Texas Cancer Registry

Cancer Reporting Handbook 2013

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1

INTRODUCTION

TO

CANCER REPORTING

TEXAS CANCER REGISTRY

Preface

With original authorization from the *1979 Texas Cancer Control Act* and the *Texas Cancer Incidence Reporting Act, (Chapter 82, Health and Safety Code, amended September, 2001)* the Texas Cancer Registry (TCR) of the Texas Department of State Health Services (DSHS) collects information on each patient seeking diagnosis and/or treatment for cancer at health care facilities and clinical laboratories, as well as physician and other outpatient offices (in certain circumstances), within the State of Texas. *Chapter 91 of the Texas Administrative Code* (amended August 2011) outlines the rules necessary to implement this act. The laws and rules may be accessed at the following website: www.dshs.state.tx.us/tcr/lawrules.shtm#law.

The mission of the TCR is to collect, maintain, and disseminate high quality cancer data that contribute towards cancer prevention and control, research, improving diagnoses, treatment, survival, and quality of life for all cancer patients. It is estimated that in 2013 there will be 111,371 Texans newly diagnosed with cancer, and another 41,362 will die of the disease. A statewide cancer registry is the foundation for cancer prevention and control. The effectiveness of the Cancer Registry is dependent on complete, timely and accurate reporting.

The TCR is the 4th largest cancer registry in the United States. Approximately 240,000 reports of cancer are received annually from over 500 hospitals, cancer treatment centers, ambulatory surgery centers, and pathology laboratories located throughout the state. The *Texas Cancer Registry Cancer Reporting Handbook, 2013 Edition* serves as the instruction manual to provide rules and guidelines which assure the consistent collection and coding of relevant cancer case information. This edition should be used for reportable cases diagnosed January 1, 2013 and forward. The contents of this manual are based on the guidelines and standards for cancer reporting established by the National Program of Cancer Registries (NPCR); Centers for Disease Control and Prevention (CDC); North American Association of Central Cancer Registries (NAACCR); Surveillance, Epidemiology, and End Results Program (SEER) of the National Cancer Institute (NCI); and the American College of Surgeons (ACoS).

The handbook can be obtained from the TCR's website: http://www.dshs.state.tx.us/tcr/reporting.shtm. For any problems please contact the TCR. Please remember to monitor the TCR website for training opportunities. The information can be found at http://www.dshs.state.tx.us/tcr/training.shtm.

HANDBOOK SOURCES

The following sources were used in the preparation of this handbook:

- *The SEER Program Coding and Staging Manual 2013,* National Cancer Institute, NIH Pub. No. 11-5581, Bethesda, MD.
- *Standards of the Commission on Cancer Volume II: Facility Oncology Registry Data Standards (FORDS).* Chicago: American College of Surgeons Commission on Cancer, Revised for 2013.
- *NAACCR Standards for Cancer Registries, Volume II, Data Standards and Data Dictionary, Sixteenth Edition, Record Layout Version 13 Revised March 2013*
- *International Classification of Diseases for Oncology*. *3rd Edition (ICD-O-3)*. Geneva: World Health Organization, 2000.
- Texas Cancer Incidence Reporting Law (Amended July 2006), Chapter 82, Health and Safety Code and Rules, Title 25, Health Services, Part I. Texas Department of State Health Services, Chapter 91. Cancer, Subchapter A. Cancer Registry (Effective August 14, 2011).
- *SEER*Rx Version 2.2.0 The Cancer Registrar's Interactive Antineoplastic Drug Database.* U.S. Department of Health and Human Services, Public Health Services, National Institutes of Health, Bethesda, MD, 2005
- Collaborative Stage Work Group of the American Joint Committee on Cancer. *Collaborative Stage Data Collection System Coding Instructions, version 02.04.40.* Incorporates updates through January 1, 2012.
- *2013 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual,* National Cancer Institute, Bethesda, MD 20892-8316
- *2012 Hematopoietic and Lymphoid Database http://seer.cancer.gov/seertools/hemelymph/*
- *SEER Inquiry System and Resolved Questions*, website www.seer.cancer.gov/seerinquiry.
- *Multiple Primary and Histology Coding Rules* January 1, 2007, revised September 27, 2011, National Cancer Institute. Bethesda, MD.
- *California Cancer Reporting System Standards, Volume One, Thirteen Edition 2013, Revision 2.2, August 2013*

Acknowledgment

We wish to acknowledge that some information presented here was taken verbatim from *The 2011 SEER Program Coding and Staging Manual , Adamo MB, Johnson CH, Ruhl JL, Dickie, LA (eds.). National Cancer Institute, NIH Publication number 11-5581, Bethesda, MD.* The complete manual for the 2007 Multiple Primary and Histology Rules in text format by the National Cancer Institute's SEER Program with 2010 revisions can be found on this link: MP/H Rules: http://seer.cancer.gov/tools/mphrules/download.html.

