00; ss by #9046, eff 12-5-07; ss by #11054, eff 3-15-16

He-P 304.07 Quality Assurance, Verification, and Confidentiality.

(a) All facilities shall respond to SCR requests for case information pursuant to He-P 304.02(b) and (c) within 14 working days of receipt of such requests.

(b) All facilities shall respond to SCR requests to perform a site visit.

(c) SCR shall perform a site visit at each facility in order to:

(1) Audit pathology reports and other information to ensure that no cancer cases are overlooked in reporting; and

(2) Monitor the completeness and accuracy of the cancer reports.

(d) Each facility shall make available for reviewing and copying all paper or electronically stored information including the following:

(1) Laboratory analyses including tissue, cytology, and pathology reports;

(2) Records regarding radiological examinations, in relation to cancer diagnoses or treatment;

(3) Reports of diagnoses of malignant disease, and notations of the reasons for such diagnoses, including both primary clinicians' reports and consultants' reports;

(4) Pharmacy records;

(5) Reports regarding any operations or an autopsy;

(6) Discharge plans and abstracts regarding cancer diagnoses;and

(7) A list of the applicable discharge diagnoses or treatment as identified in the "Casefinding Lists, Current Lists/Code List," (October 1, 2015-September 30, 2016), as listed in Appendix A and available as a free electronic document at http://seer.cancer.gov/tools/casefinding/case2016-icd10cm.html.

(e) Pursuant to 42 USC 280e(c)(2)(D)(viii), individuals complying with the law shall not be held liable in any civil action with respect to a report of cancer provided to the SCR, or with respect to access to data or information provided to the SCR.

Source. #4377, eff 3-1-88; ss by #5601, eff 3-24-93, EXPIRED: 3-24-99

New. #7406, eff 11-21-00; ss by #9046, eff 12-5-07; ss by #11054, eff 3-15-16

He-P 304.08 Procedures for Disclosure of Protected Health Information.

(a) The SCR shall use and disclose protected health information in accordance with RSA 141-B:9 and the provisions of 45 CFR 164 generally, and specifically, 45 CFR 164.502, 164.506 and 164.512.

(b) The department shall maintain the confidentiality of reports submitted to the SCR pursuant to RSA 141-B:9 except in accordance with (c) below.

(c) A report submitted to the SCR concerning an individual, and any other information maintained by the SCR, which, because of a personal identifier, can be readily associated with an individual, shall only be released:

(1) To the individual upon:

a. Receipt of a written request which shall be signed by the individual; and

b. Presentation of identification, such as a driver's license, by the individual;

(2) If the individual is a minor, to a parent of the individual upon:

a. Receipt of a written request, which shall be signed by the parent;

b. Receipt of a certified copy of the birth certificate of the individual; and

c. Receipt of a copy of the parent's identification, such as a driver's license of the parent;

(3) If the individual has a court-appointed guardian or if the individual is deceased, to the court-appointed guardian or to the executor or administrator of the individual's estate upon:

a. Receipt of a written request, which shall be signed by the court-appointed guardian, executor, or administrator of the estate;

b. Receipt of a certified copy of the order or decree which appoints the guardian, executor, or administrator; and

c. Receipt of a copy of identification, such as a driver's license, by the guardian, executor, or administrator;

(4) To an attorney or other person designated by the individual upon receipt of a written medical release request which shall be signed by the individual;

(5) To persons conducting health related research, upon receipt and approval pursuant to He-P 304.09 of a written application to the department, which shall be signed by the applicant and includes:

a. The following information about the principal investigator:

1. Name, address, and phone number;

2. Organizational affiliation;

3. Professional qualification; and

4. Name and phone number of principal investigator's contact person, if any;

b. The following information about the data or record copies being requested:

1. Type of event or record copies;

2. Time period of the data or record copies;

3. Specific data items required, if applicable;

4. Medium in which the data or record copies are to be supplied by the bureau; and

5. Any special format or layout of data required by the principal investigator;

c. A research protocol which shall contain:

1. A summary of background and origin of the research;

2. A statement of the health-related problem or issue to be addressed by the research;

3. The primary research hypothesis to be tested;

4. The research design, which shall include:

(i) Case definition;

(ii) Method of case selection; and

(iii) Method of data analysis;

5. The research methodology, which shall include:

(i) The way in which the requested data will be used; and

(ii) The procedures for follow-back to any persons or facilities named in records, if applicable;

6. Procedures to obtain informed consent from the research participants, if applicable;

7. The procedures that shall be followed to maintain the confidentiality of any data or copies of records provided to the requester; and

8. The intended completion date;

d. A statement signed by the principal investigator agreeing to the following:

1. The investigator shall acknowledge the department as the source of the data in any and all public reports, publications, or presentations generated by the requester from these data;

2. The investigator shall specify that the analyses, conclusions, and recommendations drawn from such data are solely those of the requester and are not necessarily those of the department;

3. Any data or record copies provided shall not be used for any purpose other than that described in the application;

4. The principal investigator and the research staff shall not disclose the identity of individuals revealed in the data or record copies to any persons except as is necessary to perform the research described in the application;

5. The data record shall not be further released to any other person or organization without the written consent of the commissioner or his designee; and

6. No form of information derived from the data or record copies that identify any individuals shall be made public;

e. A written statement ensuring that the investigator shall hold all information confidential; and

f. When contact with patients will occur, submission of an Institutional Review Board (IRB) approval for the study by an IRB formed in accordance with the requirements of the U.S. Department of Health and Human Services Code of Federal Regulations for Protection of Human Subjects, 45 CFR 46, June 23, 2005; or

(6) In association with an audit as required under Title III of Public Health Services Act, 42 U.S.C. 241 et seq.

(d) Persons fraudulently requesting data or information shall be subject to penalty for unsworn falsification pursuant to RSA 641:3.

Source. #9046, eff 12-5-07; ss by #11054, eff 3-15-16

He-P 304.09 Approval Criteria for Release of Confidential Data for Research Purposes.

(a) The commissioner shall review applications for the use of confidential SCR data, based on the following criteria:

(1) Completeness of application, pursuant to He-P 304.08(b)(5);

(2) Documentation of adequate measures to insure confidentiality of patients, pursuant to He-P 304.08(b)(5);

(3) Determination of whether the study, if carried out according to the application submitted pursuant to He-P 304.08(b)(5), will be able to answer the research hypothesis as stated in this application; and

(4) Qualifications of investigator(s) and research staff, as indicated by:

a. Documentation of training and previous research, such as peer reviewed publications, in the proposed or related area; and

b. Affiliation with a university, medical center or other institution, which will provide sufficient research resources.

(b) The commissioner shall deny an application in accordance with RSA 541-A: 29, II (a) when it has been determined that one or more of the requirements of He-P 304.08(b)(5) or He-P 304.09(a) have not been met.

Source. #9046, eff 12-5-07; ss by #11054, eff 3-15-16

He-P 304.10 Aggregate Data. The number of cancer cases shall not be released in any document where the numbers of cancer cases are between 1 and 4.

Source. #9046, eff 12-5-07; ss by #11054, eff 3-15-16

APPENDIX G:
CDC Comparative Effectiveness (CER) Project

DATA DICTIONARY FOR NON-NAACCR
STANDARD ITEMS

CDC Comparative Effectiveness Research Project

Data Dictionary for Non-NAACCR Standard Data Items

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention & Health Promotion
Division of Cancer Prevention and Control
Cancer Surveillance Branch
Data Items Group

***Revised* January 2012**

Overview

The purpose of this document is to define data standards for the inclusion of non-NAACCR standard data items that will be collected through the CDC Comparative Effectiveness Research (CER) Project. For all variables that are not routinely collected through NPCR and are not defined by NAACCR, the following document describes the data items, the cancer site for which the items will be collected, the codes to be used, and the standard source of the data item. The information below also applies to a subset of subsequent treatment variables defined in the NAACCR Data Standards and Data Dictionary but no longer supported by CoC.

All data items should be collected as defined in the protocol and data dictionary for cases diagnosed between January 1, 2011, and December 31, 2011.

For all variables defined by NAACCR standards and listed in the attachment *CER-NPCR Required Status Table*, abstractors are to use NAACCR's *Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition, Record Layout Version 12.1, in use for diagnosis year 2011.*

In order to collect more complete treatment information on first course and subsequent therapies while still maintaining the critical data submission timelines for the project, abstractors are required to consider all treatment information available through twelve months following the patient's date of diagnosis. Please note:

- All first course treatment information is **required** for all breast, colorectal, and CML patients, while
- All subsequent course treatment information is **requested** as available for all breast, colorectal, and CML patients.

SITE/Histology Table for Detailed Treatment Data ***(table added April 2011)***

Site	ICD-0-3 Site Code	Histology	Behavior	Gender	Dx Year
*Breast	C50.0-C50.9	All except 9050-9055, 9140, and 9590-9992	Insitu, Malignant	Male and Female	2011
**Colorectal	C18.0-18.9 C19.9, C20.9	All except 9050-9055, 9140, and 9590-9992	Insitu, Malignant	Male and Female	2011
Chronic Myeloid Leukemia	C42.1	Include 9863, 9875, 9876, 9945, and 9946	Malignant	Male and Female	2011

* The CSv2 Manual provides directions to access a list of inclusion histology codes.
**Colon and Rectum are each divided into separate schemas in the CSv2 Manual and the sections of each provide directions to access a list of histology codes.

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* Please note that Subsq Rx 2nd Course Date [NAACCR #1660] is available in NAACCR's *Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition, Record Layout Version 12.1*, but is not routinely collected and is no longer supported by CoC. As a result, we have included it in the project-specific data dictionary to highlight its inclusion in this project.

Section: Socio-Economic Status Indicators**
Area Level Education
(Item # NA)

Area Level Education

Alternate Name	Item #	Length	Source of Standard	Column #
AreaEducation	NA	NA	CDC/NPCR-CER	NA

Please note: SES variables will be transmitted outside of the NAACCR record layout file. (*note added May 2011)*

Cancer Site
All cancer sites/histologies

Description
Registry data shall be linked to a commercially purchased external data set (purchased centrally by ICF Macro and supplied to participating registries for the purposes of populating specific area-level variables), and potentially to data available from the US Census Bureau. Linkages shall be based on the patient's address at the time of diagnosis and completed at the census tract level.

Coding

The education level shall be coded to the exact value for a corresponding area level variable found on the commercially-purchased data set supplied to participating registries by ICF Macro, and potentially data available from the US Census Bureau. Participating registries shall link their patient level data to the data sets via the patient's census tract (based on address at diagnosis) and shall submit the resulting linked area-based variables as a component of the data submission.

***Please note that the selection and coding for the Socio-Economic Status variables are subject to change once full access to the available external data sets are obtained. The method of linking will remain the same and participating registries will be supplied with the external data sets for linking to registry data, however the exact variables and coding that will be used from the external data sets may be adjusted.*

Section: Socio-Economic Status Indicators**
Area Level Income (Item # NA)

Area Level Income

Alternate Name	Item #	Length	Source of Standard	Column #
AreaIncome	NA	NA	CDC/NPCR-CER	NA

Please note: SES variables will be transmitted outside of the NAACCR record layout file. (*note added May 2011)*

Cancer Site
All cancer sites/histologies

Description
Registry data shall be linked to a commercially purchased external data set (purchased centrally by ICF Macro and supplied to participating registries for the purposes of populating specific area-level variables), and potentially to data available from the US Census Bureau. Linkages shall be based on the patient's address at the time of diagnosis and completed at the census tract level.

Coding

The income level shall be coded to the exact value for a corresponding area level variable found on the commercially-purchased data set supplied to participating registries by ICF Macro, and potentially to data available from the US Census Bureau. Participating registries shall link their patient level data to the data sets via the patient's census tract (based on address at diagnosis) and shall submit the resulting linked area-based variables as a component of the data submission.

***Please note that the selection and coding for the Socio-Economic Status variables are subject to change once full access to the available external data sets are obtained. The method of linking will remain the same and participating registries will be supplied with the external data sets for linking to registry data, however the exact variables and coding that will be used from the external data sets may be adjusted.*

Section: Socio-Economic Status Indicators**
Area Level Poverty
(Item # NA)

Area Level Poverty

Alternate Name	Item #	Length	Source of Standard	Column #
AreaPoverty	NA	NA	CDC/NPCR-CER	NA

Please note: SES variables will be transmitted outside of the NAACCR record layout file. *(note added May 2011)*

Cancer Site
All cancer sites/histologies

Description
Registry data shall be linked to a commercially purchased external data set (purchased centrally by ICF Macro and supplied to participating registries for the purposes of populating specific area-level variables), and potentially to data available from the US Census Bureau. Linkages shall be based on the patient's address at the time of diagnosis and completed at the census tract level.

Coding

The poverty level shall be coded to the exact value for a corresponding area level variable found on the commercially-purchased data set supplied to participating registries by ICF Macro, and potentially to data available from the US Census Bureau. Participating registries shall link their patient level data to the data sets via the patient's census tract (based on address at diagnosis) and shall submit the resulting linked area-based variables as a component of the data submission.

***Please note that the selection and coding for the Socio-Economic Status variables are subject to change once full access to the available external data sets are obtained. The method of linking will remain the same and participating registries will be supplied with the external data sets for linking to registry data, however the exact variables and coding that will be used from the external data sets may be adjusted.*

Section: Socio-Economic Status Indicators**
Area Level Urban/Rural
(Item # NA)

Area Level Urban/Rural

Alternate Name	Item #	Length	Source of Standard	Column #
AreaUrbanRural	NA	NA	CDC/NPCR-CER	NA

Please note: SES variables will be transmitted outside of the NAACCR record layout file. *(note added May 2011)*

Cancer Site
All cancer sites/histologies

Description
Registry data shall be linked to a commercially purchased external data set (purchased centrally by ICF Macro and supplied to participating registries for the purposes of populating specific area-level variables), and potentially to data available from the US Census Bureau. Linkages shall be based on the patient's address at the time of diagnosis and completed at the census tract level.

Coding

The urban/rural level shall be coded to the exact value for a corresponding area level variable found on the commercially-purchased data set supplied to participating registries by ICF Macro, and potentially to data available from the US Census Bureau. Participating registries shall link their patient level data to the data sets via the patient's census tract (based on address at diagnosis) and shall submit the resulting linked area-based variables as a component of the data submission.

***Please note that the selection and coding for the Socio-Economic Status variables are subject to change once full access to the available external data sets are obtained. The method of linking will remain the same and participating registries will be supplied with the external data sets for linking to registry data, however the exact variables and coding that will be used from the external data sets may be adjusted.*

Section: Socio-Economic Status Indicators**
Area Level Health Professional Availability
(Item # NA)

Area Level Hlth Pro Avail

Alternate Name	Item #	Length	Source of Standard	Column #
AreaHealthProAvail	NA	NA	CDC/NPCR-CER	NA

Please note: SES variables will be transmitted outside of the NAACCR record layout file. (*note added May 2011)*

Cancer Site
All cancer sites/histologies

Description
Registry data shall be linked to a commercially purchased external data set (purchased centrally by ICF Macro and supplied to participating registries for the purposes of populating specific area-level variables), and potentially to data available from the US Census Bureau. Linkages shall be based on the patient's address at the time of diagnosis and completed at the census tract level.

Coding

The health professional availability/shortage and specialist availability level shall be coded to the exact value for a corresponding area level variable found on the commercially-purchased data set supplied to participating registries by ICF Macro, and potentially to data available from the US Census Bureau. Participating registries shall link their patient level data to the data sets via the patient's census tract (based on address at diagnosis) and shall submit the resulting linked area-based variables as a component of the data submission.

***Please note that the selection and coding for the Socio-Economic Status variables are subject to change once full access to the available external data sets are obtained. The method of linking will remain the same and participating registries will be supplied with the external data sets for linking to registry data, however the exact variables and coding that will be used from the external data sets may be adjusted.*

Section: Socio-Economic Status Indicators**
Area Level Poverty Index (Item # NA)

Area Level Poverty Index

Alternate Name	Item #	Length	Source of Standard	Column #
AreaPovertyIndex	NA	NA	CDC/NPCR-CER	NA

Please note: SES variables will be transmitted outside of the NAACCR record layout file. (*note added May 2011)*

Cancer Site
All cancer sites/histologies

Description
Registry data shall be linked to a commercially purchased external data set (purchased centrally by ICF Macro and supplied to participating registries for the purposes of populating specific area-level variables), and potentially to data available from the US Census Bureau. Linkages shall be based on the patient's address at the time of diagnosis and completed at the census tract level.

Coding

The poverty index shall be coded to the exact value for a corresponding area level variable found on the commercially-purchased data set supplied to participating registries by ICF Macro, and potentially to data available from the US Census Bureau. Participating registries shall link their patient level data to the data sets via the patient's census tract (based on address at diagnosis) and shall submit the resulting linked area-based variables as a component of the data submission.

***Please note that the selection and coding for the Socio-Economic Status variables are subject to change once full access to the available external data sets are obtained. The method of linking will remain the same and participating registries will be supplied with the external data sets for linking to registry data, however the exact variables and coding that will be used from the external data sets may be adjusted.*

Section: Socio-Economic Status Indicators**
Area Level Health Insurance Level Estimates
(Item # NA)

Area Level Hlth Ins Est

Alternate Name	Item #	Length	Source of Standard	Column #
AreaHealthInsEst	NA	NA	CDC/NPCR-CER	NA

Please note: SES variables will be transmitted outside of the NAACCR record layout file. (*note added May 2011)*

Cancer Site
All cancer sites/histologies

Description
Registry data shall be linked to a commercially purchased external data set (purchased centrally by ICF Macro and supplied to participating registries for the purposes of populating specific area-level variables), and potentially to data available from the US Census Bureau. Linkages shall be based on the patient's address at the time of diagnosis and completed at the census tract level.

Coding

The health insurance level estimates shall be coded to the exact value for a corresponding area level variable found on the commercially-purchased data set supplied to participating registries by ICF Macro, and potentially to data available from the US Census Bureau. Participating registries shall link their patient level data to the data sets via the patient's census tract (based on address at diagnosis) and shall submit the resulting linked area-based variables as a component of the data submission.

***Please note that the selection and coding for the Socio-Economic Status variables are subject to change once full access to the available external data sets are obtained. The method of linking will remain the same and participating registries will be supplied with the external data sets for linking to registry data, however the exact variables and coding that will be used from the external data sets may be adjusted.*

Section: Work Up Information
Height
(Item # 9960)

Height

Alternate Name	Item #	Length	Source of Standard	Column #
Height	9960	2	CDC/NPCR-CER	1236

Cancer Site
Required for breast, colorectal, and CML when chemotherapy or other drugs given
As available for all other sites/histologies
**Please see note under "Coding" for additional explanation (added July 2011)*

Description
Height is required for breast, colorectal, and CML when chemotherapy and/or other drugs were given, and should be entered when available for all other sites/histologies. Different tumors for the same patient may have different values. It should be collected from source records once for each cancer. Height should be taken from the Nursing Interview Guide, Flow Chart, or Vital Stats section from the patient's hospital medical record or physician office record. The height entered should be that listed at or around the time of diagnosis. If no height was listed on the date of diagnosis, please use the height recorded on the date closest to the date of diagnosis and before treatment was started.

Coding
Entered as 2 digit numbers and measured in inches (note that 1 foot=12 inches).

Code "98" for 98 inches or greater.
Code "99" for unknown height.

All inches values should be rounded to the nearest whole number; values with decimal place x .5 and greater should be rounded up (e.g., 62.5 inches would be 63 inches).

**When coding breast, colorectal, and CML cases that include chemotherapy or other drugs, please exhaust all potential sources for height before using code "99" ("unknown"). For all sites/histologies, "blanks" are not permitted and code "99" should be used to reflect unknown height. The CDC will use the volume of cases coded to "99" to help determine the availability of information related to height in the medical record. (added July 2011)*

Please see Appendix 1 for a height conversion chart. If you prefer, you can also use the following on-line conversion calculator:
http://manuelsweb.com/in_cm.htm
If you have trouble opening the link from this file, copy and paste the address into your browser.

Section: Work Up Information
Weight
(Item # 9961)

Weight

Alternate Name	Item #	Length	Source of Standard	Column #
Weight	9961	3	CDC/NPCR-CER	1238

Cancer Site
Required for breast, colorectal, and CML when chemotherapy or other drugs given
As available for all other sites/histologies

**Please see note under "Coding" for additional explanation (added July 2011)*

Description
Weight is required for breast, colorectal, and CML when chemotherapy and/or other drugs were given, and should be entered when available for all other sites/histologies. Different tumors for the same patient may have different values. It should be collected from source records once for each cancer. Weight should be taken from the Nursing Interview Guide, Flow Chart, or Vital Stats section from the patient's hospital medical record or physician office record. The weight entered should be that listed on the date of diagnosis. If no weight was listed on the date of diagnosis, please use the weight recorded on the date closest to the date of diagnosis and before treatment was started.

Coding
Entered as 3 digit numbers and measured in pounds (note that 1 kg = 2.2 pounds).

Code "999" for unknown weight.

All pound values should be rounded to the nearest whole number; values with decimal place x.5 and greater should be rounded up (e.g., 155.5 pounds would be 156 pounds). Patients with a weight of less than 100 pounds should be recorded with a leading 0

**When coding breast, colorectal, and CML cases that include chemotherapy or other drugs, please exhaust all potential sources for weight before using code "999" ("unknown"). For all sites/histologies, "blanks" are not permitted and code "999" should be used to reflect unknown weight. The CDC will use the volume of cases coded to "999" to help determine the availability of information related to weight in the medical record. (added July 2011)*

Please see Appendix 2 for a weight conversion chart. If you prefer, you can also use the following on-line conversion calculator:

http://manuelsweb.com/kg_lbs.htm

If you have trouble opening this link from this file, copy and paste the address into your browser.

Section: Work Up Information
Tobacco Use
(Items # 9965, 9966, 9967, 9968)

Tobacco Use (separated into four possible tobacco categories)

Alternate Name	Item #	Length	Source of Standard	Column #
TobaccoUseCigarette	9965	1	CDC/NPCR-CER	1293
TobaccoUseOtherSmoke	9966	1	CDC/NPCR-CER	1294
TobaccoUseSmokeless	9967	1	CDC/NPCR-CER	1295
TobaccoUseNOS	9968	1	CDC/NPCR-CER	1296

Cancer Site
All sites/histologies, as available in the source records
**Please see note under "Coding" for additional explanation (added July 2011)*

Description
Records the patient's past or current use of tobacco. Tobacco use should be recorded from sections such as the Nursing Interview Guide, Flow Chart, Vital Stats or Nursing Assessment section, or other available source from the patient's hospital medical record or physician office record.

The collection of Tobacco Use will be divided into three types of tobacco products and when tobacco use is indicated, but type is not specified:

- Cigarette smoking
- Smoking tobacco products other than cigarettes (e.g., pipes, cigars, kreteks)
- Smokeless tobacco products (e.g, chewing tobacco, snuff, etc.)
- Tobacco, NOS

Codes

0 Never used
1 Current user (i.e., "current user" as of date of diagnosis) *(added July 2011)*
2 Former user, quit within one year of the date of diagnosis
3 Former user, quit more than one year prior to the date of diagnosis
4 Former user, unknown when quit
9 Unknown/not stated/no smoking specifics provided

If the medical record only indicates "No," use code 9 (Unknown/not stated/no smoking specifics provided) rather than "Never used." If the medical record indicates "None," use 0 ("Never Used"). ** For all sites/histologies, "blanks" are not permitted and code "9" should be used to reflect unknown tobacco use. The CDC will use the volume of cases coded to "9" to help determine the availability of information related to tobacco use in the medical record. (added July 2011)*

Section: Treatment – Chemotherapy
Chemotherapy 1 NSC Number
(Item # 9751)

Chemo 1 NSC Number

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo1NSC	9751	6	CDC/NPCR-CER	804

Cancer Site
Breast, Colorectal, CML

Description
NSC number (*see below for description of NSC numbers) for the first chemotherapy agent administered or planned *(added August 2011)* **as all or part of the first course** of treatment at any facility.

Code original agent NSC numbers using the most current SEER*Rx (http://seer.cancer.gov/tools/seerrx/). Include treatment given or planned *(added August 2011)* at all facilities **as all or part of the first course** of therapy.

SEER*Rx allows you to look up the treatment category for over 1600 drugs and the individual treatment categories for the drugs in over 700 regimens. The SEER*Rx screen provides information on generic name, brand name, NSC number, drug category and subcategory, cancer sites where the drug is used, and other details, including whether or not the drug should be coded as treatment. Patient's medical records and available pharmacy data sets should be included as potential sources for obtaining this data.

*Please note that the term "NSC" [number] refers to (part of) the acronym of the Cancer Chemotherapy National Service Center (CCNSC)). The NSC number is a National Service Center assigned number from the National Cancer Institute (NCI). This number is assigned to a drug during its investigational phase, prior to the adoption of a United States Adopted Name (USAN). A full list of NSC codes is maintained in SEER*Rx.

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Coding
Enter NSC codes as 6 digit numbers, as found in the SEER*Rx database. If the agent is 5 digits, enter a leading 0 to ensure a 6 digit entry. If SEER*Rx lists more than one NSC # for the agent, use the first NSC # listed in SEER*Rx. *(added July 2011)*

NSC Number (enter the actual number)

000000 Chemotherapy was not planned to be administered OR no additional chemotherapy agents were planned

999996 Patient was enrolled in a clinical trial that included chemotherapy and it is **known** by the abstractor that the patient was assigned to receive the placebo *(added January 2012)*

999997 Patient was enrolled in a clinical trial that included chemotherapy and it is **not known** by the abstractor if the patient was assigned to receive the actual chemotherapy agent or the placebo *(added January 2012)*

999998 Chemotherapy was planned and/or administered, but the agent NSC code is unknown; the code "999998" is a temporary code that registries should use while they contact ICF Macro to obtain a permanent code to enter for agents that do not have SEER*Rx-assigned NSC codes OR if the record states only that agent was recommended and the patient refused without specifying which agent was recommended *(added August 2011)*

999999 Unknown if chemotherapy therapy planned OR not required for this primary site/histology

Example 1:

Regimen

If the chart states that the patient's first course of treatment was "FLOX regimen," abstractor should go to SEER*Rx database and type "FLOX" in the "Search for Regimen" entry box at the bottom of the screen. SEER*Rx will return a screen that shows the FLOX regimen consists of 5-fluorouracil (code as chemotherapy), folinic acid -- generic name leucovorin (this is an ancillary agent, and therefore is not collected), and oxaliplatin (code as chemotherapy). Abstractor should click on each chemotherapy drug name to obtain the corresponding NSC number and enter the NSC number in the Chemo_NSC data fields in order:

Chemotherapy Agent #1 NSC Number would correspond to 5-fluorouracil (entry = 027640)

Chemotherapy Agent #2 NSC Number would correspond to oxaliplatin (entry = 266046)

Chemotherapy Agent #3, #4, #5, and #6 NSC Number would correspond to "No additional chemotherapy documented" (entry = 000000)

Example 2:

Single Agent

If the chart states that the patient's first course of treatment was a single chemotherapeutic agent, abstractor should go to the SEER*Rx database and type the agent's name to go to the screen that will list that agent's NSC number.

Chemotherapy Agent #1 NSC Number would correspond to the agent's NSC number as listed in SEER*RX and

Chemotherapy Agent #2, Agent #3, #4, #5, and #6 NSC Number would correspond to "No additional chemotherapy documented" (entry = 000000)

Section: Treatment – Chemotherapy
Chemotherapy 2 NSC Number
(Item # 9752)

Chemo 2 NSC Number

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo2NSC	9752	6	CDC/NPCR-CER	850

Cancer Site
Breast, Colorectal, CML

Description
See description listed for Chemo 1 NSC Number in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Coding
See coding listed for Chemo 1 NSC Number in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Treatment – Chemotherapy
Chemotherapy 3 NSC Number
(Item # 9753)

Chemo 3 NSC Number

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo3NSC	9753	6	CDC/NPCR-CER	1300

Cancer Site
Breast, Colorectal, CML

Description
See description information listed for Chemo 1 NSC Number in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Coding
See coding information listed for Chemo 1 NSC Number in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Treatment – Chemotherapy
Chemotherapy 4 NSC Number
(Item # 9754)

Chemo 4 NSC Number

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo4NSC	9754	6	CDC/NPCR-CER	1346

Cancer Site
Breast, Colorectal, CML

Description
See description information listed for Chemo 1 NSC Number in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Coding
See coding information listed for Chemo 1 NSC Number in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Treatment – Chemotherapy
Chemotherapy 5 NSC Number
(Item # 9755)

Chemo 5 NSC Number

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo5NSC	9755	6	CDC/NPCR-CER	1624

Cancer Site
Breast, Colorectal, CML

Description
See description information listed for Chemo 1 NSC Number in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Coding
See coding information listed for Chemo 1 NSC Number in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Treatment – Chemotherapy
Chemotherapy 6 NSC Number
(Item # 9756)

Chemo 6 NSC Number

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo6NSC	9756	6	CDC/NPCR-CER	1670

Cancer Site
Breast, Colorectal, CML

Description
See description information listed for Chemo 1 NSC Number in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Coding
See coding information listed for Chemo 1 NSC Number in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Treatment – Chemotherapy
Chemotherapy 1 Number Doses Planned
(Item # 9761)

Chemo 1 Num Doses Planned

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo1NumDosesPlanned	9761	2	CDC/NPCR-CER	810

Cancer Site
Breast, Colorectal, CML

Description
For the first chemotherapy agent, this item records the total **number** of chemotherapy doses **planned** to be delivered to the patient **as all or part of the first course of treatment** at any facility.