HELPFUL WEBSITES

http://cancerbulletin.facs.org/forums/
http://cancercontrolplanet.cancer.gov
http://facs.org/cancer/coc/fordsmanual.html
http://seer.cancer.gov/
http://zip4.usps.com
www.anatomyatlases.orgwww.medicare.gov/find-a-plan/questions/home.aspx
www.bcm.edu (Baylor College of Medicine)
www.bls.gov/soc/#material
www.breastcancer.org
www.cancer.gov
www.cancer.org
www.cdc.gov/niosh/docs/2011-173/
www.docboard.org/tx/df/txsearch.htm
www.dshs.state.tx.us/tcr/default.shtm
www.epa.gov/enviro/html/codes/state.html
www.melissadata.com
www.naaccr.org
www.nccn.org/index.asp
www.ncra-usa.org
www.nlm.nih.gov
www.oralcancerfoundation.org
www.pathologyoutlines.com
www.txhima.org
www.whonamedit.com

ACRONYMS

- ACS American Cancer Society
- ACoS American College of Surgeons
- AJCC American Joint Committee on Cancer
- CDC Centers for Disease Control and Prevention
- CESB Cancer Epidemiology and Surveillance Branch
- CNS Central Nervous System
- CoC Commission on Cancer
- CRH Cancer Reporting Handbook
- CS Collaborative Stage
- DSHS Texas Department of State Health Services
- FIPS Federal Information Processing Standards
- FORDS Standards of the Commission on Cancer Volume II: Facility Oncology Registry Data
- ICD-O-3 International Classification of Diseases for Oncology, 3rd Edition
- ICD-O-2 International Classification of Diseases for Oncology, 2nd Edition
- MP/H Multiple Primary and Histology Coding Rules
- NAACCR North American Association of Central Cancer Registries
- NPCR National Program of Cancer Registries, CDC
- HSR Health Service Region
- SEER Surveillance, Epidemiology, and End Results Program, NCI
- SINQ SEER Inquiry System, website: www.seer.cancer.gov/seerinquiry
- TCR Texas Cancer Registry
- WHO World Health Organization
- VSU Vital Statistics Unit

OVERVIEW OF REPORTING AND CODING CHANGES

New ICD-9-CM Codes for 2013 casefinding
Two different ICD-9-CM groups have been added for casefinding, 209.30-209.36 and 209.70-209.79 See page 22 of the casefinding section.

Casefinding/Ambiguous terminology
Urine cytology stated to be malignant, is reportable. See page 37 on casefinding section.

Coding Race 1 "Other" from face sheet
If the only information about Race 1 is from the face sheet and stated as "Other" and no further information is found, code Race 1 as 99, and Race 2-5 as 99. See pages 70-74 in the demographic section.

Laterality
Use code 4 when bilateral involvement of lungs and lung of origin is unknown. See page 112 in the Cancer Information section.

Diagnostic Confirmation
Frozen section was removed from diagnosis confirmation code 1.

NEWLY REQUIRED DATA ITEMS FOR 2013

The following table lists new data items to be reported for cases diagnosed on or after January 1, 2013.

Table 1.1 Newly Required Data Items for 2013

NAACCR Data Item Description	NAACCR Data Item#
Address at DX - Country	102
Birthplace - State *	252
Birthplace – Country *	254
Place of Death - Country	1944

* For cases diagnosed 1/1/2013 and later, State and Birthplace Country replace Place of Birth (NAACCR item # 250)

FORMER CER NAACCR DATA ITEMS STILL REQUIRED BY TCR

The following table lists NAACCR Data Items still required by TCR for cases diagnosed on or after January 1, 2013.

Table 1.2 Former CER Data Items Still Required by TCR

NAACCR Data Item Description	NAACCR Data Item#
Comorbidities and Complications #1 - #10	3110, 3120, 3130, 3140, 3150, 3160, 3161, 3162, 3163, 3164

FORMER CER NON-NAACCR DATA ITEMS STILL REQUIRED BY TCR

Table 1.3 Former CER Non-NAACCR Data Items Still Required by TCR

Non-Standard Data Item Description	Non Standard Data Item #
Tobacco Use Cigarettes	9965
Tobacco Use Other Smoke	9966
Tobacco Use Smokeless	9967
Tobacco Use NOS	9968
Height	9960
Weight	9961

REQUIRED CS SITE SPECIFIC FACTORS

TCR requires the collection of CSv2 data items needed to derive SEER Summary Stage, SSFs for Breast, Brain/CNS/Intracranial, and SSF 25 for applicable sites (schema discriminators). TCR requires, as available, the collection of CSv2 data items needed to derive AJCC-7 TNM Stage. Please see Appendix A for a complete list of all required Site-Specific Factors by primary site.

CODING CANCER CASES

For cancer coding, the correct ICD-O version must be used for all cases according to the year in which the cancer case was diagnosed. If the diagnosis year is unknown, use the year in which the case was accessioned. If this process is not applied the cancer case will fail required edits and will not be accepted by the TCR.

The *International Classification of Diseases for Oncology, 3rd Edition* (ICD-O-3) **must** be used to code the primary cancer site (topography) and the cell type (morphology, behavior, and grade, NAACCR items 522 and 523) of the tumor for all cases diagnosed/admitted on January 1, 2001 and forward. In 2010 several newly reportable conditions and new ICD-O histology terms and codes for hematopoietic and lymphoid neoplasms were added. A list of these conditions and terms can be found on page 31-33 in the Casefinding Sections. These newly reportable conditions are included in the Hematopoietic Database and Manual.

For all cases diagnosed on January 1, 1992–December 31, 2000, the *International Classification of Diseases for Oncology, 2nd Edition* (ICD-O-2) **must** be used to code the primary cancer site (topography) and the cell type (morphology, behavior and grade, NAACCR item 420 and 430).

STAGING CANCER CASES

For staging cancer cases, all cases must be staged and the corresponding stage data fields must be completed according to the correct staging guidelines for the year in which the cancer was diagnosed. If the diagnosis year is unknown, the correct guidelines for the year in which the case is accessioned must be used. Otherwise, the cancer case will fail required edits and will not be accepted by the TCR.

Table 1.4 Staging Cancer Cases

Year of Diagnosis	Stage System/Manual
Prior to 2001	SEER April 1977 Summary Staging Guide
January 1, 2001 - December 31, 2003	SEER Summary Staging Manual 2000 (SSSM2K)
January 1, 2004 and forward	Collaborative Stage Data Collection System Coding Instructions, version 02.04.40

Note: Both Collaborative and Summary Stage schemas use all information (both clinical and pathological assessments) available through completion of surgery (ies) in the first course of treatment or within four months of date of diagnosis in the absence of disease progression, whichever is longer.

TCR CODING AND STAGING REQUIREMENT SUMMARY

Table 1.5 TCR Coding and Staging Requirement Summary

Coding and Staging Schema	Diagnosis Year
International Classification of Diseases for Oncology, 3rd Edition (ICD-O-3)	2001 – forward
International Classification of Diseases for Oncology, 2nd Edition (ICD-O-2)	1995 – 2000*
Collaborative Stage Data Collection System Coding Instructions, vs. 02.03.02	2004 – forward
SEER Summary Staging Manual 2000 (SSSMK2)	2001 – 2003
SEER April 1977 Summary Staging Guide	1995 – 2000*
Multiple Primary and Histology Coding Rules (MP/H)	2007 - forward
Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual	2010 - forward

***The TCR no longer requires reporting of cases diagnosed prior to 1995.**

ACOS FACILITY INSTRUCTION MANUALS AND DATE IMPLEMENTED

Table 1.6 ACoS Facility Instruction Manuals and Date Implemented

Manual/Guidelines	Implemented
Data Acquisition Manuel (DAM)	1995
Registry Operations and Data Standards (ROADS)	1996 – 2002
Facility Oncology Registry Data Standards (FORDS)	2003
Collaborative Staging (CS)	2004
Multiple Primary and Histology Coding Rules (MP/H)	2007
Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual	2010

Note: Per SEER, the new coding and staging instructions/guidelines replace the old for respective time periods.