Patient's medical records and available pharmacy data sets should be included as potential sources for obtaining this data.

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Coding

Record the total number of chemotherapy doses planned.

00 Chemotherapy was not planned OR no additional chemotherapy agents were planned

01-96 Actual number of chemotherapy doses planned*

97 97 or more chemotherapy doses planned

98 Chemo was planned and/or administered, but number doses is unknown

99 Unknown if chemotherapy planned OR not required for this primary site/histology

*For doses 1-9, use a leading 0.

If the agent is given via a prescription to be taken at home and/or self administered, the

*total number of doses **planned** should be coded "98." For example, Gleevec would be coded "98."* (*note added May 2011)*

Example:

Patient's first course of therapy is consistent with the FLOX treatment protocol for stage II and III colon cancer. FLOX consists of FULV regimen (5-FU, 500 mg/m^2 iv bolus weekly x 6; LV, 500 mg/m^2 iv weekly x 6, each 8 week cycle x 3) with oxaliplatin 85 mg/m^2 iv administered on weeks 1, 3, and 5 of each 8 week cycle x 3.

Drug	Dose	Schedule (D= Day #)	# of Cycles	Total # Doses Planned	Total Dose
5-FU	500 mg/m2	Weekly x 6 weeks (i.e., D 1, 8, 15, 22, 29, 36)	3	6 x 3 = 18	14,490 mg
Folinic Acid/ Leucovorin*	500 mg/m2	Weekly x 6 weeks (i.e., D 1, 8, 15, 22, 29, 36)	Not Applicable	Not Applicable	Not Applicable
Oxaliplatin	85 mg/m2	Week 1, 3, and 5 (D 1, 15, 29)	3	3 x 3 = 9	1232 mg

*Folinic Acid/Leucovorin is considered an ancillary agent, no information related to it will be collected.

In the above example, for this set of variables, the relevant coding would be:

Chemotherapy Agent #1 Planned Number of Doses is **18** (corresponding to the 5-FU, which is also the corresponding chemotherapy agent collected in variable Chemo1NSC previously)

Chemotherapy Agent #2 Planned Number of Doses is **09** (corresponding to the oxaliplatin, which is also the corresponding chemotherapy agent collected in variable Chemo2NSC previously)

Chemotherapy Agent #3 Planned Number of Doses will be coded **00**, no additional chemo agent Received doses given

Chemotherapy Agent #4 Planned Number of Doses will be coded **00**, no additional chemo agent received doses given

Chemotherapy Agent #5 Planned Number of Doses will be coded **00**, no additional chemo agent received doses given

Chemotherapy Agent #6 Planned Number of Doses will be coded **00**, no additional chemo agent received doses given

Section: Treatment – Chemotherapy
Chemotherapy 2 Number Doses Planned
(Item # 9762)

Chemo 2 Number Doses Planned

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo2NumDosesPlanned	9762	2	CDC/NPCR-CER	856

Cancer Site
Breast, Colorectal, CML

Description
See description information listed for Chemo 1 Number Doses Planned in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Coding
See coding information listed for Chemo 1 Number Doses Planned in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Treatment – Chemotherapy
Chemotherapy 3 Number Doses Planned
(Item # 9763)

Chemo 3 Number Doses Planned

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo3NumDosesPlanned	9763	2	CDC/NPCR-CER	1306

Cancer Site
Breast, Colorectal, CML

Description
See description information listed for Chemo 1 Number Doses Planned in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Coding
See coding information listed for Chemo 1 Number Doses Planned in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Treatment – Chemotherapy
Chemotherapy 4 Number Doses Planned
(Item # 9764)

Chemo 4 Number Doses Planned

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo4NumDosesPlanned	9764	2	CDC/NPCR-CER	1352

Cancer Site
Breast, Colorectal, CML

Description
See description information listed for Chemo 1 Number Doses Planned in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Coding
See coding information listed for Chemo 1 Number Doses Planned in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Treatment – Chemotherapy
Chemotherapy 5 Number Doses Planned
(Item # 9765)

Chemo 5 Number Doses Planned

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo5NumDosesPlanned	9765	2	CDC/NPCR-CER	1630

Cancer Site
Breast, Colorectal, CML

Description
See description information listed for Chemo 1 Number Doses Planned in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Coding
See coding information listed for Chemo 1 Number Doses Planned in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Treatment – Chemotherapy
Chemotherapy 6 Number Doses Planned
(Item # 9766)

Chemo 6 Number Doses Planned

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo6NumDosesPlanned	9766	2	CDC/NPCR-CER	1676

Cancer Site
Breast, Colorectal, CML

Description
See description information listed for Chemo 1 Number Doses Planned in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Coding
See coding information listed for Chemo 1 Number Doses Planned in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Treatment – Chemotherapy
Chemotherapy 1 Planned Dose and Planned Dose Unit
(Items # 9771, 9781)

Chemotherapy 1 Planned Dose and Planned Dose Unit

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo1PlanDose	9771	6	CDC/NPCR-CER	812
Chemo1PlanDoseUnits	9781	2	CDC/NPCR-CER	818

Cancer Site
Breast, Colorectal, CML

Description
For the first chemotherapy agent, this item records the planned **total dose** to be delivered to the patient **as all or part of the first course** of treatment at any facility (note that this is the total dosage, not the total *number* of doses.)

.
Total dose for a given agent is the sum of each dose planned for that agent. Add all doses planned into a single total value; do not record per dose rate or individual dose value.

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Coding
Record the overall total chemotherapy dose planned, including the units (when dose volume is less than 6 digits, use leading zeros):

Chemo1PlanDose Enter Dose Volume (as numbers):	Chemo1PlanDoseU Select Units:
###### Chemotherapy dose planned 000000 Chemotherapy was not planned OR no additional chemotherapy agents were planned 999998 Chemotherapy was planned and/or administered, but the dose planned is unknown 999999 Unknown if chemotherapy planned or not required for this primary site/histology	00 Chemo was not planned OR no additional chemotherapy agents were planned 01 Mg 02 Grams 07 Other (please specify in chemo text field) 98 Chemo was planned and/or administered, but dose planned unk 99 Unk if chemo planned or not required for this primary site/histology

*If the agent is given via a prescription to be taken at home and/or self administered, the **planned** dose and units should be coded "999998" and "98." For example, Gleevec would be coded "999998" and "98."* (*note added May 2011)*
For more information regarding chemo dose, see Appendix 4: Chemotherapy Example.

Section: Treatment – Chemotherapy
Chemotherapy 2 Planned Dose and Planned Dose Unit
(Items # 9772, 9782)

Chemotherapy 2 Planned Dose and Planned Dose Unit

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo2PlanDose	9772	6	CDC/NPCR-CER	858
Chemo2PlanDoseUnits	9782	2	CDC/NPCR-CER	864

Cancer Site
Breast, Colorectal, CML

Description
See description information listed for Chemo 1 Planned Dose and Planned Dose Units in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Coding
See coding information listed for Chemo 1 Planned Dose and Planned Dose Units in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Treatment – Chemotherapy
Chemotherapy 3 Planned Dose and Planned Dose Unit
(Items # 9773, 9783)

Chemotherapy 3 Planned Dose and Planned Dose Unit

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo3PlanDose	9773	6	CDC/NPCR-CER	1308
Chemo3PlanDoseUnits	9783	2	CDC/NPCR-CER	1314

Cancer Site
Breast, Colorectal, CML

Description
See description information listed for Chemo 1 Planned Dose and Planned Dose Units in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Coding
See coding information listed for Chemo 1 Planned Dose and Planned Dose Units in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Treatment – Chemotherapy
Chemotherapy 4 Planned Dose and Planned Dose Unit
(Items # 9774, 9784)

Chemotherapy 4 Planned Dose and Planned Dose Units

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo4PlanDose	9774	6	CDC/NPCR-CER	1354
Chemo4PlanDoseUnits	9784	2	CDC/NPCR-CER	1360

Cancer Site
Breast, Colorectal, CML

Description
See description information listed for Chemo 1 Planned Dose and Planned Dose Units in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Coding
See coding information listed for Chemo 1 Planned Dose and Planned Dose Units in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Treatment – Chemotherapy
Chemotherapy 5 Planned Dose and Planned Dose Unit
(Items # 9775, 9785)

Chemotherapy 5 Planned Dose and Planned Dose Unit

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo5PlanDose	9775	6	CDC/NPCR-CER	1632
Chemo5PlanDoseUnits	9785	2	CDC/NPCR-CER	1638

Cancer Site
Breast, Colorectal, CML

Description
See description information listed for Chemo 1 Planned Dose and Planned Dose Units in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Coding
See coding information listed for Chemo 1 Planned Dose and Planned Dose Units in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Treatment – Chemotherapy
Chemotherapy 6 Planned Dose and Planned Dose Unit
(Items # 9776, 9786)

Chemotherapy 6 Planned Dose and Planned Dose Unit

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo6PlanDose	9776	6	CDC/NPCR-CER	1678
Chemo6PlanDoseUnits	9786	2	CDC/NPCR-CER	1684

Cancer Site
Breast, Colorectal, CML

Description
See description information listed for Chemo 1 Planned Dose and Planned Dose Units in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Coding
See coding information listed for Chemo 1 Planned Dose and Planned Dose Units in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Treatment – Chemotherapy
Chemotherapy 1 Number Doses Received
(Item # 9791)

Chemo 1 Number Doses Received

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo1NumDosesRec	9791	2	CDC/NPCR-CER	820

Cancer Site
Breast, Colorectal, CML

Description
For the first chemotherapy agent, this item records the total **number** of chemotherapy doses delivered to the patient **as all or part of the first course of treatment** at any facility.

Patient's medical records and available pharmacy data sets should be included as potential sources for obtaining this data.

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Coding

Record the total number of chemotherapy doses received.

00 Chemotherapy was not received OR no additional chemotherapy agents were received

01-96 Actual number of chemotherapy doses received*

97 97 or more chemotherapy doses received

98 Chemotherapy was received, but the number of doses is unknown

99 Unknown if chemotherapy received or not required for this primary site/histology

*For doses 1-9, use a leading 0.

*If the agent is given via a prescription to be taken at home and/or self-administered, the total number of doses **received** should be coded "99." For example, Gleevec would be coded "99."* (*note added May 2011)*

Example:

Patient's first course of therapy is consistent with the FLOX treatment protocol for stage II and III colon cancer. FLOX consists of FULV regimen (5-FU, 500 mg/m^2 iv bolus weekly x 6; LV, 500 mg/m^2 iv weekly x 6, each 8 week cycle x 3) with oxaliplatin 85 mg/m^2 iv administered on weeks 1, 3, and 5 of each 8 week cycle x 3.

Patient became too ill to finish third cycle (as planned), and missed the last two doses of 5-FU and LV, and the last dose of oxaliplatin.

Drug	Dose	Schedule (D=Day #)	# of Cycles	Total # Doses Received	Total Dose Received
5-FU	500 mg/m2	Weekly x 6 weeks (i.e., D 1, 8, 15, 22, 29, 36)	3	6 x 3 = 18 less 2 doses = **16 total**	12,880 mg
Folinic Acid/ Leucovorin*	500 mg/m2	Weekly x 6 weeks (i.e., D 1, 8, 15, 22, 29, 36)	Not Applicable	Not Applicable	Not Applicable
Oxaliplatin	85 mg/m2	Week 1, 3, and 5 (D 1, 15, 29)	3	3 x 3 = 9 less 1 dose = **8 total**	1095 mg

*Folinic Acid/Leucovorin is considered an ancillary agent, no information related to it will be collected.

In the above example, for this set of variables, the relevant coding would be:

Chemotherapy Agent #1 Received Number of Doses is **16** (corresponding to the 5-FU, which is also the corresponding chemotherapy agent collected in variable Chemo1NSC and Chemo1PlanDose previously)

Chemotherapy Agent #2 Received Number of Doses is **08** (corresponding to the oxaliplatin, which is also the corresponding chemotherapy agent collected in variable Chemo2NSC and Chemo2PlanDose previously)

Chemotherapy Agent #3 Received Number of Doses will be coded **00**, no additional chemo agent Received doses given

Chemotherapy Agent #4 Received Number of Doses will be coded **00**, no additional chemo agent received doses given

Chemotherapy Agent #5 Received Number of Doses will be coded **00**, no additional chemo agent received doses given

Chemotherapy Agent #6 Received Number of Doses will be coded **00**, no additional chemo agent received doses given

Section: Treatment – Chemotherapy
Chemotherapy 2 Number Doses Received
(Item # 9792)

Chemo 2 Number Doses Received

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo2NumDosesRec	9792	2	CDC/NPCR-CER	866

Cancer Site
Breast, Colorectal, CML

Description
See description information listed for Chemo 1 Number Doses Received in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Coding
See coding information listed for Chemo 1 Number Doses Received in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Treatment – Chemotherapy
Chemotherapy 3 Number Doses Received
(Item # 9793)

Chemo 3 Number Doses Received

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo3NumDosesRec	9793	2	CDC/NPCR-CER	1316

Cancer Site
Breast, Colorectal, CML

Description
See description information listed for Chemo 1 Number Doses Received in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Coding
See coding information listed for Chemo 1 Number Doses Received in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Treatment – Chemotherapy
Chemotherapy 4 Number of Doses Received
(Item # 9794)

Chemo 4 Number Doses Received

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo4NumDosesRec	9794	2	CDC/NPCR-CER	1362

Cancer Site
Breast, Colorectal, CML

Description
See description information listed for Chemo 1 Number Doses Received in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Coding
See coding information listed for Chemo 1 Number Doses Received in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Treatment – Chemotherapy
Chemotherapy 5 Number Doses Received
(Item # 9795)

Chemo 5 Number Doses Received

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo5NumDosesRec	9795	2	CDC/NPCR-CER	1640

Cancer Site
Breast, Colorectal, CML

Description
See description information listed for Chemo 1 Number Doses Received in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Coding
See coding information listed for Chemo 1 Number Doses Received in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Treatment – Chemotherapy
Chemotherapy 6 Number Doses Received
(Item # 9796)

Chemo 6 Number Doses Received

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo6NumDosesRec	9796	2	CDC/NPCR-CER	1686

Cancer Site
Breast, Colorectal, CML

Description
See description information listed for Chemo 1 Number Doses Received in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Coding
See coding information listed for Chemo 1 Number Doses Received in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Treatment – Chemotherapy
Chemotherapy 1 Received Dose and Received Dose Units (Items # 9801, 9811)

Chemo 1 Received Dose and Received Dose Units

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo1RecDose	9801	6	CDC/NPCR-CER	822
Chemo1RecDoseUnits	9811	2	CDC/NPCR-CER	828

Cancer Site
Breast, Colorectal, CML

Description
For the first chemotherapy agent, this item records the **total dose** actually delivered to the patient **as all or part of the first course** of treatment at any facility. Note that this is the total dosage received, not the total *number* of doses.)

Total dose for a given agent is the sum of each dose given for that agent. Add all doses received into a single total value; do not record per dose rate or the individual dose value.

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Coding
Record the overall total chemotherapy dose received, including the units (when dose volume is less than 6 digits, use leading zeros):

Chemo1RcvDose Enter Dose Volume (as numbers):	Chemo1RcvDoseU Select Units:
###### Chemotherapy dose received 000000 Chemotherapy was not received OR no additional chemo agents were received 999998 Chemotherapy was received, but the dose Received is unknown 999999 Unknown if chemotherapy received OR not required for this primary site/histology	00 Chemo was not received OR no additional chemotherapy agents were received 01 Mg 02 Grams 07 Other (please specify in chemo text field, item # XX) 98 Chemo received, but dose recd unk 99 Unk if chemo received OR not required for this primary site/histology

*If the agent is given via a prescription to be taken at home and/or self-administered, the **received** dose and units should be coded "999999" and "99." For example, Gleevec would be coded "999999" and "99."* (*note added May 2011)*

For more information regarding chemo dose, see Appendix 4: Chemotherapy Example.

Section: Treatment – Chemotherapy
Chemotherapy 2 Received Dose and Received Dose Units
(Items # 9802, 9812)

Chemotherapy 2 Received Dose and Received Dose Units

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo2RecDose	9802	6	CDC/NPCR-CER	868
Chemo2RecDoseUnits	9812	2	CDC/NPCR-CER	874

Cancer Site
Breast, Colorectal, CML

Description
See description information listed for Chemo 1 Received Dose and Received Dose Units in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Coding
See coding information listed for Chemo 1 Received Dose and Received Dose Units in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Treatment – Chemotherapy
Chemotherapy 3 Received Dose and Received Dose Units
(Items # 9803, 9813)

Chemo 3 Received Dose and Received Dose Units

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo3RecDose	9803	6	CDC/NPCR-CER	1318
Chemo3RecDoseUnits	9813	2	CDC/NPCR-CER	1324

Cancer Site
Breast, Colorectal, CML

Description
See description information listed for Chemo 1 Received Dose and Received Dose Units in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Coding
See coding information listed for Chemo 1 Received Dose and Received Dose Units in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Treatment – Chemotherapy
Chemotherapy 4 Received Dose and Received Dose Units
(Items # 9804, 9814)

Chemo 4 Received Dose and Received Dose Units

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo4RecDose	9804	6	CDC/NPCR-CER	1364
Chemo4RecDoseUnits	9814	2	CDC/NPCR-CER	1370

Cancer Site
Breast, Colorectal, CML

Description
See description information listed for Chemo 1 Received Dose and Received Dose Units in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Coding
See coding information listed for Chemo 1 Received Dose and Received Dose Units in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Treatment – Chemotherapy
Chemotherapy 5 Received Dose and Received Dose Units
(Items # 9805, 9815)

Chemo 5 Received Dose and Received Dose Units

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo5RecDose	9805	6	CDC/NPCR-CER	1642
Chemo5RecDoseUnits	9815	2	CDC/NPCR-CER	1648

Cancer Site
Breast, Colorectal, CML

Description
See description information listed for Chemo 1 Received Dose and Received Dose Units in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Coding
See coding information listed for Chemo 1 Received Dose and Received Dose Units in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Treatment – Chemotherapy
Chemotherapy 6 Received Dose and Received Dose Units
(Items # 9806, 9816)

Chemo 6 Received Dose and Received Dose Units

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo6RecDose	9806	6	CDC/NPCR-CER	1688
Chemo6RecDoseUnits	9816	2	CDC/NPCR-CER	1694

Cancer Site
Breast, Colorectal, CML

Description
See description information listed for Chemo 1 Received Dose and Received Dose Units in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Coding
See coding information listed for Chemo 1 Received Dose and Received Dose Units in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Treatment – Chemotherapy
Chemotherapy 1 Start Date
(Item # 9821)

Chemo 1 Start Date

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo1StartDate	9821	8	CDC/NPCR-CER	830

Cancer Site
Breast, Colorectal, CML

Description
For the first chemotherapy agent, this item records the date for the first day of the first cycle that the patient started chemotherapy **as all or part of the first course** of treatment at any facility.

Patient's medical records and available pharmacy data sets should be included as potential sources for obtaining this data.

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Coding
Record the first date the patient received the first cycle of chemotherapy **as all or part of the first course** of treatment.

See *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition, page 97 for date format.*

If the agent is given via a prescription to be taken at home and/or self-administered, the chemotherapy start date should be left blank and the corresponding date flag should be coded "12." (*note added May 2011)*

Example:

Patient's first course of therapy is consistent with the FLOX treatment protocol for stage II and III colon cancer. FLOX consists of FULV regimen (5-FU, 500 mg/m^2 iv bolus weekly x 6; LV, 500 mg/m^2 iv weekly x 6, each 8 week cycle x 3) with oxaliplatin 85 mg/m^2 iv administered on weeks 1, 3, and 5 of each 8 week cycle x 3. **Patient's first treatment was on May 24, 2010.**

Patient became too ill to finish third cycle (as planned), and missed the last two doses of 5-FU and LV, and the last dose of oxaliplatin. Last day chemotherapy administered was October 4, 2010 for 5-FU and LV (patient missed October 11 and 18 planned treatments) and September 27 for oxaliplatin (patient missed October 11 planned treatment). See chart for full listing of how dates correspond to 3 cycles, 8 weeks each:

Cycle 1: Week 1 (Day 1): May 24, 2010 Start 5-FU, LV; oxaliplatin
Week 2 (Day 8): May 31, 2010 Continue 5-FU, LV
Week 3 (Day 15): June 7, 2010 Continue 5-FU, LV; oxaliplatin
Week 4 (Day 22): June 14, 2010 Continue 5-FU, LV
Week 5 (Day 29): June 21, 2010 Continue 5-FU, LV; oxaliplatin
Week 6 (Day 36): June 28, 2010 Continue 5-FU, LV
Week 7 (Day 43): July 5, 2010 No chemo agents scheduled
Week 8 (Day 50): July 12, 2010 No chemo agents scheduled

Cycle 2: Week 1 (Day 1): July 19, 2010 Start 5-FU, LV; oxaliplatin
Week 2 (Day 8): July 26, 2010 Continue 5-FU, LV
Week 3 (Day 15): August 2, 2010 Continue 5-FU, LV; oxaliplatin
Week 4 (Day 22): August 9, 2010 Continue 5-FU, LV
Week 5 (Day 29): August 16, 2010 Continue 5-FU, LV; oxaliplatin
Week 6 (Day 36): August 23, 2010 Continue 5-FU, LV
Week 7 (Day 43): August 30, 2010 No chemo agents scheduled
Week 8 (Day 50): September 6, 2010 No chemo agents scheduled

Cycle 3: Week 1: September 13, 2010 Start 5-FU, LV; oxaliplatin
Week 2: September 20, 2010 Continue 5-FU, LV
Week 3: September 27, 2010 Continue 5-FU, LV; oxaliplatin
Week 4: October 4, 2010 Continue 5-FU, LV
Week 5: October 11, 2010 Continue 5-FU, LV; oxaliplatin -- Patient became too ill to finish third cycle and missed this treatment
Week 6: October 18, 2010 Continue 5-FU, LV -- Patient became too ill to finish third cycle and missed this treatment
Week 7: October 25, 2010 No chemo agents scheduled
Week 8: November 1, 2010 No chemo agents scheduled

In the above example, for this variable, the relevant coding would be:
Chemotherapy Agent #1 Start Date is **20100524**
Chemotherapy Agent #2 Start Date is **20100524**
Chemotherapy Agent #3, #4, #5, and #6 State Date is **Blank**

Section: Treatment – Chemotherapy
Chemotherapy 1 Start Date Flag
(Item # 9831)

Chemo 1 Start Date Flag

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo1StartDateFlag	9831	2	CDC/NPCR-CER	838

Cancer Site
Breast, Colorectal, CML

Description
This flag explains why no appropriate value is in the field, Chemo 1 Start Date [9821].

Rationale
Prior to *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition,* Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields. The non-standard data items for the CDC/NPCR-CER project dates fields have been designed to follow the model set by the NAACCR standards.

Codes (see Appendix H of *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition,* Version 12, for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions).

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if any chemotherapy agent administered)
11	No proper value is applicable in this context (e.g., no chemotherapy agent administered)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., chemotherapy administered but date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., chemotherapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow up).
Blank	A valid date value is provided in item Chemo 1 Start Date [9821], or the date was not expected to have been transmitted

Comment: This is consistent with part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

If the agent is given via a prescription to be taken at home and/or self-administered, the chemotherapy start date should be left blank and the corresponding date flag should be coded "12." (*note added May 2011)*

Section: Treatment – Chemotherapy
Chemotherapy 2 Start Date
(Item # 9822)

Chemo 2 Start Date

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo2StartDate	9822	8	CDC/NPCR-CER	876

Cancer Site
Breast, Colorectal, CML

Description
See description information listed for Chemo 1 Start Date in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Coding
See coding information listed for Chemo 1 Start Date in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Treatment – Chemotherapy
Chemotherapy 2 Start Date Flag
(Item # 9832)

Chemo 2 Start Date Flag

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo2StartDateFlag	9832	2	CDC/NPCR-CER	884

Cancer Site
Breast, Colorectal, CML

Description
This flag explains why no appropriate value is in the field, Chemo 2 Start Date [9822].

Rationale
Prior to *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition,* Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields. The non-standard data items for the CDC/NPCR-CER project dates fields have been designed to follow the model set by the NAACCR standards.

Codes (see Appendix H of *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition*, Version 12, for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions).

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if any chemotherapy agent administered)
11	No proper value is applicable in this context (e.g., no chemotherapy agent administered)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., chemotherapy administered but date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., chemotherapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow up).
Blank	A valid date value is provided in item Chemo 2 Start Date [9822], or the date was not expected to have been transmitted

Comment: This is consistent with part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

If the agent is given via a prescription to be taken at home and/or self-administered, the chemotherapy start date should be left blank and the corresponding date flag should be coded "12." (*note added May 2011)*

Section: Treatment – Chemotherapy
Chemotherapy 3 Start Date
(Item # 9823)

Chemo 3 Start Date

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo3StartDate	9823	8	CDC/NPCR-CER	1326

Cancer Site
Breast, Colorectal, CML

Description
See description information listed for Chemo 1 Start Date in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Coding
See coding information listed for Chemo 1 Start Date in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Treatment – Chemotherapy
Chemotherapy 3 Start Date Flag
(Item # 9833)

Chemo 3 Start Date Flag

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo3StartDateFlag	9833	2	CDC/NPCR-CER	1334

Cancer Site
Breast, Colorectal, CML

Description
This flag explains why no appropriate value is in the field, Chemo 3 Start Date [9823].

Rationale
Prior to *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition,* Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields. The non-standard data items for the CDC/NPCR-CER project dates fields have been designed to follow the model set by the NAACCR standards.

Codes (see Appendix H of *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition,* Version 12, for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions).

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if any chemotherapy agent administered)
11	No proper value is applicable in this context (e.g., no chemotherapy agent administered)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., chemotherapy administered but date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., chemotherapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow up).
Blank	A valid date value is provided in item Chemo 3 Start Date [9823], or the date was not expected to have been transmitted

Comment: This is consistent with part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

If the agent is given via a prescription to be taken at home and/or self-administered, the chemotherapy start date should be left blank and the corresponding date flag should be coded "12." (*note added May 2011)*

Section: Treatment – Chemotherapy
Chemotherapy 4 Start Date
(Item # 9824)

Chemo 4 Start Date

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo4StartDate	9824	8	CDC/NPCR-CER	1372

Cancer Site
Breast, Colorectal, CML

Description
See description information listed for Chemo 1 Start Date in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Coding
See coding information listed for Chemo 1 Start Date in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Treatment – Chemotherapy
Chemotherapy 4 Start Date Flag
(Item # 9834)

Chemo 4 Start Date Flag

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo4StartDateFlag	9834	2	CDC/NPCR-CER	1380

Cancer Site
Breast, Colorectal, CML

Description
This flag explains why no appropriate value is in the field, Chemo 4 Start Date [9824].

Rationale
Prior to *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition,* Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields. The non-standard data items for the CDC/NPCR-CER project dates fields have been designed to follow the model set by the NAACCR standards.

Codes (see Appendix H of *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition*, Version 12, for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions).