COMPLIANCE

To assure timely and complete cancer case reporting in Texas, the TCR monitors compliance with the Texas Cancer Incidence Reporting Act. The TCR health service regions routinely monitor facility submissions of case reports. If submissions are not received complete and in a timely manner according to our current law and rules, the facility registrar/reporter will be contacted regarding the delinquent reporting status. Further action, which may include cost recovery procedures, will be instituted if submissions continue to be delinquent. These actions are necessary to meet the state and national requirements for timely cancer data. To be compliant with the law, **all records must be submitted within 6 months of initial diagnosis, or admission with active disease, or treatment for cancer at your facility.** Cancer reporting rules require monthly submissions from health care facilities with an annual caseload of greater than 400 and submissions in bundles of 20 for health care facilities with an annual caseload of 400 or fewer.

Table 1.7 Case Submission Requirements:

Caseload	Submission
>400	Monthly
Equal to or <400	≥ 20 case bundles

Small Cancer Caseload Facilities (100 or fewer):
The TCR developed the "Small Facility Casefinding and Data Collection Program" with the goal to increase and improve the reporting and data quality of cancer cases, as required by the Texas Cancer Incidence Reporting Act (Chapter 82, Texas Health and Safety Code), from Texas facilities with 100 or fewer expected cancer cases. Contracted CTRs and/or TCR staff conduct the casefinding and data collection activities for these facilities. Each year this program is contingent on the availability of funds. Facilities should contact their respective TCR representative to inquire about their facility's compliance and eligibility for participation in this program. Refer to page 10 for the appropriate regional contact information.

Note: The submission instructions and Reporting Laws & Rules are located on the TCR website at http://www.dshs.state.tx.us/tcr/reporting.shtm.

TIMELINESS OF DATA SUBMISSION

Timeliness of case reporting is important, however, data quality and completeness must be assured as well. Researchers, epidemiologists, health planners, clinicians, and laypersons benefit from access to the most current information. Due to reporting requirements of CDC and TCR, all reports of cases shall be submitted to the TCR within six months of initial diagnosis or admission at their facility with active disease and/or treatment of cancer. This information is in *Section 91.5(a) (When to Report*) of the *Texas Cancer Incidence Reporting Rules*. Refer to www.dshs.state.tx.us/tcr/lawrules.shtm#law for more information regarding reporting timeliness.