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if any chemotherapy agent administered)
11	No proper value is applicable in this context (e.g., no chemotherapy agent administered)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., chemotherapy administered but date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., chemotherapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow up).
Blank	A valid date value is provided in item Chemo 4 Start Date [9824], or the date was not expected to have been transmitted

Comment: This is consistent with part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

If the agent is given via a prescription to be taken at home and/or self-administered, the chemotherapy start date should be left blank and the corresponding date flag should be coded "12." (*note added May 2011)*

Section: Treatment – Chemotherapy
Chemotherapy 5 Start Date
(Item # 9825)

Chemo 5 Start Date

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo5StartDate	9825	8	CDC/NPCR-CER	1650

Cancer Site
Breast, Colorectal, CML

Description
See description information listed for Chemo 1 Start Date in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Coding
See coding information listed for Chemo 1 Start Date in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Treatment – Chemotherapy
Chemotherapy 5 Start Date Flag
(Item # 9835)

Chemo 5 Start Date Flag

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo5StartDateFlag	9835	2	CDC/NPCR-CER	1658

Cancer Site
Breast, Colorectal, CML

Description
This flag explains why no appropriate value is in the field, Chemo 5 Start Date [9825].

Rationale
Prior to *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition,* Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields. The non-standard data items for the CDC/NPCR-CER project dates fields have been designed to follow the model set by the NAACCR standards.

Codes (see Appendix H of *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition*, Version 12, for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions).

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if any chemotherapy agent administered)
11	No proper value is applicable in this context (e.g., no chemotherapy agent administered)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., chemotherapy administered but date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., chemotherapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow up).
Blank	A valid date value is provided in item Chemo 5 Start Date [9825], or the date was not expected to have been transmitted

Comment: This is consistent with part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

If the agent is given via a prescription to be taken at home and/or self-administered, the chemotherapy start date should be left blank and the corresponding date flag should be coded "12." (*note added May 2011)*

Section: Treatment – Chemotherapy
Chemotherapy 6 Start Date
(Item # 9826)

Chemo 6 Start Date

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo6StartDate	9826	8	CDC/NPCR-CER	1696

Cancer Site
Breast, Colorectal, CML

Description
See description information listed for Chemo 1 Start Date in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Coding
See coding information listed for Chemo 1 Start Date in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Treatment – Chemotherapy
Chemotherapy 6 Start Date Flag
(Item # 9836)

Chemo 6 Start Date Flag

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo6StartDateFlag	9836	2	CDC/NPCR-CER	1704

Cancer Site
Breast, Colorectal, CML

Description
This flag explains why no appropriate value is in the field, Chemo 6 Start Date [9826].

Rationale
Prior to *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition,* Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields. The non-standard data items for the CDC/NPCR-CER project dates fields have been designed to follow the model set by the NAACCR standards.

Codes (see Appendix H of *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition*, Version 12, for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions).

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if any chemotherapy agent administered)
11	No proper value is applicable in this context (e.g., no chemotherapy agent administered)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., chemotherapy administered but date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., chemotherapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow up).
Blank	A valid date value is provided in item Chemo 6 Start Date [9826], or the date was not expected to have been transmitted

Comment: This is consistent with part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

If the agent is given via a prescription to be taken at home and/or self-administered, the chemotherapy start date should be left blank and the corresponding date flag should be coded "12." (*note added May 2011)*

Section: Treatment – Chemotherapy
Chemotherapy 1 End Date
(Item # 9841)

Chemo 1 End Date

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo1EndDate	9841	8	CDC/NPCR-CER	840

Cancer Site
Breast, Colorectal, CML

Description
For the first chemotherapy agent, this item records the date for the last day of the last cycle that the patient received chemotherapy **as all or part of the first course** of treatment at any facility.

Patient's medical records and available pharmacy data sets should be included as potential sources for obtaining this data.

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Coding
Record the last date that the patient received chemotherapy **as all or part of the first course** of treatment

See *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition, page 97* for date format.

If the agent is given via a prescription to be taken at home and/or self-administered, the chemotherapy end date should be left blank and the corresponding date flag should be coded "12." (*note added May 2011)*

Example:

Patient's first course of therapy is consistent with the FLOX treatment protocol for stage II and III colon cancer. FLOX consists of FULV regimen (5-FU, 500 mg/m^2 iv bolus weekly x 6; LV, 500 mg/m^2 iv weekly x 6, each 8 week cycle x 3) with oxaliplatin 85 mg/m^2 iv administered on weeks 1, 3, and 5 of each 8 week cycle x 3. **Patient's first treatment was on May 24, 2010.**

Patient became too ill to finish third cycle (as planned), and missed the last two doses of 5-FU and LV, and the last dose of oxaliplatin. Last day chemotherapy

administered was October 4, 2010 for 5-FU and LV (patient missed October 11 and 18 planned treatments) and September 27 for oxaliplatin (patient missed October 11 planned treatment). See chart for full listing of how dates correspond to 3 cycles, 8 weeks each:

Cycle 1: Week 1 (Day 1): May 24, 2010 Start 5-FU, LV; oxaliplatin
Week 2 (Day 8): May 31, 2010 Continue 5-FU, LV
Week 3 (Day 15): June 7, 2010 Continue 5-FU, LV; oxaliplatin
Week 4 (Day 22): June 14, 2010 Continue 5-FU, LV
Week 5 (Day 29): June 21, 2010 Continue 5-FU, LV; oxaliplatin
Week 6 (Day 36): June 28, 2010 Continue 5-FU, LV
Week 7 (Day 43): July 5, 2010 No chemo agents scheduled
Week 8 (Day 50): July 12, 2010 No chemo agents scheduled

Cycle 2: Week 1 (Day 1): July 19, 2010 Start 5-FU, LV; oxaliplatin
Week 2 (Day 8): July 26, 2010 Continue 5-FU, LV
Week 3 (Day 15): August 2, 2010 Continue 5-FU, LV; oxaliplatin
Week 4 (Day 22): August 9, 2010 Continue 5-FU, LV
Week 5 (Day 29): August 16, 2010 Continue 5-FU, LV; oxaliplatin
Week 6 (Day 36): August 23, 2010 Continue 5-FU, LV
Week 7 (Day 43): August 30, 2010 No chemo agents scheduled
Week 8 (Day 50): September 6, 2010 No chemo agents scheduled

Cycle 3: Week 1: September 13, 2010 Start 5-FU, LV; oxaliplatin
Week 2: September 20, 2010 Continue 5-FU, LV
Week 3: September 27, 2010 Continue 5-FU, LV; oxaliplatin
Week 4: October 4, 2010 Continue 5-FU, LV
Week 5: October 11, 2010 Continue 5-FU, LV; oxaliplatin -- Patient became too ill to finish third cycle and missed this treatment
Week 6: October 18, 2010 Continue 5-FU, LV -- Patient became too ill to finish third cycle and missed this treatment
Week 7: October 25, 2010 No chemo agents scheduled
Week 8: November 1, 2010 No chemo agents scheduled

In the above example, for this variable, the relevant coding would be:
Chemotherapy Agent #1 End Date is **20101004**
Chemotherapy Agent #2 End Date is **20100927**
Chemotherapy Agent #3, #4, #5, and #6 End Date is **Blank**

Section: Treatment – Chemotherapy
Chemotherapy 1 End Date Flag
(Item # 9851)

Chemo 1 End Date Flag

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo1EndDateFlag	9851	2	CDC/NPCR-CER	848

Cancer Site
Breast, Colorectal, CML

Description
This flag explains why no appropriate value is in the field, Chemo 1 End Date [9841].

Rationale
Prior to *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition,* Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields. The non-standard data items for the CDC/NPCR-CER project dates fields have been designed to follow the model set by the NAACCR standards.

Codes (see Appendix H of *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition,* Version 12, for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions).

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if any chemotherapy agent administered)
11	No proper value is applicable in this context (e.g., no chemotherapy agent administered)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., chemotherapy administered but date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., chemotherapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow up).
Blank	A valid date value is provided in item Chemo 1 End Date [9841], or the date was not expected to have been transmitted

Comment: This is consistent with part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

If the agent is given via a prescription to be taken at home and/or self-administered, the chemotherapy end date should be left blank and the corresponding date flag should be coded "12." (*note added May 2011)*

Section: Treatment – Chemotherapy
Chemotherapy 2 End Date
(Item # 9842)

Chemo 2 End Date

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo2EndDate	9842	8	CDC/NPCR-CER	886

Cancer Site
Breast, Colorectal, CML

Description
See description information listed for Chemo 1 End Date in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Coding
See coding information listed for Chemo 1 End Date in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Treatment – Chemotherapy
Chemotherapy 2 End Date Flag
(Item # 9852)

Chemo 2 End Date Flag

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo2EndDateFlag	9852	2	CDC/NPCR-CER	894

Cancer Site
Breast, Colorectal, CML

Description
This flag explains why no appropriate value is in the field, Chemo 2 End Date [9842].

Rationale
Prior to *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition,* Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields. The non-standard data items for the CDC/NPCR-CER project dates fields have been designed to follow the model set by the NAACCR standards.

Codes (see Appendix H of *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition,* Version 12, for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions).

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if any chemotherapy agent administered)
11	No proper value is applicable in this context (e.g., no chemotherapy agent administered)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., chemotherapy administered but date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., chemotherapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow up).
Blank	A valid date value is provided in item Chemo 2 End Date [9842], or the date was not expected to have been transmitted

Comment: This is consistent with part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

If the agent is given via a prescription to be taken at home and/or self-administered, the chemotherapy end date should be left blank and the corresponding date flag should be coded "12." (*note added May 2011)*

Section: Treatment – Chemotherapy
Chemotherapy 3 End Date
(Item # 9843)

Chemo 3 End Date

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo3EndDate	9843	8	CDC/NPCR-CER	1336

Cancer Site
Breast, Colorectal, CML

Description
See description information listed for Chemo 1 End Date in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Coding
See coding information listed for Chemo 1 End Date in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Treatment – Chemotherapy
Chemotherapy 3 End Date Flag
(Item # 9853)

Chemo 3 End Date Flag

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo3EndDateFlag	9853	2	CDC/NPCR-CER	1344

Cancer Site
Breast, Colorectal, CML

Description
This flag explains why no appropriate value is in the field, Chemo 3 End Date [9843].

Rationale
Prior to *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition,* Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields. The non-standard data items for the CDC/NPCR-CER project dates fields have been designed to follow the model set by the NAACCR standards.

Codes (see Appendix H of *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition*, Version 12, for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions).

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if any chemotherapy agent administered)
11	No proper value is applicable in this context (e.g., no chemotherapy agent administered)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., chemotherapy administered but date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., chemotherapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow up).
Blank	A valid date value is provided in item Chemo 3 End Date [9843], or the date was not expected to have been transmitted

Comment: This is consistent with part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

If the agent is given via a prescription to be taken at home and/or self-administered, the chemotherapy end date should be left blank and the corresponding date flag should be coded "12." (*note added May 2011)*

Section: Treatment – Chemotherapy
Chemotherapy 4 End Date
(Item # 9844)

Chemo 4 End Date

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo4EndDate	9844	8	CDC/NPCR-CER	1382

Cancer Site
Breast, Colorectal, CML

Description
See description information listed for Chemo 1 End Date in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Coding
See coding information listed for Chemo 1 End Date in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Treatment – Chemotherapy
Chemotherapy 4 End Date Flag
(Item # 9854)

Chemo 4 End Date Flag

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo4EndDateFlag	9854	2	CDC/NPCR-CER	1390

Cancer Site
Breast, Colorectal, CML

Description
This flag explains why no appropriate value is in the field, Chemo 4 End Date [9844].

Rationale
Prior to *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition,* Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields. The non-standard data items for the CDC/NPCR-CER project dates fields have been designed to follow the model set by the NAACCR standards.

Codes (see Appendix H of *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition*, Version 12, for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions).

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if any chemotherapy agent administered)
11	No proper value is applicable in this context (e.g., no chemotherapy agent administered)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., chemotherapy administered but date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., chemotherapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow up).
Blank	A valid date value is provided in item Chemo 4 End Date [9844], or the date was not expected to have been transmitted

Comment: This is consistent with part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

If the agent is given via a prescription to be taken at home and/or self-administered, the chemotherapy end date should be left blank and the corresponding date flag should be coded "12." (*note added May 2011)*

Section: Treatment – Chemotherapy
Chemotherapy 5 End Date
(Item # 9845)

Chemo 5 End Date

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo5EndDate	9845	8	CDC/NPCR-CER	1660

Cancer Site
Breast, Colorectal, CML

Description
See description information listed for Chemo 1 End Date in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Coding
See coding information listed for Chemo 1 End Date in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Treatment – Chemotherapy
Chemotherapy 5 End Date Flag
(Item # 9855)

Chemo 5 End Date Flag

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo5EndDateFlag	9855	2	CDC/NPCR-CER	1668

Cancer Site
Breast, Colorectal, CML

Description
This flag explains why no appropriate value is in the field, Chemo 5 End Date [9845].

Rationale
Prior to *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition,* Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields. The non-standard data items for the CDC/NPCR-CER project dates fields have been designed to follow the model set by the NAACCR standards.

Codes (see Appendix H of *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition,* Version 12, for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions).

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if any chemotherapy agent administered)
11	No proper value is applicable in this context (e.g., no chemotherapy agent administered)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., chemotherapy administered but date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., chemotherapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow up).
Blank	A valid date value is provided in item Chemo 5 End Date [9845], or the date was not expected to have been transmitted

Comment: This is consistent with part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

If the agent is given via a prescription to be taken at home and/or self-administered, the chemotherapy end date should be left blank and the corresponding date flag should be coded "12." (*note added May 2011)*

Section: Treatment – Chemotherapy
Chemotherapy 6 End Date
(Item # 9846)

Chemo 6 End Date

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo6EndDate	9846	8	CDC/NPCR-CER	1706

Cancer Site
Breast, Colorectal, CML

Description
See description information listed for Chemo 1 End Date in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Note: If there is more than one chemotherapy agent planned, the order in which they are entered as agent 1, agent 2, or agent 3, etc., is unimportant as long as all of the agent's information is consistently entered in the same order across all chemotherapy fields (i.e., the same chemo agent is entered as agent 1 across NSC, chemo number doses, chemo total dose, and chemo date fields).

Coding
See coding information listed for Chemo 1 End Date in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Treatment – Chemotherapy
Chemotherapy 6 End Date Flag
(Item # 9856)

Chemo 6 End Date Flag

Alternate Name	Item #	Length	Source of Standard	Column #
Chemo6EndDateFlag	9856	2	CDC/NPCR-CER	1714

Cancer Site
Breast, Colorectal, CML

Description
This flag explains why no appropriate value is in the field, Chemo 6 End Date [9846].

Rationale
Prior to *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition,* Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields. The non-standard data items for the CDC/NPCR-CER project dates fields have been designed to follow the model set by the NAACCR standards.

Codes (see Appendix H of *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition,* Version 12, for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions).

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if any chemotherapy agent administered)
11	No proper value is applicable in this context (e.g., no chemotherapy agent administered)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., chemotherapy administered but date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (e.g., chemotherapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow up).
Blank	A valid date value is provided in item Chemo 6 End Date [9846], or the date was not expected to have been transmitted

Comment: This is consistent with part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

If the agent is given via a prescription to be taken at home and/or self-administered, the chemotherapy end date should be left blank and the corresponding date flag should be coded "12." (*note added May 2011)*

Section: Treatment – Chemotherapy
Chemotherapy Completion Status
(Item # 9859)

Chemotherapy Completion Status

Alternate Name	Item #	Length	Source of Standard	Column #
ChemoCompletionStatus	9859	1	CDC/NPCR-CER	1716

Cancer Site
Breast, Colorectal, CML

Description
This data item is used to code the completion status of chemotherapy for the first course of treatment. The chemotherapy must be part of the **first course of treatment**. Chemotherapy not complete includes only the situation that chemotherapy was terminated prematurely.

Patient's medical records and available pharmacy data sets should be included as potential sources for obtaining this data.

Coding

Code indicating whether or not the patient's chemo therapy was completed as outlined in the initial treatment plan.

Codes

0	No chemo treatment
1	Treatment completed as planned
2	Chemo not completed as planned, patient health/complications
3	Chemo not completed as planned, patient expired
4	Chemo not completed as planned, patient/family choice
5	Chemo not completed as planned, cytopenia
6	Chemo not completed as planned, other reason
7	Chemo treatment extends beyond the end of data collection for this project
8	Chemotherapy administered, unknown if completed
9	Unknown if Chemo therapy given or not required for this primary site/histology

If the agent is given via a prescription and/or self-administered, the chemotherapy completion status should be coded "8." For example, Gleevec should be coded "8." (*note added May 2011)*

Section: Treatment – Chemotherapy
Granulocyte CSF Status
(Item # 9880)

GranulocyteCSF Status

Alternate Name	Item #	Length	Source of Standard	Column #
GCSFStatus	9880	1	CDC/NPCR-CER	2074

Cancer Site
Breast, Colorectal, CML

Description
This data item is used to code if the patient was given Granulocyte-Growth Factors/Cytokines (G-CSF) agents during the twelve months after diagnosis.

Patient's medical records and available pharmacy data sets should be included as potential sources for obtaining this data.

SEER*Rx allows you to look up the treatment category for over 1600 drugs and the individual treatment categories for the drugs in over 700 regimens, including G-CSF agents. The SEER*Rx screen provides information on generic name, brand name, drug category and subcategory. If you are uncertain if the agent is a G-CSF agent, use SEER*Rx to confirm by looking up the agent name.

Three forms of G-CSF are commercially available: filgrastim (Neupogen®), pegfilgrastim (Neulasta®), and lenograstim (Granocyte®).

For additional information and descriptions on growth factors/cytokines for cancer, please use the following website as a reference:
http://www.cancer.gov/cancertopics/factsheet/Therapy/biological

Examples of agents that fall into this category are the following:
- Filgrastim (Neupogen®) (brand)
- Pegfilgrastim (Neulasta®) (brand)
- Lenograstim (Granocyte®) (brand)

Coding

Code indicating whether or not the patient received G-CSF agents during the first twelve months of treatment after date of diagnosis.

Codes
0 No G-CSF treatment given
1 G-CSF treatment was given

7 G-CSF treatment prescribed – patient, patient's family member, or patient's guardian refused
8 G-CSF treatment prescribed, unknown if administered
9 Unknown if G-CSF therapy given or not required for this primary site/histology

Section: Treatment – Chemotherapy
Erythrocyte Growth Factor Status
(Item # 9881)

Erythro Growth FactorSta

Alternate Name	Item #	Length	Source of Standard	Column #
EGFStatus	9881	1	CDC/NPCR-CER	2075

Cancer Site
Breast, Colorectal, CML

Description
This data item is used to code if the patient was given Erythrocyte-Growth Factors/Cytokines agents during the twelve months after diagnosis.

Patient's medical records and available pharmacy data sets should be included as potential sources for obtaining this data.

For additional information and descriptions on growth factors/cytokines for cancer, please use the following website as a reference:
http://www.cancer.gov/cancertopics/factsheet/Therapy/biological

Examples of agents that fall into this category are the following:
- Epoetin alfa - Procrit® (brand)
- Darbepoietin alfa - Aranesp® (brand)

Coding

Code indicating whether or not the patient received Erythrocyte-Growth Factors/Cytokines agents during the first twelve months of treatment after date of diagnosis.

Codes

0	No Erythrocyte-Growth Factors/Cytokines treatment given
1	Erythrocyte-Growth Factors/Cytokines therapy was given
7	Erythrocyte-Growth Factors/Cytokines treatment prescribed – patient, patient's family member, or patient's guardian refused
8	Erythrocyte-Growth Factors/Cytokines treatment prescribed, unknown if administered
9	Unknown if Erythrocyte-Growth Factors/Cytokines therapy given or not required for this primary site/histology

Section: Treatment – Chemotherapy
Thrombocyte Growth Factor Status
(Item # 9882)

Thrombocyte GrowthFactSta

Alternate Name	Item #	Length	Source of Standard	Column #
TGFStatus	9882	1	CDC/NPCR-CER	2076

Cancer Site
Breast, Colorectal, CML

Description
This data item is used to code if the patient was given Thrombocyte-Growth Factors/Cytokines agents during the twelve months after diagnosis.

Patient's medical records and available pharmacy data sets should be included as potential sources for obtaining this data.

For additional information and descriptions on growth factors/cytokines for cancer, please use the following website as a reference:
http://www.cancer.gov/cancertopics/factsheet/Therapy/biological

An examples of an agent that falls into this category is the following:

- Oprelvekin - Neumega® (brand)

Coding

Code indicating whether or not the patient received Thrombocyte-Growth Factors/Cytokines agents during the first twelve months of treatment after date of diagnosis.

Codes

0	No Thrombocyte-Growth Factors/Cytokines treatment given
1	Thrombocyte-Growth Factors/Cytokines treatment was given
7	Thrombocyte-Growth Factors/Cytokines treatment prescribed – patient, patient's family member, or patient's guardian refused
8	Thrombocyte-Growth Factors/Cytokines treatment prescribed, unknown if administered
9	Unknown if Thrombocyte-Growth Factors/Cytokines therapy given or not required for this primary site/histology

Section: Treatment – Hormonal
Hormone 1 NSC Number
(Item # 9861)

Hormone 1 NSC Number

Alternate Name	Item #	Length	Source of Standard	Column #
Hormone1NSC	9861	6	CDC/NPCR-CER	2050

Cancer Site
Breast, Colorectal, CML

Description
NSC number (*see below for description of NSC numbers) for the first hormonal agent administered or planned *(added August 2011)* **as all or part of the first course** of treatment at any facility.

Code original agent NSC numbers using the most current SEER*Rx (http://seer.cancer.gov/tools/seerrx/). Include treatment given or planned *(added August 2011)* at all facilities **as all or part of the first course** of therapy.

SEER*Rx allows you to look up the treatment category for over 1600 drugs and the individual treatment categories for the drugs in over 700 regimens. The SEER*Rx screen provides information on generic name, brand name, NSC number, drug category and subcategory, cancer sites where the drug is used, and other details, including whether or not the drug should be coded as treatment. Patient's medical records and available pharmacy data sets should be included as potential sources for obtaining this data.

*Please note that the term "NSC" [number] refers to (part of) the acronym of the Cancer Chemotherapy National Service Center (CCNSC)). The NSC number is a National Service Center assigned number from the National Cancer Institute (NCI). This number is assigned to a drug during its investigational phase, prior to the adoption of a United States Adopted Name (USAN). A full list of NSC codes is maintained in SEER*Rx.

Coding

NSC codes should be entered as 6 digit numbers, as found in the SEER*Rx database. If the agent is 5 digits, enter a leading 0 to ensure a 6 digit entry. *If there is more than one hormone agent, the order in which they are entered as agent 1 or agent 2 is unimportant.* If SEER*Rx lists more than one NSC # for the agent, use the first NSC # listed in SEER*Rx. *(added July 2011)*

NSC Number (enter the actual number)

000000 Hormonal therapy was not planned to be administered OR no additional hormonal therapy agents were planned

999998 Hormone therapy was planned, but the agent NSC code is unknown; the code "999998" is a temporary code that registries should use while they contact ICF Macro to obtain a permanent code to enter for agents that do not have SEER*Rx-assigned NSC codes OR if the record states only that agent was recommended and the patient refused without specifying which agent was recommended *(added August 2011)*

999999 Unknown if hormonal therapy was planned or not required for this primary site/histology

Example:

If the chart states that patient's first course of treatment included Tamoxifen abstractor should go to SEER*Rx database and type "tamoxifen" in the "Search for Drug" entry box in the middle of the screen. SEER*Rx will return a screen that displays information on Tamoxifen. Abstractor should look for the corresponding NSC number and enter the NSC number in the data fields using the following pattern:

Hormonal Agent #1 NSC Number would correspond to Tamoxifen (entry = 180973)

Hormonal Agent #2 NSC Number would correspond to "No additional hormonal therapy documented" (entry = 000000)

As noted in the FORDS manual and the SEER manual, when coding hormone:

- Record prednisone as hormonal therapy when administered as one of the treatment agents used in combination with chemotherapy, such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone) or COPP (cyclophosphamide, vincristine, procarbazine, prednisone) whether it affects cancer cells or not.
- Do not code prednisone as hormone therapy when it is administered for reasons other than with chemotherapeutic treatment.
- Do not code hormone therapy used to prolong a patient's life by controlling symptoms, to alleviate pain or to make the patient more comfortable.

Section: Treatment – Hormonal
Hormone 2 NSC Number
(Item # 9862)

Hormone 2 NSC Number

Alternate Name	Item #	Length	Source of Standard	Column #
Hormone2NSC	9862	6	CDC/NPCR-CER	2056

Cancer Site
Breast, Colorectal, CML

Description
See description information listed for Hormone 1 NSC Number in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Coding
See coding information listed for Hormone 1 NSC Number in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Treatment – Biological Response Modifier
BRM 1 NSC Number
(Item # 9871)

BRM 1 NSC Number

Alternate Name	Item #	Length	Source of Standard	Column #
BRM1NSC	9871	6	CDC/NPCR-CER	2062

Cancer Site
Breast, Colorectal, CML

Description
NSC number (*see below for description of NSC numbers) for the first BRM agent administered or planned *(added August 2011)* **as all or part of the first course** of treatment at any facility.

Code original agent NSC numbers using the most current SEER*Rx (http://seer.cancer.gov/tools/seerrx/). Include treatment given or planned *(added August 2011)* at all facilities **as all or part of the first course** of therapy.

SEER*Rx allows you to look up the treatment category for over 1600 drugs and the individual treatment categories for the drugs in over 700 regimens. The SEER*Rx screen provides information on generic name, brand name, NSC number, drug category and subcategory, cancer sites where the drug is used, and other details, including whether or not the drug should be coded as treatment. Patient's medical records and available pharmacy data sets should be included as potential sources for obtaining this data.

*Please note that the term "NSC" [number] refers to (part of) the acronym of the Cancer Chemotherapy National Service Center (CCNSC)). The NSC number is a National Service Center assigned number from the National Cancer Institute (NCI). This number is assigned to a drug during its investigational phase, prior to the adoption of a United States Adopted Name (USAN). A full list of NSC codes is maintained in SEER*Rx.

Coding

NSC codes should be entered as 6 digit numbers, as found in the SEER*Rx database. If the agent is 5 digits, enter a leading 0 to ensure a 6 digit entry. *If there is more than one BRM agent planned, the order in which they are entered as agent 1 or agent 2 is unimportant.* If SEER*Rx lists more than one NSC # for the agent, use the first NSC # listed in SEER*Rx. *(added July 2011)*

NSC Number (enter the actual number)

000000 BRM therapy was not planned to be administered OR no additional BRM therapy agents were planned

777777 Bone marrow transplant, stem cell harvests, or surgical and/or radiation endocrine therapy

999998 BRM therapy was planned, but the agent NSC code is unknown; the code "999998" is a temporary code that registries should use while they contact ICF Macro to obtain a permanent code to enter for agents that do not have SEER*Rx-assigned NSC codes OR if the record states only that agent was recommended and the patient refused without specifying which agent was recommended *(added August 2011)*

999999 Unknown if BRM therapy was planned or not required for this primary site/histology

Example:

If the chart states that patient's first course of treatment included diftitox, abstractor should go to SEER*Rx database and first type "diftitox" in the "Search for Drug" entry box in the middle of the screen. SEER*Rx will return a screen that displays information on diftitox. Abstractor should look for the corresponding NSC numbers and enter the NSC numbers in the data fields using the following pattern:

BRM Agent #1 NSC Number would correspond to diftitox (entry = 714744)

BRM Agent #2 NSC Number would be no additional BRM administered (entry = Blank)

If patient received bone marrow transplant, stem cell harvests, or surgical and/or radiation endocrine therapy that do not fit in these parameters, please code 777777

777777 Bone marrow transplant, stem cell harvests, or surgical and/or radiation endocrine therapy

Section: Treatment – Biological Response Modifier
BRM 2 NSC Number
(Item # 9872)

BRM 2 NSC Number

Alternate Name	Item #	Length	Source of Standard	Column #
BRM2NSC	9872	6	SEER-Rx	2068

Cancer Site
Breast, Colorectal, CML

Description
See description information listed for BRM 1 NSC Number in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Coding
See coding information listed for BRM 1 NSC Number in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Subsequent Treatment
Reason for Subsequent Treatment
(Item # 9920)

Reason Subsequent Rx

Alternate Name	Item #	Length	Source of Standard	Column #
ReasSubsqRx	9920	1	CDC/NPCR-CER	1788

Cancer Site

Required, Breast, Colorectal, CML *(added July 2011)*
NOT collected for all other sites/histologies

Description

This data item is used to code the reason that the patient received subsequent treatment. Subsequent treatment begins after first course is completed, stopped or changed. Please use the following link to access the SEER Program Code Manual for the full definition of first course of treatment.

http://seer.cancer.gov/manuals/2007/SPCSM_2007_maindoc.pdf

Patient's medical records and available pharmacy data sets should be included as potential sources for obtaining this data.

Coding

Code indicating the reason that the patient received subsequent or palliative treatment beyond their first course of therapy.

Codes

0 No subsequent or palliative treatment
1 Subsequent or palliative treatment due to disease progression*
2 Subsequent or palliative treatment due to recurrence of disease*
4 Subsequent or palliative treatment due to development of medical condition (e.g., heart failure or liver disease develops in patient)
5 Subsequent or palliative treatment due to other reason
9 Unknown if subsequent or palliative therapy given or not required for this primary site/histology

For breast, colorectal, and CML cases, please do not leave any cases blank (use "0" if no subsequent or palliative treatment was given or "9" if it is unknown). If codes 1-5 are entered, at least one of the subsequent treatment type fields (i.e., items #9921-9927) must have an entry other than "0" (i.e., no or none) or blank. If item 9920 (above) is coded "0" or "9," items #9921-9927 are permitted to be blank, as appropriate. *(added July 2011)*

**Note: Usually, the treating physician will note in the patient's medical record explicitly if subsequent treatment is being given as a result of disease progression or disease recurrence. If it is not noted explicitly, please use the following guideline to determine which code applies:*

If disease progresses, the interval between initial treatment and treatment change will be zero. It there is a recurrence, there will be a time interval that passes before new therapy shows up in the record.

Section: Subsequent Treatment
Subsequent Treatment Second Course Date Started
(Item # 1660)

Subsequent Rx 2nd Course Date

Alternate Name	Item #	Length	Source of Standard	Column #
SusqRx2ndDate	1660	8	NAACCR	1724

Cancer Site
As available, Breast, Colorectal, CML
NOT collected for all other sites/histologies

Description
Date of initiation of subsequent treatment.

Patient's medical records and available pharmacy data sets should be included as potential sources for obtaining this data.

Note: This data item is no longer supported by COC (as of January 1, 2003), but is being collected for the purposes of the CER special study.

Coding

See *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition, page 97 for date format.*

Section: Subsequent Treatment
Subsequent Treatment Second Date Flag CER
(Item # 9955)

Subsq RX 2nd DateFlag CER

Alternate Name	Item #	Length	Source of Standard	Column #
SubsqRX2ndDateFlagCER	9955	2	CDC/NPCR-CER	1862

Cancer Site
As available, Breast, Colorectal, CML
NOT collected for all other sites/histologies

Description
This flag explains why no appropriate value is in the field, Subsq RX 2nd Course Date [1660]. This data item was first available in Volume II Version 12 (effective January 2010).

Rationale
Prior to Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes (see Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions).

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if any subsequent therapy)
11	No proper value is applicable in this context (e.g., no subsequent therapy)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., subsequent therapy given,, but date is unknown)
15	Information is not available at this time, but it is expected that it will be available later (e.g., subsequent therapy ordered, but has not been administered at the time of the most recent follow up)
Blank	A valid date value is provided in item Subsq RX 2nd Course Date [1660], or the date was not expected to have been transmitted

Comment: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

Section: Subsequent Treatment
Subsequent Treatment Second Course – Surgery
(Item # 9921)

Subsq Rx 2nd Crs Surg

Alternate Name	Item #	Length	Source of Standard	Column #
SubsqRX2ndSurg	9921	2	CDC/NPCR-CER	1789

Cancer Site
As available, Breast, Colorectal, CML
NOT collected for all other sites/histologies

Description
This variable is used to code the type of surgery given as part of the subsequent course of treatment. Subsequent treatment is defined as: all cancer-directed therapies administered after the first course is complete due to lack of response or disease progression. Therapy administered after the first course is completed, stopped or changed is recorded as subsequent therapy.

Patient's medical records should be included as potential sources for obtaining this data. Subsequent surgery is a treatment consideration for local, regional or distant recurrence or progression of disease. Subsequent surgery is also a treatment consideration when other planned first course of treatment fails.

Coding

Refer to staging rules to determine if subsequent surgery is local, regional or for distant metastasis. Code "00" for no subsequent surgery.

Codes	
00	None OR Not applicable (e.g., not required for this primary site/histology) OR Unknown information
10	Surgery to local site
20	Surgery to regional site/lymph nodes
30	Surgery to distant site/lymph nodes
90	Surgery, NOS; a subsequent surgical procedure was done, but no information on the type of surgical procedure is provided.

Section: Subsequent Treatment
Subsequent Treatment Second Course – Radiation
(Item #9922)

Subsq Rx 2nd Crs Rad

Alternate Name	Item #	Length	Source of Standard	Column #
SubsqRX2ndRad	9922	2	CDC/NPCR-CER	1791

Cancer Site
As available, Breast, Colorectal, CML
NOT collected for all other sites/histologies

Description
This variable is used to code radiation therapy as subsequent treatment. Subsequent treatment is defined as: all cancer-directed therapies administered after the first course is complete due to lack of response or disease progression. Therapy administered after the first course is completed, stopped or changed is recorded as subsequent therapy.

Patient's medical records should be included as potential sources for obtaining this data.

Subsequent radiation therapy is a treatment consideration for local, regional or distant recurrence or progression of disease. Subsequent radiation therapy is also a treatment consideration when other planned first course of treatment fails. Subsequent radiation may be administered as part of other subsequent treatments (surgery, chemotherapy, etc).

- Radiation may be localized (at the primary site)
- Radiation may be directed to regional site and/or to regional lymph nodes
- Radiation may be directed to a distant or metastatic site or lymph nodes

Coding
Refer to staging rules to determine if subsequent radiation is for local, regional or distant progression or metastasis. Code "00" if no subsequent radiation.

Codes
00 None OR Not applicable (e.g., not required for this primary site/histology) OR Unknown information
10 Local radiation
20 Regional radiation
30 Distant radiation, NOS OR other radiation, NOS *(note: text in red font added June 2011)*
31 Bone
32 Brain
33 Liver
34 Lung
35 Other distant sites/lymph nodes or more than one distant site

Section: Subsequent Treatment
Subsequent Treatment Second Course – Chemotherapy
(Item #9923)

Subsq Rx 2nd Crs Chemo

Alternate Name	Item #	Length	Source of Standard	Column #
SubsqRX2ndChemo	9923	2	CDC/NPCR-CER	1793

Cancer Site
As available, Breast, Colorectal, CML
NOT collected for all other sites/histologies

Description
This variable is used to code for the type of chemotherapy given as part of the subsequent course of treatment. Subsequent treatment is defined as: all cancer-directed therapies administered after the first course is complete due to lack of response or disease progression. Therapy administered after the first course is completed, stopped or changed is recorded as subsequent therapy.

When coding subsequent chemotherapy, note that if the patient has an adverse reaction, the physician may change one of the drugs in a combination regimen. If the replacement drug belongs to the same group as the original drug there is no change in the regimen. If the replacement drug is in a different group than the original drug, code the new regime as subsequent therapy.

Patient's medical records and available pharmacy data sets should be included as potential sources for obtaining this data.

Coding
- Code 00 if no subsequent chemotherapy
- Refer to the *SEER*Rx Interactive Drug Database* (http://seer.cancer.gov/) for a list of chemotherapeutic agents.
- 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.

Codes

00	None OR Not applicable (e.g., not required for this primary site/histology) OR Unknown information
01	Chemotherapy administered as subsequent therapy, but the type and number of agents is not documented in patient record.
02	Single-agent chemotherapy administered as subsequent therapy.
03	Multiagent chemotherapy administered as subsequent therapy.

Section: Subsequent Treatment
Subsequent Treatment Second Course – Hormone
(Item #9924)

Subsq Rx 2nd Crs Horm

Alternate Name	Item #	Length	Source of Standard	Column #
SubsqRX2ndHorm	9924	2	CDC/NPCR-CER	1795

Cancer Site
As available, Breast, Colorectal, CML
NOT collected for all other sites/histologies

Description
This variable is used to code for the type of hormonal therapy given as part of the subsequent course of treatment. Subsequent treatment is defined as: all cancer-directed therapies administered after the first course is complete due to lack of response or disease progression. Therapy administered after the first course is completed, stopped or changed is recorded as subsequent therapy.

Patient's medical records and available pharmacy data sets should be included as potential sources for obtaining this data.

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 as subsequent treatment.
- Refer to the SEER*Rx Interactive Drug Database (http://seer.cancer.gov/) for a list of hormonal agents.

Codes

00	None OR Not applicable (e.g., not required for this primary site/histology) OR Unknown information
01	Hormone therapy administered as subsequent therapy.

Section: Subsequent Treatment
Subsequent Treatment Second Course – BRM
(Item #9925)

Subsq Rx 2nd Crs BRM

Alternate Name	Item #	Length	Source of Standard	Column #
SubsqRX2ndBRM	9925	2	CDC/NPCR-CER	1797

Cancer Site
As available, Breast, Colorectal, CML
NOT collected for all other sites/histologies

Description
This variable is used to code for the type of biological response modifier therapy (immunotherapy) given as part of the subsequent course of treatment. Subsequent treatment is defined as: all cancer-directed therapies administered after the first course is complete due to lack of response or disease progression. Therapy administered after the first course is completed, stopped or changed is recorded as subsequent therapy.

Patient's medical records and available pharmacy data sets should be included as potential sources for obtaining this data.

Coding

- Code 00 if immunotherapy was not administered as subsequent treatment
- Refer to the *SEER*Rx Interactive Drug Database* (http://seer.cancer.gov/) for a list of immunotherapeutic agents.

Codes

00	None OR Not applicable (e.g., not required for this primary site/histology) OR Unknown information
01	Immunotherapy administered as subsequent therapy.

Section: Subsequent Treatment
Subsequent Treatment Second Course – Transplant/Endocrine (Item # 9927)

Subsq Rx 2nd Crs Trans/End

Alternate Name	Item #	Length	Source of Standard	Column #
SubsqRX2ndTransEnd	9927	2	CDC/NPCR-CER	1800

Cancer Site
As available, Breast, Colorectal, CML
NOT collected for all other sites/histologies

Description
This variable is used to code for the type of transplant/endocrine therapy given as part of the subsequent course of treatment. Subsequent treatment is defined as: all cancer-directed therapies administered after the first course is complete due to lack of response or disease progression. Therapy administered after the first course is completed, stopped or changed is recorded as subsequent therapy.

Patient's medical records and available pharmacy data sets should be included as potential sources for obtaining this data.

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 allogeneic.
- 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 subsequent transplant or endocrine procedure was not administered to the patient.

Codes

00	None OR Not applicable (e.g., not required for this primary site/histology) OR Unknown information
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.)

Section: Subsequent Treatment
Subsequent Treatment Second Course – Other
(Item #9926)

Subsq Rx 2ndCrs Oth

Alternate Name	Item #	Length	Source of Standard	Column #
SubsqRX2ndOth	9926	1	CDC/NPCR-CER	1799

Cancer Site
As available, Breast, Colorectal, CML
NOT collected for all other sites/histologies

Description
This variable is used to code for the type of other treatment given as part of the subsequent course of treatment. Subsequent treatment is defined as: all cancer-directed therapies administered after the first course is complete due to lack of response or disease progression. Therapy administered after the first course is completed, stopped or changed is recorded as subsequent therapy.

Patient's medical records and available pharmacy data sets should be included as potential sources for obtaining this data.

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 the hematopoietic diseases ONLY. (See instructions for coding in Section One).

Codes

0 None -All subsequent cancer treatment was coded in other treatment fields (surgery, radiation, systemic therapy) OR Not applicable (e.g., not required for this primary site/histology) OR Unknown information.
1 Other -subsequent treatment that cannot be appropriately assigned to specified treatment data items (surgery, radiation, systemic therapy, hematopoietic cases, such as phlebotomy, transfusion, or aspirin).
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 nonmedical personnel.

Section: Subsequent Treatment – Chemotherapy
Subsequent Treatment Second Chemotherapy 1 NSC Number (Item # 9931)

Subsq RX 2nd Chemo 1 NSC

Alternate Name	Item #	Length	Source of Standard	Column #
SubsqRX2ndChemo1NSC	9931	6	CDC/NPCR-CER	1802

Cancer Site
As available, Breast, Colorectal, CML
NOT collected for all other sites/histologies

Description
See description information listed for Chemotherapy 1 NSC Number in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Coding
See coding information listed for Chemotherapy 1 NSC Number in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Subsequent Treatment – Chemotherapy
Subsequent Treatment Second Chemotherapy 2 NSC Number (Item # 9932)

Subsq RX 2nd Chemo 2 NSC

Alternate Name	Item #	Length	Source of Standard	Column #
SubsqRX2ndChemo2NSC	9932	6	CDC/NPCR-CER	1808

Cancer Site
As available, Breast, Colorectal, CML
NOT collected for all other sites/histologies

Description
See description information listed for Chemotherapy 1 NSC Number in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Coding
See coding information listed for Chemotherapy 1 NSC Number in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Subsequent Treatment – Chemotherapy
Subsequent Treatment Second Chemotherapy 3 NSC Number (Item # 9933)

Subsq RX 2nd Chemo 3 NSC

Alternate Name	Item #	Length	Source of Standard	Column #
SubsqRX2ndChemo3NSC	9933	6	CDC/NPCR-CER	1814

Cancer Site
As available, Breast, Colorectal, CML
NOT collected for all other sites/histologies

Description
See description information listed for Chemotherapy 1 NSC Number in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Coding
See coding information listed for Chemotherapy 1 NSC Number in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Subsequent Treatment – Chemotherapy
Subsequent Treatment Second Chemotherapy 4 NSC Number
(Item # 9934)

Subsq RX 2nd Chemo 4 NSC *(note: Name Corrected June 2011)*

Alternate Name	Item #	Length	Source of Standard	Column #
SubsqRX2ndChemo4NSC	9934	6	CDC/NPCR-CER	1820

Cancer Site
As available, Breast, Colorectal, CML
NOT collected for all other sites/histologies

Description
See description information listed for Chemotherapy 1 NSC Number in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Coding
See coding information listed for Chemotherapy 1 NSC Number in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Subsequent Treatment – Chemotherapy
Subsequent Treatment Second Chemotherapy 5 NSC Number (Item # 9935)

Subsq RX 2nd Chemo5 NSC

Alternate Name	Item #	Length	Source of Standard	Column #
Subsq2ndChemo5NSC	9935	6	CDC/NPCR-CER	1826

Cancer Site
As available, Breast, Colorectal, CML
NOT collected for all other sites/histologies

Description
See description information listed for Chemotherapy 1 NSC Number in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Coding
See coding information listed for Chemotherapy 1 NSC Number in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Subsequent Treatment – Chemotherapy
Subsequent Treatment Second Chemotherapy Agent 6 NSC Number (Item # 9936)

Subsq RX 2nd Chemo6 NSC

Alternate Name	Item #	Length	Source of Standard	Column #
SubsqRX2ndChemo6NSC	9936	6	CDC/NPCR-CER	1832

Cancer Site
As available, Breast, Colorectal, CML
NOT collected for all other sites/histologies

Description
See description information listed for Chemotherapy 1 NSC Number in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Coding
See coding information listed for Chemotherapy 1 NSC Number in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Subsequent Treatment – Hormone
Subsequent Treatment Second
Hormone 1 NSC Number
(Item # 9941)

Subsq RX 2nd Horm1 NSC

Alternate Name	Item #	Length	Source of Standard	Column #
SubsqRX2ndHorm1NSC	9941	6	CDC/NPCR-CER	1838

Cancer Site
As available, Breast, Colorectal, CML
NOT collected for all other sites/histologies

Description
See description information listed for Hormone 1 NSC Number in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Coding
See coding information listed for Hormone 1 NSC Number in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Subsequent Treatment – Hormone
Subsequent Treatment Second
Hormone 2 NSC Number
(Item # 9942)

Subsq RX 2nd Horm 2 NSC

Alternate Name	Item #	Length	Source of Standard	Column #
SubsqRX2ndHorm2NSC	9942	6	CDC/NPCR-CER	1844

Cancer Site
As available, Breast, Colorectal, CML
NOT collected for all other sites/histologies

Description
See description information listed for Hormone 1 NSC Number in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Coding
See coding information listed for Hormone 1 NSC Number in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Subsequent Treatment – Biological Response Modifier
Subsequent Treatment Second
BRM 1 NSC Number
(Item # 9951)

Subsq RX 2nd BRM 1 NSC

Alternate Name	Item #	Length	Source of Standard	Column #
SubsqRX2ndBRM1NSC	9951	6	CDC/NPCR-CER	1850

Cancer Site
As available, Breast, Colorectal, CML
NOT collected for all other sites/histologies

Description
See description information listed for BRM 1 NSC Number in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Coding
See coding information listed for BRM 1 NSC Number in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Subsequent Treatment – Biological Response Modifier
Subsequent Treatment Second
BRM 2 NSC Number
(Item # 9952)

Subsq RX 2nd BRM 2 NSC

Alternate Name	Item #	Length	Source of Standard	Column #
SubsqRX2ndBRM2NSC	9952	6	CDC/NPCR-CER	1856

Cancer Site
As available, Breast, Colorectal, CML
NOT collected for all other sites/histologies

Description
See description information listed for BRM 1 NSC Number in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Coding
See coding information listed for BRM 1 NSC Number in this data dictionary (CDC Comparative Effectiveness Research Project Data Dictionary for Non-NAACCR Standard Data Items).

Section: Biomarkers – BCR-ABL
BCR-ABL: Cytogenetic
(Item # 9900)

BCR-ABL: Cytogenetic Analysis

Alternate Name	Item #	Length	Source of Standard	Column #
BCRABLCytogenetic	9900	3	CDC/NPCR-CER	1241

Cancer Site
CML

Description
Record the results of the cytogenetic analysis for BCR-ABL t(9;22) (q34;q11) at the time of initial diagnosis. If multiple test results are recorded in the source records, use the results that are closest to the date of diagnosis. This variable refers to all BCR-ABL transcriptions, including BCR-ABL2. Cytogenetic analysis may be used to monitor disease response to therapy and relapse.

Do not record results of this test after initiation of treatment.

Additional information and sample reports can be found at:
http://www.healthline.com/sw/cs-cml-how-cytogenetic-testing-is-used-for-diagnosis-and-to-monitor-treatment

http://www.genzymegenetics.com/~/media/Files/Genetics/PDF/SampleReports/OncologyPathology/sample-report-bcr-abl-mutation-analysis-positive.pdf

http://www.genzymegenetics.com/~/media/Files/Genetics/PDF/SampleReports/OncologyPathology/sample-report-bcr-abl-gene-rearrangement-quantitative-rt-pcr-analysis.pdf

http://www.genzymegenetics.com/~/media/Files/Genetics/PDF/SampleReports/OncologyPathology/sample-report-chromosome-analysis-cytogenetic-positive.pdf

Note 1: Other names for this test include: Karyotyping, conventional cytogenetics, Philadelphia chromosome analysis, chromosomal banding analysis

Coding

000* Negative result OR
Not applicable (e.g., information not collected for this case) OR
Test not done (e.g., test not ordered and was not performed) OR
Unknown information (e.g., not documented in source record) OR
OR Test ordered (e.g., results not in source records)
010 Positive

*Please note that this variable will be used in combination with the corresponding BCR-ABL related date and date flag variables to further substantiate which reason applies for coding "000" for a given case.

Section: Biomarkers – BCR-ABL
BCR-ABL: Cytogenetic Date
(Item # 9901)

BCR-ABL: Cytogenetic Date

Alternate Name	Item #	Length	Source of Standard	Column #
BCRABLCytogeneticDate	9901	8	CDC/NPCR-CER	1244

Cancer Site
CML

Description
Record the date of the cytogenetic analysis for BCR-ABL t(9;22) (q34;q11) at the time of initial diagnosis. If multiple test results are recorded in the source records, use the date of the test results that are closest to the date of diagnosis. This variable refers to all BCR-ABL transcriptions, including BCR-ABL2. Cytogenetic analysis may be used to monitor disease response to therapy and relapse.

Use the date that the specimen was obtained and sent for analysis and not the report date. Do not record date related to results of this test after initiation of treatment.

Additional information and sample reports can be found at:
http://www.healthline.com/sw/cs-cml-how-cytogenetic-testing-is-used-for-diagnosis-and-to-monitor-treatment

http://www.genzymegenetics.com/~/media/Files/Genetics/PDF/SampleReports/OncologyPathology/sample-report-bcr-abl-mutation-analysis-positive.pdf

http://www.genzymegenetics.com/~/media/Files/Genetics/PDF/SampleReports/OncologyPathology/sample-report-bcr-abl-gene-rearrangement-quantitative-rt-pcr-analysis.pdf

http://www.genzymegenetics.com/~/media/Files/Genetics/PDF/SampleReports/OncologyPathology/sample-report-chromosome-analysis-cytogenetic-positive.pdf

Note 1: Other names for this test include: Karyotyping, conventional cytogenetics, Philadelphia chromosome analysis, chromosomal banding analysis

Coding

See *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition, page 97* for date format.

Section: Biomarkers – BCR-ABL
BCR-ABL: Cytogen Date Flag
(Item # 9902)

BCR-ABL: Cytogen Date Flag

Alternate Name	Item #	Length	Source of Standard	Column #
BCRABLCytogenDateFlag	9902	2	CDC/NPCR-CER	1252

Cancer Site
CML

Description
This flag explains why no appropriate value is in the field, BCR-ABL: Cytogenetic Date [9901].

Rationale
Prior to *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition,* Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields. The non-standard data items for the CDC/NPCR-CER project dates fields have been designed to follow the model set by the NAACCR standards.

Codes (see Appendix H of *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition,* Version 12, for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions).

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if BCR-ABL: Cytogentetic test done)
11	No proper value is applicable in this context (e.g., no BCR-ABL: Cytogentetic test done or not applicable)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., BCR-ABL: Cytogentetic test done, but date is unknown)
15	Information is not available at this time, but it is expected that it will be available later (e.g., BCR-ABL: Cytogentetic test ordered, but has not been administered at the time of the most recent follow up)
Blank	A valid date value is provided in item BCR-ABL: Cytogenetic Date [9901], or the date was not expected to have been transmitted

Comment: This is consistent with part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

Section: Biomarkers – BCR-ABL
BCR-ABL: FISH
(Item # 9903)

BCR-ABL: FISH

Alternate Name	Item #	Length	Source of Standard	Column #
BCRABL_FISH	9903	3	CDC/NPCR-CER	1254

Cancer Site
CML

Description
Record the results of only the Fluorescence in Situ Hybridization for BCR-ABL t(9;22)(q34;q11) at the time of initial diagnosis. If multiple test results are recorded in the source records, use the results that are closest to the date of diagnosis. This variable refers to all BCR-ABL transcriptions, including BCR-ABL2.

BCR-ABL FISH may be used to monitor disease response to therapy and relapse.

Do not record results of this test after initiation of treatment.

Additional information and sample reports can be found at:
http://www.healthline.com/sw/cs-cml-how-cytogenetic-testing-is-used-for-diagnosis-and-to-monitor-treatment

http://www.genzymegenetics.com/~/media/Files/Genetics/PDF/SampleReports/OncologyPathology/sample-report-bcr-abl-mutation-analysis-positive.pdf

http://www.genzymegenetics.com/~/media/Files/Genetics/PDF/SampleReports/OncologyPathology/sample-report-bcr-abl-gene-rearrangement-quantitative-rt-pcr-analysis.pdf

http://www.genzymegenetics.com/~/media/Files/Genetics/PDF/SampleReports/OncologyPathology/sample-report-chromosome-analysis-cytogenetic-positive.pdf

Coding

000* Negative result OR
Not applicable (e.g., information not collected for this case) OR
Test not done (e.g., test not ordered and was not performed) OR
Unknown information (e.g., not documented in source record) OR
OR Test ordered (e.g., results not in source records)

010 Positive

*Please note that this variable will be used in combination with the corresponding BCR-ABL related date and date flag variables to further substantiate which reason applies for coding "000" for a given case.

Section: Biomarkers – BCR-ABL
BCR-ABL: FISHDate
(Item # 9904)

BCR-ABL: FISH Date

Alternate Name	Item #	Length	Source of Standard	Column #
BCRABL_FISHDate	9904	8	CDC/NPCR-CER	1257

Cancer Site
CML

Description
Record the date of only the Fluorescence in Situ Hybridization for BCR-ABL t(9;22)(q34;q11) at the time of initial diagnosis. If multiple test results are recorded in the source records, use the date of the test results that are closest to the date of diagnosis. This variable refers to all BCR-ABL transcriptions, including BCR-ABL2.

BCR-ABL FISH may be used to monitor disease response to therapy and relapse.

Use the date that the specimen was obtained and sent for analysis and not the report date. Do not record results of this test after initiation of treatment.

Additional information and sample reports can be found at:
http://www.healthline.com/sw/cs-cml-how-cytogenetic-testing-is-used-for-diagnosis-and-to-monitor-treatment

http://www.genzymegenetics.com/~/media/Files/Genetics/PDF/SampleReports/OncologyPathology/sample-report-bcr-abl-mutation-analysis-positive.pdf

http://www.genzymegenetics.com/~/media/Files/Genetics/PDF/SampleReports/OncologyPathology/sample-report-bcr-abl-gene-rearrangement-quantitative-rt-pcr-analysis.pdf

http://www.genzymegenetics.com/~/media/Files/Genetics/PDF/SampleReports/OncologyPathology/sample-report-chromosome-analysis-cytogenetic-positive.pdf

Coding

See *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition, page 97* for date format.

Section: Biomarkers – BCR-ABL
BCR-ABL: FISH Date Flag
(Item # 9905)

BCR-ABL: FISH Date Flag

Alternate Name	Item #	Length	Source of Standard	Column #
BCRABLFISHDateFlag	9905	2	CDC/NPCR-CER	1265

Cancer Site
CML

Description
This flag explains why no appropriate value is in the field, BCR-ABL: FISH Date [9904].

Rationale
Prior to *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition,* Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields. The non-standard data items for the CDC/NPCR-CER project dates fields have been designed to follow the model set by the NAACCR standards.

Codes (see Appendix H of *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition,* Version 12, for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions).

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if BCR-ABL: FSH test done)
11	No proper value is applicable in this context (e.g., no BCR-ABL: FISH test done or not applicable)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., BCR-ABL: FISH test done, but date is unknown)
15	Information is not available at this time, but it is expected that it will be available later (e.g., BCR-ABL: FISH test ordered, but has not been administered at the time of the most recent follow up)
Blank	A valid date value is provided in item BCR-ABL: FISH Date [9904], or the date was not expected to have been transmitted

Comment: This is consistent with part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

Section: Biomarkers – BCR-ABL
BCR-ABL: RT-PCR Qualitative
(Item # 9906)

BCR-ABL: RT-PCR Qual

Alternate Name	Item #	Length	Source of Standard	Column #
BCRABL_RTPCRQUAL	9906	3	CDC/NPCR-CER	1267

Cancer Site
CML

Description
Record the results of the *qualitative* Reverse Transcriptase Polymerase Chain Reaction RT-PCR for BCR-ABL t(9;22) (q34;q11) at the time of initial diagnosis. If multiple test results are recorded in the source records, use the results that are closest to the date of diagnosis. This variable refers to all BCR-ABL transcriptions, including BCR-ABL2.

RT-PCR Qualitative may be used to monitor disease response to therapy and relapse.

Do not record results of this test after initiation of treatment.

Additional information and sample reports can be found at:
http://www.healthline.com/sw/cs-cml-how-cytogenetic-testing-is-used-for-diagnosis-and-to-monitor-treatment

http://www.genzymegenetics.com/~/media/Files/Genetics/PDF/SampleReports/OncologyPathology/sample-report-bcr-abl-mutation-analysis-positive.pdf

http://www.genzymegenetics.com/~/media/Files/Genetics/PDF/SampleReports/OncologyPathology/sample-report-bcr-abl-gene-rearrangement-quantitative-rt-pcr-analysis.pdf

http://www.genzymegenetics.com/~/media/Files/Genetics/PDF/SampleReports/OncologyPathology/sample-report-chromosome-analysis-cytogenetic-positive.pdf

Coding

000*	Negative result OR Not applicable (e.g., information not collected for this case) OR Test not done (e.g., test not ordered and was not performed) OR Unknown information (e.g., not documented in source record) OR OR Test ordered (e.g., results not in source records)
010	Positive

*Please note that this variable will be used in combination with the corresponding BCR-ABL related date and date flag variables to further substantiate which reason applies for coding "000" for a given case.

Section: Biomarkers – BCR-ABL
BCR-ABL: RT-PCR Qual Date
(Item # 9907)

BCR-ABL: RT-PCR Qual Date

Alternate Name	Item #	Length	Source of Standard	Column #
BCRABL_RTPCRQUALDATE	9907	8	CDC/NPCR-CER	1270

Cancer Site
CML

Description
Record the date of the *qualitative* Reverse Transcriptase Polymerase Chain Reaction RT-PCR for BCR-ABL t(9;22) (q34;q11) at the time of initial diagnosis. If multiple test results are recorded in the source records, use the date of the results that are closest to the date of diagnosis. This variable refers to all BCR-ABL transcriptions, including BCR-ABL2. RT-PCR Qualitative may be used to monitor disease response to therapy and relapse.

Use the date that the specimen was obtained and sent for analysis and not report date. Do not record results of this test after initiation of treatment.

Additional information and sample reports can be found at:
http://www.healthline.com/sw/cs-cml-how-cytogenetic-testing-is-used-for-diagnosis-and-to-monitor-treatment

http://www.genzymegenetics.com/~/media/Files/Genetics/PDF/SampleReports/OncologyPathology/sample-report-bcr-abl-mutation-analysis-positive.pdf

http://www.genzymegenetics.com/~/media/Files/Genetics/PDF/SampleReports/OncologyPathology/sample-report-bcr-abl-gene-rearrangement-quantitative-rt-pcr-analysis.pdf

http://www.genzymegenetics.com/~/media/Files/Genetics/PDF/SampleReports/OncologyPathology/sample-report-chromosome-analysis-cytogenetic-positive.pdf

Coding

See *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition, page 97* for date format.

Section: Biomarkers – BCR-ABL
BCR-ABL: RT-PCR Qual Date Flag
(Item # 9908)

BCR-ABL: RT PCR Qual Date Flag

Alternate Name	Item #	Length	Source of Standard	Column #
BCRABL_RTPCRQualDateFlag	9908	2	CDC/NPCR-CER	1278

Cancer Site
CML

Description
This flag explains why no appropriate value is in the field, BCR-ABL: RT-PCR Qual Date [9907].

Rationale
Prior to *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition,* Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields. The non-standard data items for the CDC/NPCR-CER project dates fields have been designed to follow the model set by the NAACCR standards.

Codes (see Appendix H of *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition,* Version 12, for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions).

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if BCR-ABL: RT-PCR Qual test done)
11	No proper value is applicable in this context (e.g., no BCR-ABL: RT-PCR Qual test done or not applicable)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., BCR-ABL: RT-PCR Qual test done, but date is unknown)
15	Information is not available at this time, but it is expected that it will be available later (e.g., BCR-ABL: RT-PCR Qual test ordered, but has not been administered at the time of the most recent follow up)
Blank	A valid date value is provided in item BCR-ABL: RT-PCR Qual Date [9907], or the date was not expected to have been transmitted

Comment: This is consistent with part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

Section: Biomarkers – BCR-ABL
BCR-ABL: RT-PCR Quant
(Item # 9909)

BCR-ABL: RT-PCR Quant

Alternate Name	Item #	Length	Source of Standard	Column #
BCRABL_RTPCRQUANT	9909	3	CDC/NPCR-CER	1280

Cancer Site
CML

Description
Record results of the quantitative Reverse Transcriptase Polymerase Chain Reaction RT-PCR for BCR-ABL t(9;22) (q34;q11) at time of initial diagnosis. If multiple test results are recorded in the source records, use results that are closest to the date of diagnosis. This variable refers to all BCR-ABL transcriptions, including BCR-ABL2.

Quantitative RT-PCR may be used to monitor disease response to therapy and relapse.

Do not record results of this test after initiation of treatment.

Quantitative units for BCR-ABL transcript levels are reported as a ratio of fusion gene transcript to β-2-microgloblin reference gene transcript.

Additional information and sample reports can be found at:
http://www.healthline.com/sw/cs-cml-how-cytogenetic-testing-is-used-for-diagnosis-and-to-monitor-treatment

http://www.genzymegenetics.com/~/media/Files/Genetics/PDF/SampleReports/OncologyPathology/sample-report-bcr-abl-mutation-analysis-positive.pdf

http://www.genzymegenetics.com/~/media/Files/Genetics/PDF/SampleReports/OncologyPathology/sample-report-bcr-abl-gene-rearrangement-quantitative-rt-pcr-analysis.pdf

http://www.genzymegenetics.com/~/media/Files/Genetics/PDF/SampleReports/OncologyPathology/sample-report-chromosome-analysis-cytogenetic-positive.pdf

Note 1: Other names for this test include: real time RT-PCR, BCR-ABL Gene Rearrangement Analysis

Coding

000*	Negative result OR Not applicable (e.g., information not collected for this case) OR Test not done (e.g., test not ordered and was not performed) OR Unknown information (e.g., not documented in source record) OR OR Test ordered (e.g., results not in source records)

001 - 998	Ratio of 0.001 to 0.998 (enter exact ratio)
999	Ratio greater than or equal to 0.999

*Please note that this variable will be used in combination with the corresponding BCR-ABL related date and date flag variables to further substantiate which reason applies for coding “000” for a given case.

Section: Biomarkers – BCR-ABL
BCR-ABL: RT-PCR Quant Date
(Item # 9910)

BCR-ABL: RT-PCR Quant Date

Alternate Name	Item #	Length	Source of Standard	Column #
BCRABL_RTPCRQUANTDATE	9910	8	CDC/NPCR-CER	1283

Cancer Site
CML

Description
Record date of quantitative Reverse Transcriptase Polymerase Chain Reaction RT-PCR for BCR-ABL t(9;22) (q34;q11) at time of initial diagnosis. If multiple test results are recorded in source records, use date related to results that are closest to date of diagnosis. This variable refers to all BCR-ABL transcriptions, including BCR-ABL2.

Quantitative RT-PCR may be used to monitor disease response to therapy and relapse.

Use the date that the specimen was obtained and sent for analysis and not the report date. Do not record results of this test after initiation of treatment.

Quantitative units for BCR-ABL transcript levels are reported as a ratio of fusion gene transcript to β-2-microgloblin reference gene transcript.

Additional information and sample reports can be found at:
http://www.healthline.com/sw/cs-cml-how-cytogenetic-testing-is-used-for-diagnosis-and-to-monitor-treatment

http://www.genzymegenetics.com/~/media/Files/Genetics/PDF/SampleReports/OncologyPathology/sample-report-bcr-abl-mutation-analysis-positive.pdf

http://www.genzymegenetics.com/~/media/Files/Genetics/PDF/SampleReports/OncologyPathology/sample-report-bcr-abl-gene-rearrangement-quantitative-rt-pcr-analysis.pdf

http://www.genzymegenetics.com/~/media/Files/Genetics/PDF/SampleReports/OncologyPathology/sample-report-chromosome-analysis-cytogenetic-positive.pdf

Note 1: Other names for this test include: real time RT-PCR, BCR-ABL Gene Rearrangement Analysis

Coding
See *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition, page 97* for date format.

Section: Biomarkers – BCR-ABL
BCR-ABL: RT-PCR Quan Date Flag
(Item # 9911)

BCR-ABL: RT PCR Quan Dt Flg

Alternate Name	Item #	Length	Source of Standard	Column #
BCRABL_RTPCRQuantDateFlag	9911	2	CDC/NPCR-CER	1291

Cancer Site
CML

Description
This flag explains why no appropriate value is in the field, BCR-ABL: RT-PCR Quan Date [9910].

Rationale
Prior to *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition,* Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields. The non-standard data items for the CDC/NPCR-CER project dates fields have been designed to follow the model set by the NAACCR standards.

Codes (see Appendix H of *NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition,* Version 12, for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions).

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if BCR-ABL: RT-PCR Quant test done)
11	No proper value is applicable in this context (e.g., no BCR-ABL: RT-PCR Quant test done or not applicable)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., BCR-ABL: RT-PCR Quant test done, but date is unknown)
15	Information is not available at this time, but it is expected that it will be available later (e.g., BCR-ABL: RT-PCR Quant test ordered, but has not been administered at the time of the most recent follow up)
Blank	A valid date value is provided in item BCR-ABL: RT-PCR Quant Date [9910], or the date was not expected to have been transmitted

Comment: This is consistent with part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

Section: NBCCEDPLinkage Results
(Item # 9980)

NBCCEDP Linkage Results

Alternate Name	Item #	Length	Source of Standard	Column #
NBCCEDPLinkageResults	9980	1	CDC/NPCR-CER	2840

Cancer Site
Breast, Cervix

Description
The purpose of this variable is to enhance the completeness and quality of the central registry database by expanding the linkage with the state Breast and Cervical Cancer Early Detection Program (BCCEDP) data system, and to capture and maintain the resulting information. The information to be captured and maintained includes a BCCEDP link variable and BCCEDP link date. The NBCCEDP MDE Link variable will identify breast or cervical cancer cases in the registry database that matched the same patient and tumor in the NBCCEDP data set (i.e.; patient Jane Doe right breast infiltrating duct carcinoma diagnosed in 2004 in the registry database matched the same Jane Doe right breast infiltrating duct carcinoma diagnosed in 2004 in the NBCCEDP data set).
The BCCEDP link date indicates the date this linkage occurred.

Results from the linkage between central cancer registries and the breast and cervical cancer screening programs should be used to:

- Update MDE data with central cancer registry staging and final diagnosis data
- Identify missing cancer cases in either data set
- Reconcile differences between the two data sets
- Registries are expected to expand these linkages to include post-linkage capture and maintenance of selected data from the BCCEDP data system within the cancer registry; and submit those variables to CDC in the annual NPCR-CSS Call for Data.

Coding

0	record sent for linkage, no match for this cancer with BCCEP data
1	record sent for linkage, match for this cancer with BCCEP data
BLANK	record not sent for linkage or linkage result pending
	(note: "or linkage result pending" added June 2011)

For reportable breast and cervical cancer cases, use the BCCEDP MDE Link variable and BCCEDP MDE Link date to record results from your registry's data linkage with the

appropriate BCCEDP program(s) in your state/territory/jurisdiction. For the BCCEDP MDE Link variable, use codes 0 (record sent for linkage, no match for this cancer with BCCEDP data) or 1 (record sent for linkage, match for this cancer with BCCEDP data) to indicate linkage results. If the record was not sent for linkage, this variable is to be left blank. If the registry database record links with a BCCEDP database record, indicated by code 1 in the BCCEDP MDE Link variable, the BCCEDP MDE Link date must be completed to indicate the date the linkage occurred. Otherwise, the BCCEDP MDE Link date must be blank.

See Appendix 9: NBCCEDP MDE Link Variables for additional background.

Section: NBCCEDP
Linkage Date
(Item # 9981)

NBCCEDP Linkage Date

Alternate Name	Item #	Length	Source of Standard	Column #
NBCCEDPLinkageDate	9981	8	CDC/NPCR-CER	2841

Cancer Site
Female Breast, Cervix

Description
The purpose of this variable is to enhance the completeness and quality of the central registry database by expanding the linkage with the state Breast and Cervical Cancer Early Detection Program (BCCEDP) data system and to capture and maintain the resulting information. The information to be captured and maintained includes a BCCEDP link variable and BCCEDP link date. The NBCCEDP MDE Link variable will identify breast or cervical cancer cases in the registry database that matched the same patient and tumor in the NBCCEDP data set (i.e.; patient Jane Doe right breast infiltrating duct carcinoma diagnosed in 2004 in the registry database matched the same Jane Doe right breast infiltrating duct carcinoma diagnosed in 2004 in the NBCCEDP data set). The BCCEDP link date indicates the date this linkage occurred.

Results from the linkage between central cancer registries and the breast and cervical cancer screening programs should be used to:

- Update MDE data with central cancer registry staging and final diagnosis data
- Identify missing cancer cases in either data set
- Reconcile differences between the two data sets
- Registries are expected to expand these linkages to include post-linkage capture and maintenance of selected data from the BCCEDP data system within the cancer registry; and submit those variables to CDC in the annual NPCR-CSS Call for Data.

Coding

YYYYMMDD = date this cancer linked with BCCEDP data
BLANK = record did not link with BCCEDP data or linkage result pending
(note: "or linkage result pending" added June 2011)

For reportable breast and cervical cancer cases, use the BCCEDP MDE Link variable and BCCEDP MDE Link date to record results from your registry's data linkage with the appropriate BCCEDP program(s) in your state/territory/jurisdiction. For the BCCEDP

MDE Link variable, use codes 0 (record sent for linkage, no match for this cancer with BCCEDP data) or 1 (record sent for linkage, match for this cancer with BCCEDP data) to indicate linkage results. If the record was not sent for linkage, this variable is to be left blank. If the registry database record links with a BCCEDP database record, indicated by code 1 in the BCCEDP MDE Link variable, the BCCEDP MDE Link date must be completed to indicate the date the linkage occurred. Otherwise, the BCCEDP MDE Link date must be blank.

See Appendix 9: NBCCEDP MDE Link Variables for additional background.

Section: Comorbidities
Source Comorbidity
(Item # 9970)

Source Comorbidity

Alternate Name	Item #	Length	Source of Standard	Column #
SourceComorbidity	9970	1	CDC/NPCR-CER	1297

Cancer Site
All

Description
This data item is to record the data source from which comorbidities/complications were collected. This data item refers back to standard NAACCR data item # 3110, 3120, 3130, 3140, 3150, 3160, 3161, 3162, 3163, and 3164.

Coding

0 No comorbid condition or complication identified/Not Applicable
1 Collected from facility face sheet
2 Linkage to facility/hospital discharge data set
3 Linkage to Medicare/Medicaid data set
4 Linkage with another claims data set
5 Combination of two or more sources above
9 Other source

APPENDIX H:
CDC Patient-Centered Outcomes (PCO) Project

DATA DICTIONARY FOR NON-NAACCR
STANDARD ITEMS

CDC Patient Centered Outcomes Research

Data Dictionary for Patient Centered Outcomes Research (PCOR) Data Items

March 5, 2014

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention & Health Promotion
Division of Cancer Prevention and Control
Cancer Surveillance Branch

Overview

The purpose of this document is to define data standards for Patient Centered Outcomes Research (PCOR)-specific data items that will be collected through the CDC's expanding data collection infrastructure of the National Program of Cancer Registries (NPCR). For all variables that are not routinely collected through NPCR and are not defined by NAACCR, this document describes the data items, the cancer site for which these data items will be collected, the codes to be used, and the source(s) of the data items. In addition, for variables included in the PCOR data set that are defined by the NAACCR Standards for Cancer Registries, Volume II, Data Standards and Data Dictionary, this document also includes their definitions, codes, and the cancer site for which the items will be collected.

Patient Centered Outcomes Research (PCOR)

The purpose of the PCOR activities is to collect longitudinal follow-up of 2011 diagnosed cancer cases of the colon, rectum and breast (male and female). Follow-up will include assessment of vital status, disease recurrence, disease progression and additional type of treatment. If you discover first course treatment data that was not previously collected under CER, please collect that information in the relevant CER data variables.

Follow-up of NPCR Specialized Registries breast, colon, and rectal cancer cases diagnosed in 2011

CDC submitted a proposal to HHS for Patient Centered Outcomes Research funds in order to continue the follow-up of breast, colon, and rectal cancer cases for whom detailed treatment data was collected within the NPCR Specialized Registries. Funding was obtained in FY2013 for this continued follow-up. The focus of this new additional data collection is to assess recurrence and progression of cancer as well as the type of any additional treatment (chemotherapy, radiotherapy, surgery). Additionally minimal data will be collected using standard NAACCR rules on diagnosis data and site of any subsequent primary. These data will permit researchers to evaluate the effectiveness of various treatments for these cancer patients using intermediate outcomes (i.e. recurrence, progression) rather than relying solely on mortality data. The results from analyses may substantially alter future treatment recommendations; therefore, it is critical that the information collected be as accurate as possible.

While passive follow-up measures may be used to assist in identifying recurrence or progression as rapidly as possible, active periodic review of medical records and/or physician contact, as well as active searching for additional information, are mandatory parts of this data collection.

Passive methods to identify progression or recurrence may include reports from hospitals or other providers, such as radiotherapy centers, and linkage with hospital discharge or other data sets. These types of reports need follow-up to determine the date of progression or recurrence, and whether there was a documented period with no evidence of disease / NED / disease-free.

Active assessment of disease status is necessary to minimize patients considered lost to follow-up since physician records may contain additional information and to ensure that the most accurate data are collected. Active assessment of disease status includes review of medical charts (physician notes,

radiology reports, pathology reports, etc.) by the registry or specific verification via the provider for each eligible breast, colon, and rectum case.

To aid in collection of this data, appendix one discusses NCCN guidelines for site specific (and stage as appropriate) post treatment surveillance activities to help the abstractor know what to expect in the medical record of these patients. Additionally we have provided example scenarios and a list of ambiguous terms equivalent to "Disease Free".

Registries will start the follow-up with the cases diagnosed in January 2011 and work their way forward in time to maximize the follow-up time period, to reduce opportunities for loss to follow-up, and to create similar follow up time periods between diagnosis and active review. Active review requires review of the medical chart(s) or other direct communication with the office of the medical care provider in sufficient detail to provide the required information on progression or recurrence. It is NOT recommended that you rely on reports from CoC hospital registries alone. The source of case status ascertainment will also be collected (e.g. via medical chart, physician contact, etc.). The registries should distribute the active follow-up of cases over the time period to spread the work load and also to create similar follow-up dates for all cases (32 months post diagnosis, for example).

Timing of follow-up and additional critical instructions

Please note that it is requested that registries collect any first course treatment information that is identified but that was not collected during the CER project.

A minimum of 32 months active follow-up is required and all related PCOR data items should be collected for each case via active follow-up. Passive follow-up can be used to continue follow-up as long as possible. Follow-up should begin with those cases diagnosed in early 2011.

We know that it may be possible for registries to review a medical chart at 32 months, but that the actual last visit for the case was less than 32 months. This is acceptable. The active follow-up (review of records) should extend to at least 32 months for each case.

One method of focusing work on those cases that may be difficult to locate could be:

- Contact providers and verify when the patient was last seen at that provider. This should help identify patients who have visited the physician and for whom records should be available for review versus those for who may require additional searching.

Please note:

- As part of the passive follow-up, recurrence and progression may be identified through different means; however, passive follow-up (reports from CoC hospitals, data linkages) are not expected to be the primary sources of information and should be followed up with documentation or verification.

SUMMARY	
Active Follow-up At least 32 months post 2011 initial diagnosis: date of active follow-up by registry/abstractor	• PCOR # 8000, ActiveFUDt (Active Follow Up Date)
Estimated date of completion of first course therapy Used to put in disease status dates into context. This is meant to be an estimated date (month and year accepted).	• PCOR # 8001, Comp1stCrsRxStat (*provides information on completion of first course therapy)* • PCOR # 8002, Comp1stCrsRxDt (***estimated** date of completion of first course therapy, month and year*) • PCOR # 8003, Comp1stCrsStatusDatSrc (*provides source of information on status – lab tests, physical, etc.)*
Disease Free / No Evidence of Disease Information on patients' disease free status and dates of **first (earliest)** and **last (most recent)** medical evidence of patient disease free status are recorded in these fields. Do not skip these questions; there are opportunities in the status variables to record if a patient was never disease free. Dates can be left blank if no date is applicable.	• PCOR # 8004, DsFreeStatus (*indicates if the patient ever had a documented disease free status*) • PCOR # 8005, FrstDsFreeDt (***first / earliest date** after treatment that "disease free" status is noted*) • PCOR # 8006, FrstDsFreeDatSrcUsd (*provides source of information on status – lab tests, physical, etc.)* • PCOR # 8007, AddnlDsFreeStatus (*indicates if the patient ever had multiple records reporting disease free status*) • *P*COR # 8008, LstDsFreeDt ***(latest / most recent** date that there were indications that patient was disease free)* • PCOR # 8009, AddnlDsFreeDatSrcUsd (*provides source of information on status – lab tests, physical, etc.)*
Recurrence, Progression, or Residual Disease These variable fields are used to collect information on recurrence, progression and residual disease. Do not skip these questions; there are opportunities to record not applicable status.	• PCOR # 8010, RecStatus (*indicates if the patient ever had a documented recurrence)* • PCOR # 8011, FrstRecDt (*first date where medical evidence indicates recurrence*) • PCOR # 8012, TypeOfRecurrence (*detailed variable on recurrence*) • PCOR # 8013, RcrDatSrc (*medical evidence of recurrence based on physical, lab tests, imaging, etc.*) • PCOR # 8014, ProgResidDsStatus (*indicates if patient progressed during or after first course therapy or had residual disease after completion of first course therapy*) • PCOR # 8015, ProgressionDt (*date where medical evidence indicates progression or residual disease*) • PCOR # 8016, ProgResidDatSrc (*medical evidence of recurrence based on physical, lab tests, imaging, etc.*)

Subsequent Primary Describes recorded medical evidence of subsequent primary cancers relative to the patients 2011 colon, breast, or rectal cancer.	• PCOR # 8017, SubseqPrmryStatus, (*records evidence and site of subsequent tumors)* • PCOR #8018, SubsqPrmryDt (*first / earliest date where subsequent primary mentioned*) • PCOR #8019, SubsqPrmryDatSrc (*medical evidence of recurrence based on physical, lab tests, imaging, etc.)*
Subsequent treatment for primary (Yes, No, Unknown for each type) ***For CER#9921-9926, states may record more detailed information using CER codes provided (these will be indented and italicized)***	• NAACCR #1660, Subseq Tx 2nd Crs Start Date • CDC CER # 9955, Subseq Tx 2nd Crs Start Date Flag • CDC CER # 9921, Subseq Tx 2nd Crs Surgery • CDC CER # 9922, Subseq Tx 2nd Crs Radiation • CDC CER # 9923, Subseq Tx 2nd Crs Chemotherapy • CDC CER # 9925, Subseq Tx 2nd Crs BRM • CDC CER # 9926, Subseq Tx 2nd Crs Other (non-hormone therapy)
Vital status	• NAACCR # 1760, Vital Status • NAACCR # 1750, Date of Last Contact • NAACCR # 1751, Date of Last Contact Flag

(Item # 8000)

Alternate Name	Item #	Length	Source of Standard	Column #
ActiveFUDt	8000	8	CDC/PCOR	2292-2299

Cancer Site
Breast, Colon, and Rectum

Description
This variable is used to code the latest date in which abstractors conducted active follow up for the patient. Active follow up requires that the abstractors go beyond receiving COC hospital cancer registry reports and that (abstractors) check hospital, physician office, and non-hospital/non-physician offices sources (including independent/non-hospital based pathology laboratories). This date should be a minimum of 32 months post diagnosis.

Coding Instructions
The date format (YYYYMMDD) specifically addresses the NAACCR standard data transmission format; not how the data should be stored in an individual registry's database or viewed on the screen.

Format
YYYYMMDD

The field is fixed-length and left-justified.

Coding

See above format instructions from NAACCR Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary, Fifteenth Edition, page 97 for date format.

Complete date must be entered; Blanks, 9's /Unknown may not be entered for this variable.

Completion 1st Course Therapy Status

(Item # 8001)

Alternate Name	Item #	Length	Source of Standard	Column #
Comp1stCrsRxStat	8001	1	CDC/PCOR	1624-1624

Cancer Site
Breast, Colon, and Rectum

Description
This variable is used to code the status of completion of first course therapy (excluding use of hormonal therapy). This information will be used to establish an understanding of whether or not the patient may have completed first course therapy and how this relates to information on known disease status collected later.

NOTE: For the purposes of the PCOR

Coding Instructions

Coding

0 N/A - No information on patient other than a diagnosis of cancer (lost to follow-up).

1 Patient completed 1st course therapy (excluding hormonal therapy).

2 Pt never completed 1st course therapy (excluding hormonal therapy), i.e. patient still receiving 1st course therapy.

3 First course therapy declined or stopped prior to completion by the patient, the patient's family member, or the patient's guardian.

4 First course therapy terminated by physician prior to completion (progression or inadequate response).

5 Patient died prior to completion of first course therapy

9 Unknown. It is uncertain if patient completed first course therapy. *Should be used when patient known to either begin 1st course treatment but then is lost to follow-up, or received 1st course treatment out of state and are unable to obtain record of treatment.*

Completion 1st Course Therapy Date

(Item # 8002)

Alternate Name	Item #	Length	Source of Standard	Column #
Comp1stCrsRxdt	8002	8	CDC/PCOR	1625-1632

Cancer Site
Breast, Colon, and Rectum

Description
This variable is used to code the ESTIMATED DATE of completion of first course therapy (excluding use of hormonal therapy). This information will be used to establish an understanding of when a patient may have completed first course therapy and how this relates to information on known disease status collected later.

NOTE: For the purposes of the PCOR we are not relying on diagnosis date or date of surgery alone to calculate survival but are attempting to put in the context of survival length after completion of first course therapy (obtaining information on completion of adjuvant chemotherapy and other first course therapies excluding hormonal therapy gives us this ability).

Coding Instructions
The date format (YYYYMMDD) specifically addresses the NAACCR standard data transmission format; not how the data should be stored in an individual registry's database or viewed on the screen.

Every effort must be made to collect, at a minimum, the estimated month and year.

YYYYMMDD – when year, month and day are known and valid
9's can be used when no date can be estimated (patient did not complete first course of treatment)
Any missing date component should be replaced by 9s.

Note: Year only should not be used.

The field is fixed-length and left-justified. If there are no known date components, the fixed-length variable will be 99999999.

Completion of First Course Therapy Status Data Sources Used

(Item # 8003)

Alternate Name	Item #	Length	Source of Standard	Column #
Comp1stCrsStatusDatSrc	8003	1	CDC/PCOR	1633-1633

Cancer Site
Breast, Colon, and Rectum

Description
This variable is used to code the source(s) from which confirmation of the patient's completion of first course therapy (or lack thereof) was obtained.

Rationale
This item will help registries and researchers know the location from which information on the patient's status was collected and help assess the breadth of medical documentation available through active surveillance to determine this information. *(Please note that, while we anticipate the vast majority of cases will fit into code 5, being able to identify when cases do not fit into code 5 will be useful to researchers using the data set. If lost to follow-up should document what sources were used prior to patient being lost – i.e. if patient reported by pathology laboratory only and no other information can be found then select option 4.)*

Coding Instructions
Select the best code based upon the sources from which active follow up was completed.

Coding Instructions
Use the following codes to specify the source from which the patient's cancer status was determined as of the first round of active follow up.

0 N/A – No documentation other than a diagnosis of cancer (lost to follow-up).

1 COC hospital cancer registry reporting only (*note: relying only on reports from COC hospitals is NOT recommended*)

2 Hospital-only documents and files

3 Physician-office only sources

4 Non-hospital/non-physician office only sources (including independent/non-hospital based pathology laboratories, out of state case sharing, etc.)

5 A combination of sources 2-4 with or without CoC registries

Documented Disease Free Status
(Item # 8004)

Alternate Name	Item #	Length	Source of Standard	Column #
DsFreeStatus	8004	1	CDC/PCOR	2300-2300

Cancer Site
Breast, Colon, and Rectum

Description
This variable is used to indicate if the patient ever had a documented disease free / no evidence of disease status. Information recorded here should correspond with one of the following: history and physical, labs or imaging used to determine disease status. Please note that the laboratory tests or scans can include (but are not limited to): blood tests, liver tests, mammogram, CT scans, colonoscopy, MRI, bone scan, chest imaging, biopsy, etc.).

Coding

0 No information on patient other than a diagnosis of cancer.

1 Patient never found to be disease free (includes those with residual disease, progression, and those who may have died prior to being disease free).

2 Patient had at least one record of documented disease free status.

9 Unknown. It is unclear in patient record if ever disease free.

First (earliest) Documented Disease Free Date (Item # 8005)

Alternate Name	Item #	Length	Source of Standard	Column #
FrstDsFreeDt	8005	8	CDC/PCOR	2301-2308

Cancer Site
Breast, Colon, and Rectum

Description
This variable is used to code the **first (earliest) date** that the patient was determined to be disease free. This date should correspond with one of the following: history and physical, labs or imaging used to clinically evaluate cancer status reported in variable #8004. Please note that the laboratory tests or scans can include (but are not limited to): blood tests, liver tests, mammogram, CT scans, colonoscopy, MRI, bone scan, chest imaging, biopsy, etc.).

The date can correspond with whatever evidence appears to have been used to make the note in the medical record and does not need to correspond to a hierarchy of definitive sources (e.g., if a physician noted "disease free" based on H&P, and later confirmed via a laboratory test, the date of the H&P is still the corresponding date).

Note: *Although many research papers choose either the date of diagnosis or the date of surgery as the start date in survival analysis, we would like the first date where the patient is documented as having no evidence of disease (NED). This may not occur until patient has had some post treatment follow-up such as a CT scan or serial CEA's.*

Coding Instructions
Use date format YYYYMMDD to record the earliest date associated with evidence of disease progression or of the patient being considered disease free (no clinical evidence of disease, disease free; in remission)

Format
YYYYMMDD when complete date is known and valid
9's should be used when the date is unknown or the patient was never disease free.
Any missing date component should be replaced by 9s.
Year only should not be recorded.

The field is fixed-length and left-justified.

Coding

9's may be used when not documented to ever be disease free.

First (earliest) Disease Free Status Data Sources Used (Item # 8006)

Alternate Name	Item #	Length	Source of Standard	Column #
FrstDsFreeDatSrcUsd	8006	1	CDC/PCOR	2309-2309

Cancer Site
Breast, Colon, and Rectum

Description
This variable is used to code the source(s) from which confirmation of the patient's first disease free cancer status (**or lack thereof**) was obtained.

Rationale
This item will help registries and researchers know the location from which information on the patient's status was collected and help assess the breadth of medical documentation available through active surveillance to determine this information. *(Please note that, while we anticipate the vast majority of cases will fit into code 5, being able to identify when cases do not fit into code 5 will be useful to researchers using the data set.)*

Coding Instructions
Select the best code based upon the sources from which active follow up was completed.

Coding Instructions
Use the following codes to specify the source from which the patient's cancer status was determined as of the first round of active follow up.

0 N/A – No documentation other than a diagnosis of cancer (lost to follow-up).

1 COC hospital cancer registry reporting only (*note: relying only on reports from COC hospitals is NOT recommended*)

2 Hospital-only documents and files

3 Physician-office only sources

4 Non-hospital/non-physician office only sources (including independent/non-hospital based pathology laboratories, out of state case sharing, etc.)

5 A combination of sources 2-4 with or without CoC registries

Additional Disease Free Status (Item # 8007)

Alternate Name	Item #	Length	Source of Standard	Column #
AddnlDsFreeStatus	8007	1	CDC/PCOR	2310-2310

Cancer Site
Breast, Colon, and Rectum

Description
This variable is used to further describe the patients recorded disease free status. This information should be based on one or more of the following: history and physical, labs or imaging used to clinically evaluate cancer status. Please note that the laboratory tests or scans can include (but are not limited to): complete blood count, liver tests, mammogram, CT scans, colonoscopy, MRI, bone scan, chest imaging, biopsy, etc.).

Coding

0 N/A – No information on patient other than a diagnosis of cancer, patient never found to be disease free (residual disease or progression, Item #8005), or unclear in patient record if ever disease free.

1 Patient had multiple documented encounters on different dates in medical record and had no evidence of disease through completion of active follow-up for this patient (the first / earliest recorded disease free date recorded in Item #8005)

2 Patient had two or more disease free encounters (the first / earliest recorded in Item #8005) documented in medical record but eventually had documented recurrence.

3 Patient found to be disease free (Item #8005 complete) but only one record of being disease free no additional medical records found – lost to follow-up

4 Patient found to be disease free but only one record of being disease free (Item #8005 complete) but next patient record found recurrence

9 Unknown. Patient was disease free (Item #8005 completed) and additional patient documentation exists, however it is unclear if remained disease free.

Last (most recent) Disease Free Date (Item # 8008)

Alternate Name	Item #	Length	Source of Standard	Column #
LstDsFreeDt	8008	8	CDC/PCOR	2311-2318

Cancer Site
Breast, Colon, and Rectum

Description
This variable is used to code the last (most recent/most current) date the patient was considered disease free. This may be the same as the earliest disease free date (i.e. when no additional information is available or a patient is noted to have recurrence on the next encounter). This date should correspond with one or a combination of the following: history and physical, labs or imaging used to clinically evaluate cancer status reported in variable #8007. Please note that the laboratory tests or scans can include (but not limited to): complete blood count, liver tests, mammogram, CT scans, colonoscopy, MRI, bone scan, chest imaging, biopsy, etc.). The date can correspond with whatever evidence appears to have been used to make the note in the medical record and does not need to correspond to a hierarchy of definitive sources.

NOTE: A series of H &P's, lab studies and imaging studies may be part of a recommended surveillance plan where the disease status and date should be assessed from the collection of these as a group (a cluster of appointments and tests). See the following examples and Appendix One for further information.

Examples:

1) If a patient had a medical appointment where the physician noted "No Evidence of Disease / NED" based on physical exam but ordered a colonoscopy and CT scan which were completed one week later and were negative**, the date of the most recent test/study should be used.**
2) However if a patient had a medical appointment where the physician noted "No Evidence of Disease / NED" based on physical exam but ordered a colonoscopy and CT scan where one of them was positive for recurrence, *none of these dates should be used as last (most recent) disease free since they were part of a surveillance grouping*. In this case the group of tests and appointments **prior to this would be used as the last (most recent) disease free date.**

This item differs from the standard NAACCR date of last contact variable in that it is not updated based on sources other than clinical data. While the standard NAACCR variable date of last contact can be updated based on linkages to a variety of databases (including department of motor vehicles, NDI, etc.), this date must correspond to active follow up of clinical sources for the PCOR study.

Coding Instructions
Use date format YYYYMMDD to record the latest/most recent date associated with evidence of the patient being considered disease free (see guidance above for a cluster of appointments or tests)
Format
YYYYMMDD when complete date is known and valid
9's could be used when the date is unknown or never disease free
Any missing component should be replaced by s9's. Year only should not be recorded.
The field is fixed-length and left-justified.
Coding
Note: 9's may be used when not documented to ever be disease free.

Additional Disease Free Status Data Sources Used (Item # 8009)

Alternate Name	Item #	Length	Source of Standard	Column #
AddnlDsFreeDatSrcUsd	8009	1	CDC/PCOR	2319-2319

Cancer Site
Breast, Colon, and Rectum

Description
This variable is used to code the source(s) from which confirmation of the patient's additional disease free cancer status and date (**or lack thereof**) was recorded.

Rationale
This item will help registries and researchers know the location from which information on the patient's status was collected and help assess the breadth of medical documentation available through active surveillance to determine this information. *(Please note that, while we anticipate the vast majority of cases will fit into code 5, being able to identify when cases do not fit into code 5 will be useful to researchers using the data set.)*

Coding Instructions
Select the best code based upon the sources from which active follow up was completed.

Coding Instructions
Use the following codes to specify the source from which the patient's cancer status was determined as of the first round of active follow up.

0 N/A - No documentation other than a diagnosis of cancer (lost to follow-up).

1 COC hospital cancer registry reporting only (*note: relying only on reports from COC hospitals is NOT recommended*)

2 Hospital-only documents and files

3 Physician-office only sources

4 Non-hospital/non-physician office only sources (including independent/non-hospital based pathology laboratories, out of state case sharing, etc.)

5 A combination of sources 2-4 with or without CoC registries

Recurrence Status
(Item # 8010)

Alternate Name	Item #	Length	Source of Standard	Column #
RecStatus	8010	1	CDC/PCOR	2320-2320

Cancer Site
Breast, Colon, and Rectum

Description
This variable is used to further describe any recorded evidence of recurrence (this means there was a disease free period before the cancer reappeared -- not residual disease or progression). This information should be based on one of the following: history and physical, labs or imaging used to clinically evaluate cancer status. Please note that the laboratory tests or scans can include (but are not limited to): blood tests, liver tests, mammogram, CT scans, colonoscopy, MRI, bone scan, chest imaging, biopsy, etc.).

Coding

0 Patient never found to be disease free (for example if patient progressed, has residual disease, lost to follow-up after diagnosis, or died prior to becoming disease free and therefore not able to have a recurrence).

1 Found to be disease free and remained disease free till end of study.

2 Documented recurrence (after a documented status of disease free / no evidence of disease / NED)

3 Uncertain if recurrence or residual disease based on incomplete documentation.

4 Uncertain if recurrence or residual disease based on conflicting documentation (one provider reports recurrence and another reports residual disease).

9 Unknown. Patient was disease free (Item #8005complete) and additional patient documentation exists, however it is unclear if remained disease free or recurred.

First Recurrence Date
(Item # 8011)

Alternate Name	Item #	Length	Source of Standard	Column #
FrstRecDt	8011	8	CDC/PCOR	2321-2328

Cancer Site
Breast, Colon, and Rectum

Description
This variable is used to code the **first** date where there was evidence of recurrence (this means there was a disease free / no evidence of disease period before the cancer reappeared -- not residual disease or progression). This date should correspond with one of the following: history and physical, labs or imaging used to clinically evaluate cancer status reported in PCOR variable #8010. Please note that the laboratory tests or scans can include (but are not limited to): blood tests, liver tests, mammogram, CT scans, colonoscopy, MRI, bone scan, chest imaging, biopsy, etc.).

The date can correspond with whatever evidence appears to have been used to make the first note in the medical record of recurrence and does not need to correspond to a hierarchy of definitive sources (e.g., if a physician noted "recurrence" based on H&P, and later confirmed via a laboratory test, the date of the H&P is still the corresponding date).

Coding Instructions
Use date format YYYYMMDD to record the earliest date associated with the first recurrence of the primary tumor.

Format
YYYYMMDD when complete date is known and valid
9s should be used when the date is unknown or no known date applies
Any missing component should be replaced by s9's
Year only should not be recorded.
The field is fixed-length and left-justified.. If there are no known date components, the fixed-length variable will be filled with eight 9's.

Coding

Note: 9's may be used when not documented to ever be disease free.

Type of Recurrence
(Item # 8012)

Alternate Name	Item #	Length	Source of Standard	Column #
Typeof Recurrence	8012	2	CDC/PCOR	2329-2330

Cancer Site
Breast, Colon, and Rectum

Description
Recurrence Type First
This variable is similar to standard NAACCR variable 1880 Type of First Recurrence, but has been revised to specific PCOR standards. The PCOR specific variable serves the following purposes: 1) collapses information from COC hospitals collected via NAACCR data item 1880 into broader categories; 2) defines broader categories for collection of information from non-COC facilities, and 3) creates one variable that will be consistent in how recurrence is define across PCOR collaborators. For registries collecting this information via COC hospitals that use standard NAACCR item 1880, a cross-walk file that converts codes in NAACCR item 1880 to codes in PCOR item 8008 is on the following page.

Coding
Code for the type of first recurrence after a period of documented disease free intermission or remission.

- 00 Patient became disease free after treatment and has not had a recurrence
- 01 In situ recurrence
- 10 Local recurrence
- 20 Regional recurrence, NOS
  - 21 Regional recurrence (adjacent tissues or organs)
  - 22 Regional lymph node (LN) recurrence
  - 25 Regional tissue/organ and Regional LN
- 30 Local and Regional (either LN or tissue/organ) Recurrence
- 40 Distant recurrence
- 70 Patient never disease free (residual disease, progression, or death).
- 88 Recurrence, type unknown
- 99 Unknown if recurrence or if patient was ever disease free (unclear / conflicting reports in medical record or lost to follow-up)

Conversion Type of First Recurrence: NAACCR Item #1880 to PCOR Item #8012

NAACCR Item #1880 Code	Definition	CDC/PCOR Item # 8012 Code/Recode	Comment
00	Patient became disease-free after treatment and has not had a recurrence.	00 Patient became disease free and has not had recurrence	
04	In situ recurrence of an invasive tumor.	01 Insitu recurrence	
06	In situ recurrence of an in situ tumor.	01 Insitu recurrence	
10	Local recurrence and there is insufficient information available to code to 13-17. Recurrence is 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.	10 Local recurrence	
13	Local recurrence of an invasive tumor.	10 Local recurrence	
14	Trocar recurrence of an invasive tumor. Includes recurrence in the trocar path or entrance site following prior surgery.	10 Local recurrence	
15	Both local and trocar recurrence of an invasive tumor (both 13 and 14)	10 Local recurrence	
16	Local recurrence of an in situ tumor.	10 Local recurrence	
17	Both local and trocar recurrence of an in situ tumor.	10 Local recurrence	
20	Regional recurrence, and there is insufficient information available to code to 21-27.	20 Regional recurrence tissue/organ	
21	Recurrence of an invasive tumor in adjacent tissue or organ(s) only.	21 Regional recurrence	
22	Recurrence of an invasive tumor in regional lymph nodes only.	22 Regional recurrence LN	

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.	25 Regional recurrence LN and tissue/organ	
26	Regional recurrence of an in situ tumor, NOS.	20 Regional recurrence	
27	Recurrence of an in situ tumor in adjacent tissue or organ(s) and in regional lymph nodes at the same time.	20 Regional recurrence	
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).	30 Regional and Local Recurrence	
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).	30 Regional and Local Recurrence	
40	Distant recurrence and there is insufficient information available to code to 46-62.	40 Distant Recurrence	
46	Distant recurrence of an in situ tumor.	40 Distant Recurrence	
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.	40 Distant Recurrence	
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.	70 Residual disease or progression.	
88	Disease has recurred, but the type of recurrence is unknown.	88 Recurrence, Unknown type	
99	It is unknown whether the disease has recurred or if the patient was ever disease-free.	99 Unknown	

Recurrence Status Data Sources Used
(Item # 8013)

Alternate Name	Item #	Length	Source of Standard	Column #
RcrDatSrc	8013	1	CDC/PCOR	2331-2331

Cancer Site
Breast, Colon, and Rectum

Description
This variable is used to code the source(s) from which confirmation of the patient's recurrence status (**or lack thereof**) was determined.

Rationale
This item will help registries and researchers know the location from which information on the patient's status was collected and help assess the breadth of medical documentation available through active surveillance to determine this information. *(Please note that, while we anticipate the vast majority of cases will fit into code 5, being able to identify when cases do not fit into code 5 will be useful to researchers using the data set.)*

Coding Instructions
Select the best code based upon the sources from which active follow up was completed.

Coding Instructions
Use the following codes to specify the source from which the patient's cancer status was determined as of the first round of active follow up.

0 N/A - No documentation other than a diagnosis of cancer (lost to follow-up)

1 COC hospital cancer registry reporting only (*note: relying only on reports from COC hospitals is NOT recommended*)

2 Hospital-only documents and files

3 Physician-office only sources

4 Non-hospital/non-physician office only sources (including independent/non-hospital based pathology laboratories, out of state case sharing, etc.)

5 A combination of sources 2-4 with or without CoC registries

Progression / Residual Disease Status
(Item # 8014)

Alternate Name	Item #	Length	Source of Standard	Column #
ProgResidDsStatus	8014	1	CDC/PCOR	2332-2332

Cancer Site
Breast, Colon, and Rectum

Description
This variable is used to further describe any recorded evidence of progression or residual disease (**NOT recurrence)**. This information should correspond with one of the following: history and physical, labs or imaging used to clinically evaluate cancer status. Please note that the laboratory tests or scans can include (but are not limited to): blood tests, liver tests, mammogram, CT scans, colonoscopy, MRI, bone scan, chest imaging, biopsy, etc.).

Coding

0 Patient found to be disease free.

1 Patient had partial response to therapy with residual disease (never disease free but not progressed).

2 Patient had documented progression during or after completion of first course therapy.

3 Patient never disease free but uncertain if progressed or residual.

9 Unknown –No information on patient other than a diagnosis of cancer or incomplete medical information (lost to follow-up or died prior to documentation of response to therapy)

Progression Date
(Item # 8015)

Alternate Name	Item #	Length	Source of Standard	Column #
ProgressionDt	8015	8	CDC/PCOR	3321-3328

Cancer Site
Breast, Colon, and Rectum

Description
This variable is used to code the **first** date where there was evidence of **progression** (not residual disease, no date collected for residual disease) either **during** 1st course therapy **or after completion** of 1st course therapy. (*Note: Collection of this information is not meant to address pre-treatment progression).* This date should correspond with one of the following: history and physical, labs or imaging used to clinically evaluate cancer status reported in PCOR variable #8014. Please note that the laboratory tests or scans can include (but are not limited to): blood tests, liver tests, mammogram, CT scans, colonoscopy, MRI, bone scan, chest imaging, biopsy, etc.).

The date can correspond with whatever evidence appears to have been used to make the first note in the medical record of progression (if applicable) and does not need to correspond to a hierarchy of definitive sources (e.g., if a physician noted "progression" based on H&P, and later confirmed via a laboratory test, the date of the H&P is still the corresponding date).

Coding Instructions
Use date format YYYYMMDD to record the earliest date associated with evidence of disease progression.

Format
YYYYMMDD when complete date is known and valid
9's could be used when the date is unknown or no known date applies
Any missing component should be replaced by s9's.
Year only should not be recorded.
The field is fixed-length and left-justified. If there are no known date components, the fixed-length variable will be filled with eight 9's.

Coding

Note: 9's may be used when no disease progression.

Progression Residual Disease Status Sources Used (Item # 8016)

Alternate Name	Item #	Length	Source of Standard	Column #
ProgResidDatSrcUsd	8016	1	CDC/PCOR	3329-3329

Cancer Site
Breast, Colon, and Rectum

Description
This variable is used to code the source(s) from which confirmation of the patient's cancer status (progression / residual disease **or lack thereof**)) was determined.

Rationale
This item will help registries and researchers know the location from which information on the patient's status was collected and help assess the breadth of medical documentation available through active surveillance to determine this information. *(Please note that, while we anticipate the vast majority of cases will fit into code 5, being able to identify when cases do not fit into code 5 will be useful to researchers using the data set.)*

Coding Instructions
Select the best code based upon the sources from which active follow up was completed.

Coding Instructions
Use the following codes to specify the source from which the patient's cancer status was determined as of the first round of active follow up.

0 N/A - No documentation other than a diagnosis of cancer (lost to follow-up).

1 COC hospital cancer registry reporting only (*note: relying only on reports from COC hospitals is NOT recommended*)

2 Hospital-only documents and files

3 Physician-office only sources

4 Non-hospital/non-physician office only sources (including independent/non-hospital based pathology laboratories, out of state case sharing, etc.)

5 A combination of sources 2-4 with or without CoC registries

Subsequent Primary Status
(Item # 8017)

Alternate Name	Item #	Length	Source of Standard	Column #
SubseqPrmryStatus	8017	1	CDC/PCOR	3330-3330

Cancer Site
Breast, Colon, and Rectum

Description
This variable is used to further describe any recorded evidence of a subsequent primary relative to a patients' initial 2011 CER-eligible tumor.

Abstractors should follow Multiple Primary and Histology Coding Rules Manual rules to determine subsequent primary for breast and colon.

Coding Instructions
Select the best code based upon documented evidence of the patient's cancer status during active follow up. Data collectors should NOT include information on synchronous primary cancers (cancers diagnosed at the same time in 2011 and within the same primary organ) in this data item.

Codes

0 N/A – No evidence of subsequent primary.

1 Evidence of subsequent primary, same site as initial tumor

2 Evidence of subsequent primary, site other than initial tumor

3 Evidence of subsequent primary, site unknown

9 Unknown. Conflicting documentation of possible subsequent primary versus recurrence or metastasis.

Subsequent Primary Date
(Item # 8018)

Alternate Name	Item #	Length	Source of Standard	Column #
SubsqntPrmryDt	8018	8	CDC/PCOR	3331-3338

Cancer Site
Breast, Colon, and Rectum

Description
This variable is used to code the **first** date where there was evidence of subsequent primary. This date should correspond with one of the following: history and physical, labs or imaging used to clinically evaluate cancer status reported in PCOR variable #8017. Please note that the laboratory tests or scans can include (but are not limited to): blood tests, liver tests, mammogram, CT scans, colonoscopy, MRI, bone scan, chest imaging, biopsy, etc.).

The date can correspond with whatever evidence appears to have been used to make the first note in the medical record of a subsequent primary and does not need to correspond to a hierarchy of definitive sources.

Coding Instructions
Use date format YYYYMMDD to record the earliest date associated with evidence of a subsequent primary.

Format
YYYYMMDD when complete date is known and valid
9's could be used when the date is unknown or no known date applies
Any missing component should be replaced by s9's
Year only should not be recorded.
The field is fixed-length and left-justified.. If there are no known date components, the fixed-length variable will be filled with eight 9's.

Coding

Note: 9's may be used when no documented subsequent primary.

Subsequent Primary Data Sources Used
(Item # 8019)

Alternate Name	Item #	Length	Source of Standard	Column #
SubsqPrmryDatSrcUsd	8019	1	CDC/PCOR	3339-3339

Cancer Site
Breast, Colon, and Rectum

Description
This variable is used to code the source(s) from which confirmation of the patient's cancer status (subsequent primary or lack thereof) was determined.

Rationale
This item will help registries and researchers know the location from which information on the patient's status was collected and help assess the breadth of medical documentation available through active surveillance to determine this information. *(Please note that, while we anticipate the vast majority of cases will fit into code 5, being able to identify when cases do not fit into code 5 will be useful to researchers using the data set.)*

Coding Instructions
Select the best code based upon the sources from which active follow up was completed.

Coding Instructions
Use the following codes to specify the source from which the patient's cancer status was determined as of the first round of active follow up.

0 N/A - No documentation other than a diagnosis of cancer (lost to follow-up).

1 COC hospital cancer registry reporting only (*note: relying only on reports from COC hospitals is NOT recommended*)

2 Hospital-only documents and files

3 Physician-office only sources

4 Non-hospital/non-physician office only sources (including independent/non-hospital based pathology laboratories, out of state case sharing, etc.)

5 A combination of sources 2-4 with or without CoC registries

Primary Tumor Subsequent Treatment

The following items refer to subsequent therapy given for the primary tumor. Item 1660 is a standard NAACCR data item for the date in which subsequent therapy began. Item number 9921 through 9926 were first introduced for the 2011 CER project and have been included for this PCOR project with some modifications.

In an attempt to make collection of subsequent therapy easier additional codes have been added to each data item to clearly indicate if the patient did receive subsequent therapy, did not receive subsequent therapy, or if it is unknown.

For coding purposes please use the new codes to indicate **not receiving** subsequent therapy or if it is unknown (these codes are 04 or 4 and 99 or 9 respectively depending on the length of the subsequent therapy item).

A code of 05 or 5, again depending on the item number should be used to code that the patient **did receive** subsequent therapy unless the state wishes to collect additional detail information regarding the subsequent therapy by using the codes previously established under CER with the exception of 00 or 0. The codes that may be collected for additional detailed information are indented.

- ***The codes that may be collected for additional detailed information are indented.***

Under no circumstances should 00 or 0 be coded for item number 9921 through 9926 for the PCOR project.

Primary Tumor Subsequent Treatment Start Date (Item # 1660)

Subsequent Rx 2nd Course Date

Alternate Name	Item #	Length	Source of Standard	Column #
SubsqRX2CrsDate	**1660**	**8**	**NAACCR**	**1724-1731**

Cancer Site
Breast, Colon, and Rectum

Description
Date of initiation of subsequent treatment for **primary tumor**.

Patient's medical records and available pharmacy data sets should be included as potential sources for obtaining this data.

Note: This data item is no longer supported by COC (as of January 1, 2003), but is being collected for the purposes of the PCOR special study.

Coding Instructions
Use date format YYYYMMDD to record the earliest date of subsequent treatment associated with evidence of disease progression or **recurrence.**
Format
YYYYMMDD when complete date is known and valid
9's could be used when the date is unknown or no known date applies
Any missing component should be replaced by s9's
Year only should not be recorded.
The field is fixed-length and left-justified.. If there are no known date components, the fixed-length variable will be filled with eight 9's.

Coding

Note: 9's may be used when no documented subsequent treatment.

Subsequent Treatment Date Flag CER (Item # 9955)

Subsq RX DateFlag CER

Alternate Name	Item #	Length	Source of Standard	Column #
SubsqRx2CrsDateFlagCER	9955	2	CDC/NPCR-CER	1862-1863

Cancer Site
Breast, Colon, and Rectum

Description
This flag explains why no appropriate value is in the field, Subsq RX 2nd Course Date [1660]. This data item was first available in Volume II Version 12 (effective January 2010).

Rationale
Prior to Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes (see NAACCR data dictionary Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions).

10	No information whatsoever can be inferred from this exceptional value (e.g., unknown if any subsequent therapy)
11	No proper value is applicable in this context (e.g., no subsequent therapy)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., subsequent therapy given, but date is unknown)
15	Information is not available at this time, but it is expected that it will be available later (e.g., subsequent therapy ordered, but has not been administered at the time of the most recent follow up)
Blank	A valid date value is provided in item Subsq RX 2nd Course Date [1660], or the date was not expected to have been transmitted

Subsequent Treatment Surgery
(Item # 9921)

Subsq Rx Crs Surg

Alternate Name	Item #	Length	Source of Standard	Column #
SubsqRX2ndCrsSurg	9921	2	CDC/NPCR-CER	1789-1790

Cancer Site
Breast, Colon, and Rectum

Description
This variable is used to code if surgery was given as part of the subsequent course of treatment for **primary tumor**. Subsequent treatment is defined as: all cancer-directed therapies administered after the first course is complete due to lack of response or disease progression or recurrence. Therapy administered after the first course is completed, stopped or changed is recorded as subsequent therapy.

Patient's medical records should be included as potential sources for obtaining this data.

Subsequent surgery is a treatment consideration for local, regional or distant recurrence or progression of disease. Subsequent surgery is also a treatment consideration when other planned first course of treatment fails.

Codes

04 None

05 Patient had a documented subsequent surgery

10 Surgery to local site

20 Surgery to regional site/lymph nodes

30 Surgery to distant site/lymph nodes

90 Surgery, NOS; a subsequent surgical procedure was done, but no information on the type of surgical procedure is provided.

99 Unknown.

Note: States may use the indented codes if you wish to collect more detailed information (10-90). However, if coding the detailed codes please consistently collect the detailed codes for all subsequent treatment variables.

Subsequent Treatment Radiation

(Item #9922)

Alternate Name	Item #	Length	Source of Standard	Column #
SubsqRX2ndRad	9922	2	CDC/NPCR-CER	1791-1792

Cancer Site
Breast, Colon, and Rectum

Description
This variable is used to code if radiation therapy was used as subsequent treatment for **primary tumor**. Subsequent treatment is defined as: all cancer-directed therapies administered after the first course is complete due to lack of response or disease progression or recurrence. Therapy administered after the first course is completed, stopped or changed is recorded as subsequent therapy.

Patient's medical records should be included as potential sources for obtaining this data.

Subsequent radiation therapy is a treatment consideration for local, regional or distant recurrence or progression of disease. Subsequent radiation therapy is also a treatment consideration when other planned first course of treatment fails. Subsequent radiation may be administered as part of other subsequent treatments (surgery, chemotherapy, etc).

- Radiation may be localized (at the primary site)
- Radiation may be directed to regional site and/or to regional lymph nodes
- Radiation may be directed to a distant or metastatic site or lymph nodes

Codes

04 None

05 Patient had a documented subsequent radiation

10 Local radiation

20 Regional radiation

30 Distant radiation, NOS OR other radiation, NOS

31 Bone

32 Brain

33 Liver

34 Lung

35 Other distant sites/lymph nodes or more than one distant site

99 Unknown

Note: States may use the indented codes if you wish to collect more detailed information (10-35). However, if coding the detailed codes please consistently collect the detailed codes for all subsequent treatment variables.

Subsequent Treatment Chemotherapy (Item #9923)

Subsq Rx 2ndCrs Chemo

Alternate Name	Item #	Length	Source of Standard	Column #
SubsqRX2ndChemo	9923	2	CDC/NPCR-CER	1793-1794

Cancer Site
Breast, Colon, and Rectum

Description
This variable is used to code if chemotherapy was given as part of the subsequent course of treatment for **primary tumor**. Subsequent treatment is defined as: all cancer-directed therapies administered after the first course is complete due to lack of response or disease progression or recurrence. Therapy administered after the first course is completed, stopped or changed is recorded as subsequent therapy.

Patient's medical records and available pharmacy data sets should be included as potential sources for obtaining this data.

Codes

01 Chemotherapy administered as subsequent therapy, but the type and number of agents is not documented in patient record.

02 Single-agent chemotherapy administered as subsequent therapy.

03 Multiagent chemotherapy administered as subsequent therapy.

04 None

05 Patient had a documented subsequent chemotherapy

99 Unknown

Note: States may use the indented codes if you wish to collect more detailed information (01-03). However, if coding the detailed codes please consistently collect the detailed codes for all subsequent treatment variables.

- Refer to the *SEER*Rx Interactive Drug Database* (http://seer.cancer.gov/) for a list of chemotherapeutic agents.
- If the managing physician changed one of the agents in a combination regimen, and the replacement agent belonged to a different group (chemotherapeutic agents are grouped as alkylating agents, antimetabolites, natural products, or other miscellaneous) than the original agent, the new regimen represented the start of subsequent therapy.

Subsequent Treatment BRM (Item #9925)

Subsq Rx Crs BRM

Alternate Name	Item #	Length	Source of Standard	Column #
SubsqRX2ndBRM	9925	2	CDC/NPCR-CER	1797-1798

Cancer Site
Breast, Colon, and Rectum

Description

This variable is used to code if any biological response modifier therapy (immunotherapy) was given as part of the subsequent course of treatment for **primary tumor**. Subsequent treatment is defined as: all cancer-directed therapies administered after the first course is complete due to lack of response or disease progression or recurrence. Therapy administered after the first course is completed, stopped or changed is recorded as subsequent therapy.

Patient's medical records and available pharmacy data sets should be included as potential sources for obtaining this data.

Coding

Refer to the *SEER*Rx Interactive Drug Database* (http://seer.cancer.gov/) for a list of immunotherapeutic agents.

Codes

01 Immunotherapy administered as subsequent therapy.

04 None

05 Patient had a documented subsequent BRM

99 Unknown

Subsequent Treatment Other (excluding hormonal therapy) (Item #9926)

Alternate Name	Item #	Length	Source of Standard	Column #
SubsqRX2ndOth	9926	1	CDC/NPCR-CER	1799-1799

Cancer Site
Breast, Colon, and Rectum

Description
This variable is used to code if any other treatment was given as part of the subsequent course of treatment (excluding hormonal therapy) for **primary tumor**. Subsequent treatment is defined as: all cancer-directed therapies administered after the first course is complete due to lack of response or disease progression or recurrence. Therapy administered after the first course is completed, stopped or changed is recorded as subsequent therapy.

Patient's medical records and available pharmacy data sets should be included as potential sources for obtaining this data.

Codes

1 Other – Subsequent treatment that cannot be appropriately assigned to specified treatment data items (surgery, radiation, and systemic therapy, hematopoietic cases, such as phlebotomy, transfusion, or aspirin).

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.

4 None

5 Patient had other documented subsequent treatment (excluding hormone therapy)

6 Other – Unproven Cancer treatments administered by nonmedical personnel.

9 Unknown.

Note: States may use the indented codes if you wish to collect more detailed information (1-3 and 6). However, if coding the detailed codes please consistently collect the detailed codes for all subsequent treatment variables.

Date of Last Contact

(Item #1750)

Date of Last Contact

Alternate Name	Item #	Length	Source of Standard	Column #
Date of Last Contact or Death (COC) Date of Last Follow Up or Death (SEER)	1750	8	SEER/COC	2116-2123

Cancer Site
Breast, Colon, and Rectal

Description
Date of last contact with the patient, or date of death. If the patient has multiple tumors, Date of Last Contact should be the same for all tumors. See Chapter X for date format.

Rationale
Used for recording Date of Last Contact from active or passive follow-up. Used to record date of death and to calculate survival.

Coding Instructions
Use date format YYYYMMDD to record the earliest date associated with evidence of disease progression or of the patient being considered disease free (no clinical evidence of disease, disease free; in remission)

Format
YYYYMMDD when complete date is known and valid
Any missing component should be replaced by s9's
Year only should not be recorded.
The field is fixed-length and left-justified
NOTE: An entire date of unknown (99999999) is unacceptable for this item.

Date of Last Contact Flag

(Item #1751)

Date of Last Contact Flag

Alternate Name	Item #	Length	Source of Standard	Column #
	1751	2	NAACCR	2124-2125

Cancer Site
Breast, Colon, and Rectum

Description

This flag explains why no appropriate value is in the field, Date of Last Contact [1750]. This data item first available in Volume II Version 12.

Rationale
Before Version 12 (through 2009 diagnosis), date fields included codes that provided information other than dates. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Codes (See Appendix H for the complete Flavors of Null table, which includes the NAACCR codes, HL7 codes and definitions.)

12 A proper value is applicable but not known. This event occurred, but the date is unknown (e.g., date of last contact is unknown).

Blank A valid date value is provided in item Date of Last Contact [1750], or the date was not expected to have been transmitted.

Comment: This is part of the initiative of the transformation from the old NAACCR date standards to interoperable dates.

Vital Status
(Item #1760)

Vital Status

Alternate Name	Item #	Length	Source of Standard	Column #
Vital Status	1760	1	SEER/COC	2126-2126

Cancer Site
Breast, Colon, and Rectal

Description
Vital status of the patient as of the date entered in Date of Last Contact [1750]. If the patient has multiple tumors, vital status should be the same for all tumors.

Codes
0 Dead (CoC)
1 Alive
4 Dead (SEER)

Follow-up Source Central

SAS Alternate Name	Item #	Length	Source of Standard	Column #

I1791_FollowUpSrcCntrl	1791	2	NAACCR	2278-2279

Description
This field is created by the central registry. It records the source from which the consolidated information was obtained on a patient's vital status and date of last contact. Follow-up Source Central would be updated when new or more reliable information becomes available. However, when the existing date of last contact/vital status is deemed to be more reliable than newly obtained information, then neither the date of last contact/vital status nor the follow-up source central would be changed.

Rationale
For central registries performing follow-up, this field could help evaluate the success rates of various methods of follow-up. When new follow-up information conflicts with the existing information, knowing the follow-up source can help resolve any discrepancies.

Codes

00	Follow-up not performed for this patient
(01-29)	File Linkages
01	Medicare/Medicaid File
02	Center for Medicare and Medicaid Services (CMS, formerly HCFA)
03	Department of Motor Vehicle Registration
04	National Death Index (NDI)
05	State Death Tape/Death Certificate File
06	County/Municipality Death Tape/ Death Certificate File
07	Social Security Administration Death Master File
08	Hospital Discharge Data
09	Health Maintenance Organization (HMO) file
10	Social Security Epidemiological Vital Status Data
11	Voter Registration File
12	Research/Study Related Linkage
29	Linkages, NOS
(30-39)	Hospitals and Treatment Facilities
30	Hospital in-patient/outpatient
31	Casefinding
32	Hospital cancer registry
33	Radiation treatment center
34	Oncology clinic
35	Ambulatory surgical center
39	Clinic/facility, NOS
(40-49)	Physicians
40	Attending physician
41	Medical oncologist
42	Radiation oncologist
43	Surgeon
48	Other specialist
49	Physician, NOS
(50-59)	Patient
50	Patient contact
51	Relative contact
59	Patient, NOS
(60-98)	Other

60	Central or Regional cancer registry
61	Internet sources
62	Hospice
63	Nursing homes
64	Obituary
65	Other research/study related sources
98	Other, NOS
99	Unknown source

Reference

Thornton M, (ed). *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Record Layout Version 12.1,* 15th ed. Springfield, Ill.: North American Association of Central Cancer Registries, June 2010.
http://www.naaccr.org/LinkClick.aspx?fileticket=LJJNRVo4lT4%3D&tabid=268&mid=746

APPENDIX I:
CASEFINDING LIST

This list is taken from the Surveillance Epidemiology and End Results (SEER) program. (Available at: *http://seer.cancer.gov/tools/casefinding/*)

This appendix consists of ICD-10-CM codes used to identify potentially reportable cancer cases. Some of these codes may contain conditions that are not considered reportable; however, these diagnoses may indicate a reportable cancer associated with the condition. Casefinding must include both primary and up to four (4) secondary diagnoses. At a minimum, cases with the codes listed under the “Reportable Neoplasms” should be screened. The patient medical record should be reviewed to verify whether or not the case is a reportable cancer to the NHSCR.

COMPREHENSIVE ICD-10-CM Casefinding Code List for Reportable Tumors
(Effective 10/1/2015-9/30/2016)

Please refer to your standard setter(s) for specific reporting requirements before using the Casefinding list.

REPORTABLE NEOPLASMS	
ICD-10-CM Code	**Explanation of ICD-10-CM Code**
C00.- - C43.-, C4A.-, C45.- - C96.-	Malignant neoplasms (excluding category C44), stated or presumed to be primary (of specified site) and certain specified histologies
C44.00, C44.09	Unspecified/other malignant neoplasm of skin of lip
C44.10-, C44.19-	Unspecified/other malignant neoplasm of skin of eyelid
C44.20-, C44.29-	Unspecified/other malignant neoplasm skin of ear and external auricular canal
C44.30-, C44.39-	Unspecified/other malignant neoplasm of skin of other/unspecified parts of face
C44.40, C44.49	Unspecified/other malignant neoplasm of skin of scalp & neck
C44.50-, C44.59-	Unspecified/other malignant neoplasm of skin of trunk
C44.60-, C44.69-	Unspecified/other malignant neoplasm of skin of upper limb, incl. shoulder
C44.70-, C44.79-	Unspecified/other malignant neoplasm of skin of lower limb, including hip
C44.80, C44.89	Unspecified/other malignant neoplasm of skin of overlapping sites of skin
C44.90, C44.99	Unspecified/other malignant neoplasm of skin of unspecified sites of skin
D00.- - D09.-	In-situ neoplasms *Note: Carcinoma in situ of the cervix (CIN III-8077/2) and Prostatic Intraepithelial Carcinoma (PIN III-8148/2) are not reportable*
D18.02	Hemangioma of intracranial structures and any site
D18.1	Lymphangioma, any site *Note: Includes Lymphangiomas of Brain, Other parts of nervous system and endocrine glands, which are reportable*
D32.-	Benign neoplasm of meninges (cerebral, spinal and unspecified)
D33.-	Benign neoplasm of brain and other parts of central nervous system
D35.2 - D35.4	Benign neoplasm of pituitary gland, craniopharyngeal duct and pineal gland
D42.-, D43.-	Neoplasm of uncertain or unknown behavior of meninges, brain, CNS
D44.3 - D44.5	Neoplasm of uncertain or unknown behavior of pituitary gland, craniopharyngeal duct and pineal gland
D45	Polycythemia vera (9950/3) *ICD-10-CM Coding instruction note: Excludes familial polycythemia (C75.0), secondary polycythemia (D75.1)*
D46.-	Myelodysplastic syndromes (9980, 9982, 9983, 9985, 9986, 9989, 9991, 9992)
D47.1	Chronic myeloproliferative disease (9963/3, 9975/3) *ICD-10-CM Coding instruction note: Excludes the following:* *Atypical chronic myeloid leukemia BCR/ABL-negative (C92.2_)* *Chronic myeloid leukemia BCR/ABL-positive (C92.1_)* *Myelofibrosis & Secondary myelofibrosis (D75.81)* *Myelophthisic anemia & Myelophthisis (D61.82)*
D47.3	Essential (hemorrhagic) thrombocythemia (9962/3) *Includes: Essential thrombocytosis, idiopathic hemorrhagic thrombocythemia*

REPORTABLE NEOPLASMS	
ICD-10-CM Code	**Explanation of ICD-10-CM Code**
D47.4	Osteomyelofibrosis (9961/3) Includes: Chronic idiopathic myelofibrosis Myelofibrosis (idiopathic) (with myeloid metaplasia) Myelosclerosis (megakaryocytic) with myeloid metaplasia) Secondary myelofibrosis in myeloproliferative disease
D47.Z-	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9960/3, 9970/1, 9971/3, 9931/3)
D47.9	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9970/1, 9931/3)
D49.6, D49.7	Neoplasm of unspecified behavior of brain, endocrine glands and other CNS
R85.614	Cytologic evidence of malignancy on smear of anus
R87.614	Cytologic evidence of malignancy on smear of cervix
R87.624	Cytologic evidence of malignancy on smear of vagina

Note: Pilocytic/juvenile astrocytoma M-9421 moved from behavior /3 (malignant) to /1 (borderline malignancy) in ICD-O-3. However, SEER registries will CONTINUE to report these cases and code behavior as /3 (malignant).

NOTE: Cases with the codes listed below should be screened as registry time allows. Experience in the SEER registries has shown that using the supplemental list increases casefinding for benign brain and CNS, hematopoietic neoplasms, and other reportable diseases.

SUPPLEMENTAL CODES	
ICD-10-CM Code	**Explanation of ICD-10-CM Code**
B20	Human immunodeficiency virus [HIV] disease with other diseases
B97.33, B97.34, B97.35	Human T-cell lymphotrophic virus,(type I [HTLV-1], type II [HTLV-II], type 2 [HIV 2]) as the cause of diseases classified elsewhere
B97.7	Papillomarvirus as the cause of diseases classified elsewhere
C44.01, C44.02	Basal/squamous cell carcinoma of skin of lip
C44.11-, C44.12-	Basal/squamous cell carcinoma of skin of eyelid
C44.21-, C44.22-	Basal/squamous cell carcinoma of skin of ear and external auricular canal
C44.31-, C44.32-	Basal/squamous cell carcinoma of skin of other and unspecified parts of face
C44.41, C44.42	Basal/squamous cell carcinoma of skin of scalp and neck
C44.51-, C44.52-	Basal/squamous cell carcinoma of skin of trunk
C44.61-, C44.62-	Basal/squamous cell carcinoma of skin of upper limb, including shoulder
C44.71-, C44.72-	Basal/squamous cell carcinoma of skin of lower limb, including hip
C44.81, C44.82	Basal/squamous cell carcinoma of skin of overlapping sites of skin
C44.91, C44.92	Basal/squamous cell carcinoma of skin of unspecified sites of skin
D10.- - D31.-, D34, D35.0, D35.1, D35.5-	Benign neoplasms (see "must collect" list for reportable benign neoplasms) *Note: Screen for incorrectly coded malignancies or reportable by agreement tumors*

SUPPLEMENTAL CODES	
ICD-10-CM Code	**Explanation of ICD-10-CM Code**
D35.9, D36.-	*Note: Borderline cystadenomas M-8442, 8451, 8462, 8472, 8473, of the ovaries moved from behavior /3 (malignant) to /1 (borderline malignancy) in ICD-O-3. SEER registries are not required to collect these cases for diagnoses made 1/1/2001 and after. However, cases diagnosed prior to 1/1/2001 should still be abstracted and reported to SEER.*
D3A._	Benign carcinoid tumors
D37._ - D41._	Neoplasms of uncertain or unknown behavior (see "must collect" list for reportable neoplasms of uncertain or unknown behavior) *Note: Screen for incorrectly coded malignancies or reportable by agreement tumors*
D44.0 - D44.2, D44.6-D44.9	Neoplasm of uncertain or unknown behavior of other endocrine glands (see "must collect" list for D44.3-D44.5) *Note: Screen for incorrectly coded malignancies or reportable by agreement tumors*
D47.0	Histiocytic and mast cell tumors of uncertain behavior *ICD-10-CM Coding instruction note: Excludes: malignant mast cell tumor (C96.2), mastocytosis (congenital)(cutaneous) (Q852.2)*
D47.2	Monoclonal gammopathy *Note: Screen for incorrectly coded Waldenstrom's macroglobulinemia*
D48.-	Neoplasm of uncertain behavior of other and unspecified sites
D49.0 - D49.9	Neoplasm of unspecified behavior (except for D49.6 and D49.7)
D61.1	Drug-induced aplastic anemia (also known as *"aplastic anemia due to antineoplastic chemotherapy")* *ICD-10-CM Coding instruction note: Use additional code for adverse effect, if applicable, to identify drug*
D61.810	Antineoplastic chemotherapy induced pancytopenia
D61.82	Myelophthisis *ICD-10-CM Coding instruction: Code first the underlying disorder, such as: malignant neoplasm of breast (C50._)*
D63.0	Anemia in neoplastic disease *ICD-10-CM Coding instruction: Code first neoplasm (C00-C49)*
D64.81	Anemia due to antineoplastic chemotherapy
D69.49, D69.59, D69.6	Other thrombocytopenia *Note: Screen for incorrectly coded thrombocythemia*
D70.1	Agranulocytosis secondary to cancer chemotherapy *ICD-10-CM Coding instruction: code also underlying neoplasm*
D72.1	Eosinophilia (*Note: Code for eosinophilia (9964/3). Not every case of eosinophilia is a malignancy. Reportable Diagnosis is "Hypereosonophilic syndrome."*)
D75.81	Myelofibrosis (note: this is not primary myelofibrosis [9961/3] *ICD-10-CM Coding instruction note: Code first the underlying disorder, such as: malignant neoplasm of breast (C50._)*
D76.-	Other specified diseases with participation of lymphoreticular and reticulohistiocytic tissue

SUPPLEMENTAL CODES	
ICD-10-CM Code	**Explanation of ICD-10-CM Code**
D89.0, D89.1	Other disorders involving the immune mechanism, not elsewhere classified *Note: Review for miscodes*
E08	Diabetes mellitus due to underlying condition *ICD-10-CM Coding instruction note: Code first the underlying condition, such as: malignant neoplasm (C00-C96)*
E31.2-	Multiple endocrine neoplasia [MEN] syndromes *ICD-10-CM Coding instruction: Code also any associated malignancies and other conditions associated with the syndromes*
E34.0	Carcinoid syndrome *ICD-10-CM Coding instruction: May be used as an additional code to identify functional activity associated with a carcinoid tumor*
E83.52	Hypercalcemia
E88.09	Other disorders of plasma-protein metabolism, not elsewhere classified
E88.3	Tumor lysis syndrome (following antineoplastic chemotherapy)
G13.0	Paraneoplastic neuromyopathy and neuropathy *ICD-10-CM Coding instruction note:: Code first underlying neoplasm (C00-D49)*
G13.1	Other systemic atrophy primarily affecting central nervous system in neoplastic disease *ICD-10-CM Coding instruction note:: Code first underlying neoplasm (C00-D49)*
G32.8-	Other specified degenerative disorders of nervous system in diseases classified elsewhere *ICD-10-CM Coding instruction note: Code first underlying disease, such as: cerebral degeneration (due to) neoplasm (C00-D49)*
G53	Cranial nerve disorders in diseases classified elsewhere *Note: Code first underlying neoplasm (C00-D49)*
G55	Nerve root and plexus compressions in diseases classified elsewhere *ICD-10-CM Coding instruction note: code also underlying disease, such as neoplasm (C00-D49)*
G63	Polyneuropathy in diseases classified elsewhere *ICD-10-CM Coding instruction note: Code first underlying disease, such as: neoplasm (C00-D49)*
G73.1	Lambert-Eaton syndrome in neoplastic disease *ICD-10-CM Coding instruction: Code first underlying neoplasm (C00-D49)*
G89.3	Neoplasm related pain (acute)(chronic)
G99.2	Myelopathy in diseases classified elsewhere *ICD-10-CM Coding instruction: Code first underlying disease, such as: neoplasm (C00-D49)*
H47.42	Disorders of optic chiasm in (due to) neoplasm *ICD-10-CM Coding instruction: Code also underlying condition*
H47.52-	Disorders of visual pathways in (due to) neoplasm *ICD-10-CM Coding instruction: Code also underlying condition*
H47.63-	Disorders of visual cortex in (due to) neoplasm *ICD-10-CM Coding instruction: Code also underlying condition*

SUPPLEMENTAL CODES	
ICD-10-CM Code	**Explanation of ICD-10-CM Code**
J34.81	Nasal mucositis (ulcerative)
J91.0	Malignant pleural effusion *ICD-10-CM Coding instruction: Code first underlying neoplasm*
J93.12	Secondary spontaneous pneumothorax *ICD-10-CM Coding instruction: Code first underlying condition, such as:* *Malignant neoplasm of bronchus and lung (C34._)* *Secondary malignant neoplasm of lung (C78.0_)*
K12.31	Oral mucositis (ulcerative) due to antineoplastic therapy
K12.33	Oral mucositis (ulcerative) due to radiation
K22.711	Barrett's esophagus with high grade dysplasia
K62.7	Radiation proctitis
K62.82	Dysplasia of anus (AIN I and AIN II)
K92.81	Gastrointestinal mucositis (ulcerated) (due to antineoplastic therapy)
M36.0	Dermato(poly)myositis in neoplastic disease *ICD-10-CM Coding instruction: Code first underlying neoplasm (C00-D49)*
M36.1	Arthropathy in neoplastic disease *ICD-10-CM Coding instruction: Code first underlying neoplasm, such as:* Leukemia (C91-C95), malignant histiocytosis (C96.A), multiple myeloma (C90.0)
M84.5-	Pathologic fracture in neoplastic disease *ICD-10-CM Coding instruction: Code also underlying neoplasm (C00-D49)*
M90.6-	Osteitis deformans in neoplastic disease *ICD-10-CM Coding instruction: Code first the neoplasm (C40._, C41._)*
N42.3	Dysplasia of prostate (PIN I and PIN II)
N76.81	Mucositis (ulcerative) of vagina and vulva
N87.-	Dysplasia of cervix uteri (CIN I and CIN II)
N89.0, N89.1, N89.3	Vaginal dysplasia (VIN I and VIN II)
N90.0, N90.1, N90.3	Vulvar dysplasia (VAIN I and VAIN II)
O01.-	Hydatidiform mole *Note: Benign tumor that can become malignant. If malignant, report as Choriocarcinoma (9100/3,) malignancy code in the C00- C97 range*
O9A.1-	Malignant neoplasm complicating pregnancy, childbirth and the puerperium (conditions in C00-C96) *ICD-10-CM Coding instruction: Use additional code to identify neoplasm*
Q85.0-	Neurofibromatosis (nonmalignant) (9540/1) *Note: Neurofibromatosis is not cancer. These tumors can be precursors to acoustic neuromas, which are reportable*
R18.0	Malignant ascites *ICD-10-CM Coding instruction: Code first malignancy, such as:* *Malignant neoplasm of ovary (C56._), secondary malignant neoplasm of retroperitoneum and peritoneum (C78.6)*
R53.0	Neoplastic (malignant) related fatigue

SUPPLEMENTAL CODES	
ICD-10-CM Code	**Explanation of ICD-10-CM Code**
	ICD-10-CM Coding instruction: Code first associated neoplasm
R59.-	Enlarged lymph nodes
R85.6-	Abnormal findings on cytological and histological examination of digestive organs *Note: see "must collect" list for R85.614*
R87.61-, R87.62-	Abnormal findings on cytological/histological examination of female genital organs *Note: see "must collect" list for R87.614 and R87.624*
R92.-	Abnormal findings on diagnostic imaging of breast
R97.-	Abnormal tumor markers
T38.6-	Poisoning by antigonadotrophins, antiestrogens, antiandrogens, not elsewhere classified
T38.8-, T38.9-	Poisoning by hormones and their synthetic substitutes
T45.1-	Poisoning by, adverse effect of and under dosing of antineoplastic and immunosuppressive drugs
T45.8-, T45.9-	Poisoning by primary systemic and hematological agent, unspecified
T66	Unspecified effects of radiation
T80.1	Vascular complications following infusion, transfusion and therapeutic injection
T80.2-	Infections following infusion, transfusion and therapeutic injection
T80.810	Extravasation of vesicant antineoplastic chemotherapy
T80.818	Extravasation of other vesicant agent
T86.0	Complications of bone marrow transplant *ICD-10-CM Coding instruction: Use addition code to identify other transplant complications, such as: malignancy associated with organ transplant (C80.2) or post-transplant lymphoproliferative disorders (PTLD) (D47.Z1)*
Y63.2	Overdose of radiation given during therapy
Y84.2	Radiological procedure and radiotherapy as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure
Z03.89	Encounter for observation for other suspected diseases and conditions ruled out
Z08	Encounter for follow-up examination after completed treatment for malignant neoplasm (medical surveillance following completed treatment) *ICD-10-CM Coding instruction: Use additional code to identify the personal history of malignant neoplasm (Z85._)*
Z12.-	Encounter for screening for malignant neoplasms
Z13.0	Encounter for screening for diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
Z15.0	Genetic susceptibility to malignant neoplasm *ICD-10-CM Coding instruction: Code first, if applicable, any current malignant neoplasm (C00-C75, C81-C96); Use additional code, if applicable, for any personal history of malignant neoplasm (Z85._)*
Z17.0, Z17.1	Estrogen receptor positive and negative status *ICD-10-CM Coding instruction: Code first malignant neoplasm of breast (C50._)*
Z40.0-	Encounter for prophylactic surgery for risk factors related to malignant

SUPPLEMENTAL CODES	
ICD-10-CM Code	**Explanation of ICD-10-CM Code**
	neoplasms
Z42.1	Encounter for breast reconstruction following mastectomy
Z48.3	Aftercare following surgery for neoplasm *ICD-10-CM Coding instruction: Use additional code to identify the neoplasm*
Z48.290	Encounter for aftercare following bone marrow transplant
Z51.0	Encounter for antineoplastic radiation therapy
Z51.1-	Encounter for antineoplastic chemotherapy and immunotherapy
Z51.5, Z51.89	Encounter for palliative care and other specified aftercare
Z79.81-	Long term (current) use of agents affecting estrogen receptors and estrogen levels *ICD-10-CM Coding instruction: Code first, if applicable, malignant neoplasm of breast (C50._), malignant neoplasm of prostate (C61)*
Z80.-	Family history of primary malignant neoplasm
Z85.-	Personal history of malignant neoplasm *ICD-10-CM Coding instruction: Code first any follow-up examination after treatment of malignant neoplasm (Z08)*
Z86.0-, Z86.01-, Z86.03	Personal history of in situ and benign neoplasms and neoplasms of uncertain behavior
Z92.21, Z92.23, Z92.25. Z92.3	Personal history of antineoplastic chemotherapy, estrogen therapy, immunosuppression therapy or irradiation (radiation)
Z94.81, Z94.84	Bone marrow and stem cell transplant status

^ *International Classification of Diseases, ICD-10-CM Tabular List of Diseases and Injuries, FY 2016*

APPENDIX J:
NEW HAMPSHIRE TOWN/COUNTY & ZIP CODES

The city, town, and village zip codes with county were taken from the website of the New Hampshire Hospital Association (http://www.nhha.org/) and reformatted by NHSCR to reflect the required county names and codes to be used by reporting registries.

If the town you are looking for is not in "Town Name"column, check the "Zip Name" column, which is sorted by the town's zip code name.

TOWN NAME	ZIP NAME	ZIP CODE	NHSCR Residence Code	
			County	Code
ACWORTH,NH	ACWORTH,NH	03601	Sullivan	019
ACWORTH,NH	SOUTH ACWORTH, NH	03607	Sullivan	019
ALBANY,NH	CONWAY,NH	03818	Carroll	003
ALEXANDRIA,NH	BRISTOL,NH	03222	Grafton	009
ALLENSTOWN,NH	SUNCOOK,NH	03275	Merrimack	013
ALSTEAD,NH	ALSTEAD,NH	03602	Cheshire	005
ALTON BAY,NH	ALTON BAY,NH	03810	Belknap	001
ALTON,NH	ALTON,NH	03809	Belknap	001
AMHERST,NH	AMHERST,NH	03031	Hillsborough	011
ANDOVER,NH	ANDOVER,NH	03216	Merrimack	013
ANTRIM,NH	ANTRIM,NH	03440	Hillsborough	011
ASHLAND,NH	ASHLAND,NH	03217	Grafton	009
ASHUELOT,NH	ASHUELOT,NH	03441	Cheshire	005
ATKINSON & GILMANTON,NH	ERROL,NH	03579	Coos	007
ATKINSON,NH	ATKINSON,NH	03811	Rockingham	015
AUBURN,NH	AUBURN,NH	03032	Rockingham	015
BARNSTEAD,NH	BARNSTEAD,NH	03218	Belknap	001
BARRINGTON,NH	BARRINGTON,NH	03825	Strafford	017
BARTLETT,NH	BARTLETT,NH	03812	Carroll	003
BATH,NH	BATH,NH	03740	Grafton	009
BEANS PURCHASE,NH	GORHAM,NH	03581	Coos	007
BEDFORD,NH	BEDFORD,NH	03110	Hillsborough	011
BEEBE RIVER,NH	BEEBE RIVER,NH	03219	Grafton	009
BELMONT,NH	BELMONT,NH	03220	Belknap	001
BENNINGTON,NH	BENNINGTON,NH	03442	Hillsborough	011
BENTON,NH	WOODSVILLE,NH	03785	Grafton	009
BERLIN,NH	BERLIN,NH	03570	Coos	007
BETHLEHEM,NH	BETHLEHEM,NH	03574	Grafton	009
BLODGETT'S LANDING,NH	NEWBURY,NH	03255	Merrimack	013
BLOOMFIELD, VT	NORTH STRATFORD, NH	03590	Grafton	009
BOSCAWEN,NH	CONCORD,NH	03303	Merrimack	013
BOW,NH	BOW,NH	03304	Merrimack	013
BRADFORD,NH	BRADFORD,NH	03221	Merrimack	013
BRENTWOOD,NH	EXETER,NH	03833	Rockingham	015
BRETTON WOODS,NH	BRETTON WOODS,NH	03575	Coos	007
BRIDGEWATER,NH	BRISTOL,NH	03222	Grafton	009
BRISTOL,NH	BRISTOL,NH	03222	Grafton	009
BROOKFIELD,NH	SANBORNVILLE,NH	03872	Carroll	003
BROOKLINE,NH	BROOKLINE,NH	03033	Hillsborough	011
BURKEHAVEN,NH	SUNAPEE,NH	03782	Carroll	003
CAMBRIDGE,NH	MILAN,NH	03588	Coos	007
CAMPTON,NH	CAMPTON,NH	03223	Grafton	009
CANAAN,NH	CANAAN,NH	03741	Grafton	009

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CANDIA,NH	CANDIA,NH	03034	Rockingham	015
CANTERBURY,NH	CANTERBURY,NH	03224	Merrimack	013
CARROLL,NH	WHITEFIELD,NH	03598	Coos	007
CASCADE,NH	GORHAM,NH	03581	Coos	007
CENTER BARNSTEAD,NH	CTR BARNSTEAD,NH	03225	Belknap	001
CENTER HARBOR,NH	CENTER HARBOR,NH	03226	Belknap	001
CENTER OSSIPEE,NH	CTR OSSIPEE,NH	03814	Carroll	003
CENTER SANDWICH,NH	CTR SANDWICH,NH	03227	Carroll	003
CENTER STRAFFORD,NH	CTR STRAFFORD,NH	03815	Strafford	017
CENTER TUFTONBORO,NH	CTR TUFTNBORO,NH	03816	Carroll	003
CHARLESTOWN,NH	CHARLESTOWN,NH	03603	Sullivan	019
CHATHAM,NH	CENTER CONWAY,NH	03813	Carroll	003
CHESTER,NH	CHESTER,NH	03036	Rockingham	015
CHESTERFIELD,NH	CHESTERFIELD,NH	03443	Cheshire	005
CHICHESTER,NH	CHICHESTER,NH	03258	Merrimack	013
CHOCORUA,NH	CHOCORUA,NH	03817	Carroll	003
CLAREMONT,NH	CLAREMONT,NH	03743	Sullivan	019
CLARKSVILLE,NH	PITTSBURG,NH	03592	Coos	007
COLEBROOK,NH	COLEBROOK,NH	03576	Coos	007
COLUMBIA,NH	COLEBROOK,NH	03576	Coos	007
CONCORD,NH	CONCORD,NH	03301	Merrimack	013
CONCORD,NH	CONCORD,NH	03302	Merrimack	013
CONCORD,NH	CONCORD,NH	03304	Merrimack	013
CONCORD,NH	CONCORD,NH	03305	Merrimack	013
CONCORD,NH	CONCORD,NH	03306	Merrimack	013
CONTOOCOOK,NH	CONTOOCOOK,NH	03229	Merrimack	013
CONWAY,NH	CONWAY,NH	03818	Carroll	003
CORNISH FLAT,NH	CORNISH FLAT,NH	03746	Sullivan	019
CORNISH,NH	CORNISH,NH	03745	Sullivan	019
CROYDON,NH	NEWPORT,NH	03773	Sullivan	019
CRYSTAL,NH	GROVETON,NH	03582	Coos	007
DALTON,NH	WHITEFIELD,NH	03598	Coos	007
DANBURY,NH	DANBURY,NH	03230	Merrimack	013
DANVILLE, NH	S DANVILLE, NH	03881	Rockingham	015
DANVILLE,NH	DANVILLE,NH	03819	Rockingham	015
DEERFIELD,NH	DEERFIELD,NH	03037	Rockingham	015
DEERING,NH	HILLSBORO,NH	03244	Hillsborough	011
DERRY,NH	DERRY,NH	03038	Rockingham	015
DIXVILLE,NH	COLEBROOK,NH	03576	Coos	007
DORCHESTER,NH	RUMNEY,NH	03266	Grafton	009
DOVER,NH	DOVER,NH	03820	Strafford	017
DOVER,NH	DOVER,NH	03821	Strafford	017
DOVER,NH	DOVER,NH	03822	Strafford	017
DREWSVILLE,NH	DREWSVILLE,NH	03604	Cheshire	005
DUBLIN,NH	DUBLIN,NH	03444	Cheshire	005

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DUMMER,NH	MILAN,NH	03588	Coos	007
DUNBARTON,NH	DUNBARTON,NH	03046	Merrimack	013
DURHAM,NH	DURHAM,NH	03824	Strafford	017
EAST ANDOVER,NH	EAST ANDOVER,NH	03231	Merrimack	013
EAST CANDIA,NH	EAST CANDIA,NH	03040	Rockingham	015
EAST DERRY,NH	EAST DERRY,NH	03041	Rockingham	015
EAST HAMPSTEAD,NH	EAST HAMPSTEAD,NH	03826	Rockingham	015
EAST HEBRON,NH	EAST HEBRON,NH	03232	Grafton	009
EAST KINGSTON,NH	EAST KINGSTON,NH	03827	Rockingham	015
EAST LEMPSTER,NH	EAST LEMPSTER,NH	03605	Sullivan	019
EAST ROCHESTER,NH	EAST ROCHESTER,NH	03868	Strafford	017
EAST SWANZEY,NH	EAST SWANZEY,NH	03446	Cheshire	005
EAST WAKEFIELD,NH	EAST WAKEFIELD,NH	03830	Carroll	003
EASTON,NH	FRANCONIA,NH	03580	Grafton	009
EATON,NH	EATON CENTER,NH	03832	Carroll	003
EFFINGHAM,NH	SOUTH EFFINGHAM,NH	03882	Carroll	003
ELKINS,NH	ELKINS,NH	03233	Merrimack	013
ELLSWORTH,NH	PLYMOUTH,NH	03264	Grafton	009
ENFIELD CENTER,NH	ENFIELD CTR,NH	03749	Grafton	009
ENFIELD,NH	ENFIELD,NH	03748	Grafton	009
EPPING,NH	EPPING,NH	03042	Rockingham	015
EPSOM,NH	EPSOM,NH	03234	Merrimack	013
ERROL,NH	ERROL,NH	03579	Coos	007
ERVINGS LOCATION,NH	COLEBROOK,NH	03576	Coos	007
ETNA,NH	ETNA,NH	03750	Grafton	009
EXETER,NH	EXETER,NH	03833	Rockingham	015
FARMINGTON,NH	FARMINGTON,NH	03835	Strafford	017
FITZWILLIAM,NH	FITZWILLIAM,NH	03447	Cheshire	005
FRANCESTOWN,NH	FRANCESTOWN,NH	03043	Hillsborough	011
FRANCONIA,NH	FRANCONIA,NH	03580	Grafton	009
FRANKLIN,NH	FRANKLIN,NH	03235	Merrimack	013
FREEDOM,NH	FREEDOM,NH	03836	Carroll	003
FREMONT,NH	FREMONT,NH	03044	Rockingham	015
GEORGES MILLS,NH	GEORGES MILLS,NH	03751	Sullivan	019
GERRISH,NH	CONCORD,NH	03303	Merrimack	013
GILFORD,NH	GILFORD,NH	03249	Belknap	001
GILMANTON IRON WORKS,NH	GLMTN IRN WKS,NH	03837	Belknap	001
GILMANTON,NH	GILMANTON,NH	03237	Belknap	001
GILSUM,NH	GILSUM,NH	03448	Cheshire	005
GLEN,NH	GLEN,NH	03838	Carroll	003
GLENCLIFF (HOME FOR,NH	WOODSVILLE,NH	03785	Grafton	009
GLENCLIFF,NH	GLENCLIFF,NH	03238	Grafton	009
GOFF'S FALLS,NH	MANCHESTER,NH	03103	Hillsborough	011
GOFFSTOWN,NH	GOFFSTOWN,NH	03045	Hillsborough	011
GONIC,NH	GONIC,NH	03839	Strafford	017

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GOSHEN,NH	GOSHEN,NH	03752	Sullivan	019
GOSSVILLE,NH	EPSOM,NH	03234	Merrimack	013
GRAFTON,NH	GRAFTON,NH	03240	Grafton	009
GRANTHAM,NH	GRANTHAM,NH	03753	Sullivan	019
GRASMERE,NH	GOFFSTOWN,NH	03045	Hillsborough	011
GREENFIELD,NH	GREENFIELD,NH	03047	Hillsborough	011
GREENLAND,NH	GREENLAND,NH	03840	Rockingham	015
GREENS GRANT,NH	GORHAM,NH	03581	Coos	007
GREENVILE,NH	GREENVILLE,NH	03048	Hillsborough	011
GROTON,NH	HEBRON,NH	03241	Grafton	009
GROVETON,NH	GROVETON,NH	03582	Coos	007
GUILD,NH	GUILD,NH	03754	Sullivan	019
HAMPSTEAD,NH	HAMPSTEAD,NH	03841	Rockingham	015
HAMPTON FALLS,NH	HAMPTON FALLS,NH	03844	Rockingham	015
HAMPTON,NH	HAMPTON,NH	03842	Rockingham	015
HAMPTON,NH	HAMPTON	03843	Rockingham	015
HANCOCK,NH	HANCOCK,NH	03449	Hillsborough	011
HANOVER,NH	HANOVER,NH	03755	Grafton	009
HANOVER,NH	HANOVER,NH	03756	Grafton	009
HARRISVILLE(CHESHAM)	CHESHAM	03455	Cheshire	005
HARRISVILLE,NH	HARRISVILLE,NH	03450	Cheshire	005
HARTS LOCATION,NH	BARTLETT,NH	03812	Carroll	003
HAVERHILL,NH	HAVERHILL,NH	03765	Grafton	009
HEBRON,NH	HEBRON,NH	03241	Grafton	009
HEDDING,NH	EPPING,NH	03042	Rockingham	015
HENNIKER,NH	HENNIKER,NH	03242	Merrimack	013
HILL,NH	HILL,NH	03243	Merrimack	013
HILLSBORO, HILLSBORO,NH	HILLSBORO,NH	03244	Hillsborough	011
HINSDALE,NH	HINSDALE,NH	03451	Cheshire	005
HOLDERNESS,NH	HOLDERNESS,NH	03245	Grafton	009
HOLLIS,NH	HOLLIS,NH	03049	Hillsborough	011
HOOKSETT,NH	MANCHESTER,NH	03106	Merrimack	013
HOPKINTON,NH	CONTOOCOOK,NH	03229	Merrimack	013
HUDSON,NH	HUDSON,NH	03051	Hillsborough	011
INTERVALE,NH	INTERVALE,NH	03845	Carroll	003
JACKSON,NH	JACKSON,NH	03846	Carroll	003
JAFFREY CENTER,NH	JAFFREY CTR,NH	03454	Cheshire	005
JAFFREY,NH	JAFFREY,NH	03452	Cheshire	005
JEFFERSON,NH	JEFFERSON,NH	03583	Coos	007
KEARSARGE,NH	KEARSARGE,NH	03847	Carroll	003
KEENE STATE COLLEGE, NH	KEENE STATE COLLEGE, NH	03435	Cheshire	005
KEENE,NH	KEENE,NH	03431	Cheshire	005
KELLYVILLE,NH	NEWPORT,NH	03773	Sullivan	019
KENSINGTON,NH	EXETER,NH	03833	Rockingham	015
KILKENNY TOWNSHIP,NH	BERLIN,NH	03570	Coos	007

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KINGSTON,NH	KINGSTON,NH	03848	Rockingham	015
LACONIA P.O.,NH	LACONIA,NH	03247	Belknap	001
LACONIA,NH	LACONIA,NH	03246	Belknap	001
LAKEPORT,NH	LACONIA,NH	03246	Belknap	001
LANCASTER,NH	LANCASTER,NH	03584	Coos	007
LANDAFF,NH	LISBON,NH	03585	Grafton	009
LANGDON,NH	ALSTEAD,NH	03602	Sullivan	019
LEBANON,NH	LEBANON,NH	03766	Grafton	009
LEE,NH	DOVER,NH	03820	Strafford	017
LEMPSTER,NH	LEMPSTER,NH	03606	Sullivan	019
LINCOLN,NH	LINCOLN,NH	03251	Grafton	009
LISBON,NH	LISBON,NH	03585	Grafton	009
LITCHFIELD,NH	LITCHFIELD,NH	03052	Hillsborough	011
LITTLETON,NH	LITTLETON,NH	03561	Grafton	009
LIVERMORE,NH	BARTLETT,NH	03812	Grafton	009
LOCHMERE,NH	LOCHMERE,NH	03252	Belknap	001
LONDONDERRY,NH	LONDONDERRY,NH	03053	Rockingham	015
LOUDON,NH	LOUDON, NH	03307	Merrimack	013
LYMAN,NH	LISBON,NH	03585	Grafton	009
LYME CENTER,NH	LYME CENTER,NH	03769	Grafton	009
LYME,NH	LYME,NH	03768	Grafton	009
LYNDEBOROUGH, LYNDEB,NH	LYNDEBOROUGH,NH	03082	Hillsborough	011
MADBURY,NH	DOVER,NH	03820	Strafford	017
MADISON,NH	MADISON,NH	03849	Carroll	003
MANCHESTER,NH	MANCHESTER,NH	03101	Hillsborough	011
MANCHESTER,NH	MANCHESTER,NH	03102	Hillsborough	011
MANCHESTER,NH	MANCHESTER,NH	03103	Hillsborough	011
MANCHESTER,NH	MANCHESTER,NH	03104	Hillsborough	011
MANCHESTER,NH	MANCHESTER,NH	03105	Hillsborough	011
MANCHESTER,NH	MANCHESTER,NH	03107	Hillsborough	011
MANCHESTER,NH	MANCHESTER,NH	03108	Hillsborough	011
MANCHESTER,NH	MANCHESTER,NH	03109	Hillsborough	011
MARLBORO, MARLBOROUG,NH	MARLBOROUGH,NH	03455	Cheshire	005
MARLOW,NH	MARLOW,NH	03456	Cheshire	005
MARTINS LOCATION,NH	GORHAM,NH	03581	Coos	007
MASCOMA,NH	LEBANON,NH	03766	Grafton	009
MASON,NH	GREENVILLE,NH	03048	Hillsborough	011
MEADOWS,NH	MEADOWS,NH	03587	Coos	007
MELVIN MILLS,NH	WARNER,NH	03278	Merrimack	013
MELVIN VILLAGE,NH	MELVIN VLG,NH	03850	Carroll	003
MEREDITH,NH	MEREDITH,NH	03253	Belknap	001
MERIDEN,NH	MERIDEN,NH	03770	Sullivan	019
MERRIMACK,NH	MERRIMACK,NH	03054	Hillsborough	011
MIDDLETON,NH	UNION,NH	03887	Strafford	017
MILAN,NH	MILAN,NH	03588	Coos	007

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MILFORD,NH	MILFORD,NH	03055	Hillsborough	011
MILLSFIELD,NH	ERROL,NH	03579	Coos	007
MILTON MILLS,NH	MILTON MILLS,NH	03852	Strafford	017
MILTON,NH	MILTON,NH	03851	Strafford	017
MIRROR LAKE,NH	MIRROR LAKE,NH	03853	Carroll	003
MONROE,NH	MONROE,NH	03771	Grafton	009
MONT VERNON,NH	MONT VERNON,NH	03057	Hillsborough	011
MOULTONBORO,NH	MOULTONBORO,NH	03254	Carroll	003
MOULTONVILLE,NH	CTR OSSIPEE,NH	03814	Carroll	003
MOUNT SUNAPEE,NH	MOUNT SUNAPEE,NH	03772	Merrimack	013
MOUNT WASHINGTON,NH	MT WASHINGTON,NH	03589	Coos	007
MUNSONVILLE,NH	MUNSONVILLE,NH	03457	Cheshire	005
NASHUA,NH	NASHUA,NH	03060	Hillsborough	011
NASHUA,NH	NASHUA,NH	03061	Hillsborough	011
NASHUA,NH	NASHUA,NH	03062	Hillsborough	011
NASHUA,NH	NASHUA,NH	03063	Hillsborough	011
NASHUA,NH	NASHUA,NH	03064	Hillsborough	011
NELSON,NH	MUNSONVILLE,NH	03457	Cheshire	005
NEW BOSTON,NH	NEW BOSTON,NH	03070	Hillsborough	011
NEW CASTLE,NH	NEW CASTLE,NH	03854	Rockingham	015
NEW DURHAM,NH	NEW DURHAM,NH	03855	Strafford	017
NEW HAMPTON,NH	NEW HAMPTON,NH	03256	Belknap	001
NEW IPSWICH,NH	NEW IPSWICH,NH	03071	Hillsborough	011
NEW LONDON,NH	NEW LONDON,NH	03257	Merrimack	013
NEWBURY,NH	NEWBURY,NH	03255	Merrimack	013
NEWFIELDS,NH	NEWFIELDS,NH	03856	Rockingham	015
NEWINGTON,NH	PORTSMOUTH,NH	03801	Rockingham	015
NEWMARKET,NH	NEWMARKET,NH	03857	Rockingham	015
NEWPORT,NH	NEWPORT,NH	03773	Sullivan	019
NEWTON JUNCTION,NH	NEWTON JCT,NH	03859	Rockingham	015
NEWTON,NH	NEWTON,NH	03858	Rockingham	015
NORTH CONWAY,NH	NORTH CONWAY,NH	03860	Carroll	003
NORTH HAMPTON,NH	NORTH HAMPTON,NH	03862	Rockingham	015
NORTH HAVERHILL,NH	NORTH HAVERHILL,NH	03774	Grafton	009
NORTH SALEM,NH	NORTH SALEM,NH	03073	Rockingham	015
NORTH SANDWICH,NH	NORTH SANDWICH,NH	03259	Carroll	003
NORTH SUTTTON,NH	NORTH SUTTON,NH	03260	Merrimack	013
NORTH WALPOLE,NH	NORTH WALPOLE,NH	03609	Cheshire	005
NORTH WOODSTOCK,NH	NORTH WOODSTOCK,NH	03262	Grafton	009
NORTHFIELD,NH	TILTON,NH	03276	Merrimack	013
NORTHUMBERLAND,NH	GROVETON,NH	03582	Coos	007
NORTHWOOD,NH	NORTHWOOD,NH	03261	Rockingham	015
NOTTINGHAM,NH	NOTTINGHAM,NH	03290	Rockingham	015
ODELL,NH	COLEBROOK,NH	03576	Coos	007
ORANGE,NH	CANAAN,NH	03741	Grafton	009

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ORFORD,NH	ORFORD,NH	03777	Grafton	009
ORFORDVILLE,NH	ORFORD,NH	03777	Grafton	009
OSSIPEE,NH	OSSIPEE,NH	03864	Carroll	003
PELHAM,NH	PELHAM,NH	03076	Hillsborough	011
PEMBROKE,NH	SUNCOOK,NH	03275	Merrimack	013
PENACOOK,NH	CONCORD,NH	03303	Merrimack	013
PERCY,NH	GROVETON,NH	03582	Coos	007
PETERBOROUGH, NH	PETERBOROUGH,NH	03458	Hillsborough	011
PETERBOROUGH, NH	PETERBOROUGH, NH	03460	Hillsborough	011
PIERMONT,NH	PIERMONT,NH	03779	Grafton	009
PIKE,NH	PIKE,NH	03780	Grafton	009
PINKHAMS GRANT,NH	GORHAM,NH	03581	Coos	007
PITTSBURG,NH	PITTSBURG,NH	03592	Coos	007
PITTSFIELD,NH	PITTSFIELD,NH	03263	Merrimack	013
PLAINFIELD,NH	PLAINFIELD,NH	03781	Sullivan	019
PLAISTOW,NH	PLAISTOW,NH	03865	Rockingham	015
PLYMOUTH,NH	PLYMOUTH,NH	03264	Grafton	009
PORTSMOUTH,NH	PORTSMOUTH,NH	03801	Rockingham	015
PORTSMOUTH,NH	PORTSMOUTH,NH	03802	Rockingham	015
PORTSMOUTH,NH	PORTSMOUTH,NH	03803	Rockingham	015
PORTSMOUTH,NH	PORTSMOUTH,NH	03804	Rockingham	015
POTTER PLACE,NH	POTTER PLACE,NH	03265	Merrimack	013
QUINCY,NH	RUMNEY,NH	03266	Grafton	009
RANDOLPH,NH	BERLIN,NH	03570	Coos	007
RAYMOND,NH	RAYMOND,NH	03077	Rockingham	015
REDSTONE,NH	CENTER CONWAY,NH	03813	Carroll	003
REEDS FERRY,NH	MERRIMACK,NH	03054	Hillsborough	011
RICHMOND,NH	WINCHESTER,NH	03470	Cheshire	005
RINDGE,NH	RINDGE,NH	03461	Cheshire	005
RIVERHILL,NH	CONCORD,NH	03303	Merrimack	013
RIVERSIDE,NH	COLEBROOK,NH	03576	Coos	007
RIVERTON,NH	JEFFERSON,NH	03583	Coos	007
ROCHESTER,NH	ROCHESTER	03866	Strafford	017
ROCHESTER,NH	ROCHESTER,NH	03867	Strafford	017
ROLLINSFORD,NH	ROLLINSFORD,NH	03869	Strafford	017
ROXBURY,NH	KEENE,NH	03431	Cheshire	005
RUMNEY,NH	RUMNEY,NH	03266	Grafton	009
RYE BEACH,NH	RYE BEACH,NH	03871	Rockingham	015
RYE,NH	RYE,NH	03870	Rockingham	015
SALEM,NH	SALEM,NH	03079	Rockingham	015
SALISBURY,NH	SALISBURY,NH	03268	Merrimack	013
SALMON FALLS,NH	ROLLINSFORD,NH	03869	Strafford	017
SANBORNTON,NH	SANBORNTON,NH	03269	Belknap	001
SANBORNVILLE,NH	SANBORNVILLE,NH	03872	Carroll	003
SANDOWN,NH	SANDOWN,NH	03873	Rockingham	015

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SANDWICH,NH	SANDWICH,NH	03270	Carroll	003
SEABROOK,NH	SEABROOK,NH	03874	Rockingham	015
SHARON,NH	PETERBOROUGH,NH	03458	Hillsborough	011
SHELBURNE,NH	GORHAM,NH	03581	Coos	007
SHORT FALLS,NH	EPSOM,NH	03234	Merrimack	013
SILVER LAKE,NH	SILVER LAKE,NH	03875	Carroll	003
SMITHTOWN,NH	SEABROOK,NH	03874	Rockingham	015
SNOWVILLE,NH	MADISON,NH	03849	Carroll	003
SOMERSWORTH,NH	SOMERSWORTH,NH	03878	Strafford	017
SOUTH EFFINGHAM,NH	SOUTH EFFINGHAM,NH	03882	Carroll	003
SOUTH HAMPTON,NH	EAST KINGSTON,NH	03827	Rockingham	015
SOUTH NEWBURY,NH	SOUTH NEWBURY,NH	03272	Merrimack	013
SOUTH SUTTON,NH	SOUTH SUTTON,NH	03273	Merrimack	013
SOUTH TAMWORTH,NH	SOUTH TAMWORTH,NH	03883	Carroll	003
SPOFFORD,NH	SPOFFORD,NH	03462	Cheshire	005
SPRINGFIELD,NH	WEST SPRINGFIELD,NH	03284	Sullivan	019
STARK,NH	GROVETON,NH	03582	Coos	007
STATELINE,NH	FITZWILLIAM,NH	03447	Cheshire	005
STATELINE,NH	FITZWILLIAM,NH	03447	Cheshire	005
STEWARTSTOWN,NH	COLEBROOK,NH	03576	Coos	007
STINSON LAKE,NH	STINSON LAKE,NH	03274	Grafton	009
STODDARD,NH	STODDARD,NH	03464	Cheshire	005
STRAFFORD,NH	STRAFFORD,NH	03884	Strafford	017
STRATFORD,NH	NORTH STRATFORD,NH	03590	Coos	007
STRATHAM,NH	STRATHAM,NH	03885	Rockingham	015
STRAWBERRY BANKE,NH	PORTSMOUTH,NH	03801	Rockingham	015
SUCCESS, SUCCESS TOW,NH	MILAN,NH	03588	Coos	007
SUGAR HILL,NH	LISBON,NH	03585	Grafton	009
SULLIVAN,NH	EAST SULLIVAN,NH	03445	Cheshire	005
SUNAPEE,NH	SUNAPEE,NH	03782	Sullivan	019
SUNCOOK,NH	SUNCOOK,NH	03275	Merrimack	013
SURRY,NH	KEENE,NH	03431	Cheshire	005
SUTTON,NH	BRADFORD,NH	03221	Merrimack	013
SWANZEY,NH	WINCHESTER,NH	03470	Cheshire	005
TAMWORTH,NH	TAMWORTH,NH	03886	Carroll	003
TEMPLE,NH	TEMPLE,NH	03084	Hillsborough	011
THORNTON,NH	CAMPTON,NH	03223	Grafton	009
TILTON,NH	TILTON,NH	03276	Belknap	001
TROY,NH	TROY,NH	03465	Cheshire	005
TUFTONBORO,NH	OSSIPEE,NH	03864	Carroll	003
TWIN MOUNTAIN,NH	TWIN MOUNTAIN,NH	03595	Coos	007
UNION,NH	UNION,NH	03887	Carroll	003
UNITY,NH	CHARLESTOWN,NH	03603	Sullivan	019
WAKEFIELD,NH	SANBORNVILLE,NH	03872	Carroll	003
WALPOLE,NH	WALPOLE,NH	03608	Cheshire	005

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WARNER,NH	WARNER,NH	03278	Merrimack	013
WARREN,NH	WARREN,NH	03279	Grafton	009
WASHINGTON,NH	WASHINGTON,NH	03280	Sullivan	019
WATER VILLAGE,NH	OSSIPEE,NH	03864	Carroll	003
WATERVILLE, WATERVIL,NH	WATERVL VLY,NH	03215	Grafton	009
WEARE,NH	WEARE,NH	03281	Hillsborough	011
WEBSTER,NH	CONCORD,NH	03303	Merrimack	013
WEIRS BEACH,NH	LACONIA,NH	03246	Belknap	001
WENDALL,NH	SUNAPEE,NH	03782	Sullivan	019
WENTWORTH,NH	WENTWORTH,NH	03282	Grafton	009
WENTWORTHS LOCATION,NH	ERROL,NH	03579	Coos	007
WEST CAANAN,NH	CANAAN,NH	03741	Grafton	009
WEST CHESTERFIELD,NH	WEST CHESTERFLD,NH	03466	Cheshire	005
WEST LEBANON,NH	WEST LEBANON,NH	03784	Grafton	009
WEST NOTTINGHAM,NH	WEST NOTTINGHAM,NH	03291	Rockingham	015
WEST OSSIPEE,NH	WEST OSSIPEE,NH	03890	Carroll	003
WEST PETERBOROUGH,NH	WEST PETERBORO,NH	03468	Hillsborough	011
WEST STEWARTSTOWN,NH	WEST STEWARTSTWN,NH	03597	Coos	007
WEST SWANZEY,NH	WEST SWANZEY,NH	03469	Cheshire	005
WEST THORNTON,NH	WEST THORNTON,NH	03285	Grafton	009
WESTMORELAND,NH	WESTMORELAND,NH	03467	Cheshire	005
WESTPORT,NH	WINCHESTER,NH	03470	Cheshire	005
WESTVILLE,NH	PLAISTOW,NH	03865	Rockingham	015
WHITEFIELD,NH	WHITEFIELD,NH	03598	Coos	007
WHITTIER,NH	TAMWORTH,NH	03886	Carroll	003
WILLEY HOME/HOUSE,NH	BARTLETT,NH	03812	Carroll	003
WILMOT, WILMOT FLAT,NH	WILMOT FLAT,NH	03287	Merrimack	013
WILTON,NH	WILTON,NH	03086	Hillsborough	011
WINCHESTER,NH	WINCHESTER,NH	03470	Cheshire	005
WINDHAM,NH	WINDHAM,NH	03087	Rockingham	015
WINDSOR,NH	HILLSBORO,NH	03244	Hillsborough	011
WINNISQUAM,NH	WINNISQUAM,NH	03289	Belknap	001
WOLFEBORO FALLS,NH	WOLFEBORO FLS,NH	03896	Carroll	003
WOLFEBORO,NH	WOLFEBORO,NH	03894	Carroll	003
WONALANCET,NH	WONALANCET,NH	03897	Carroll	003
WOODSTOCK,NH	WOODSTOCK,NH	03293	Grafton	009
WOODSVILLE,NH	WOODSVILLE,NH	03785	Grafton	009
WORDELL,NH	SUNAPEE,NH	03782	Sullivan	019

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