TIMELY REPORTING CALENDAR

Table 1.8 Timely Reporting Calendar for 2013

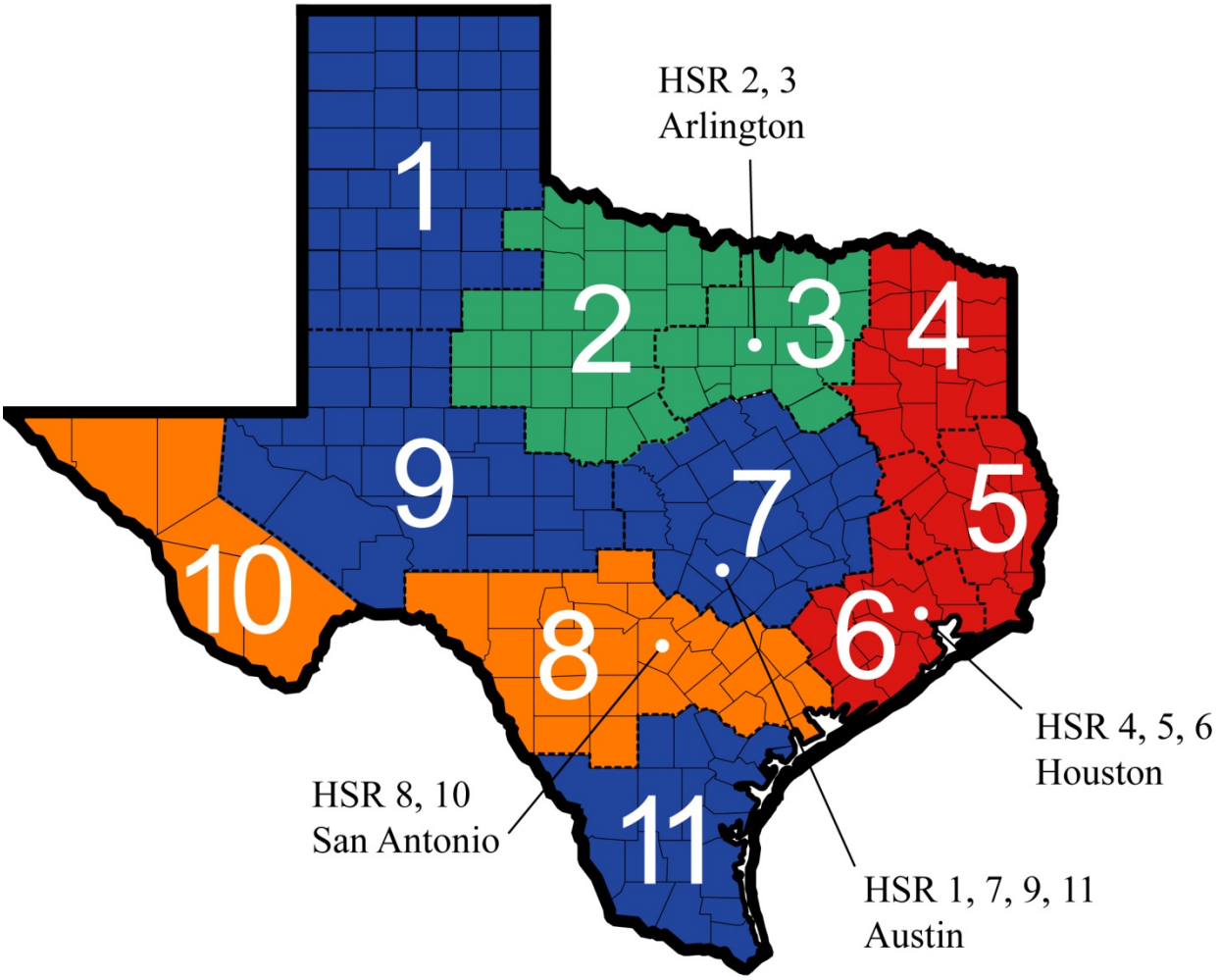
Cases Admitted in:	Should be Reported the Following:
January	July
February	August
March	September
April	October
May	November
June	December
July	January
August	February
September	March
October	April
November	May
December	June

REGIONAL CONTACTS

Table 1.9 Regional Contacts

HEALTH SERVICE REGIONS 1, 7, 9, 11 Miriam Robles, RHIT, CTR Regional Program Specialist Department of State Health Services Cancer Epidemiology & Surveillance Branch-1928 Health Service Regions 1, 7, 9, 11 1100 W. 49th Street Austin, Texas 78756 (512) 305-8168 or 1-800-252-8059 Fax (512) 305-8405 Miriam.Robles@dshs.state.tx.us	**HEALTH SERVICE REGIONS 2,3** Debra Anderson, BS, CTR Regional Program Specialist Department of State Health Services Cancer Epidemiology & Surveillance Branch-1869 Health Service Regions 2/3 1301 South Bowen Rd, Suite 200 Arlington, Texas 76013 (817) 264-4594 Fax (817) 264-4583 Debra.Anderson@dshs.state.tx.us	**HEALTH SERVICE REGIONS 4,5,6** Judy Spong, MS, CTR Regional Program Specialist Department of State Health Services Cancer Epidemiology & Surveillance Branch-1906 Health Service Region 6 5425 Polk St, Suite J Houston, Texas 77023 (713) 767-3180 Fax (713) 767-3284 Judy.Spong@dshs.state.tx.us
HEALTH SERVICE REGIONS 8, 10 Dwenda Smith, CTR Regional Program Specialist Department of State Health Services Cancer Epidemiology & Surveillance Branch-1928 1100 W. 49th St Austin, Texas 78756 (512) 305-8455 or 1-800-252-8059 Fax (512) 305-8405 Dwenda.Smith@dshs.state.tx.us	**REGISTRY OPERATIONS MANAGERS** Dora Rodriguez-Flores, CTR HSRs 2/3/4/5/6 Arlington, Texas (817) 264-4592 Dora.Rodriguez@dshs.state.tx.us Velma Garza, CTR HSRs 1/7/8/9/10/11 Austin, Texas (512) 776-3635 or 1-800-252-8059 Ext. 3635 Velma.Garza@dshs.state.tx.us	**NON-HOSPITAL OPERATIONS MANAGER** Beatriz Gutierrez, MPH, CTR Austin, Texas (512) 305-8114 or 1-800-252-8059 Fax (512) 305-8405 Beatriz.Gutierrez@dshs.state.tx.us

PUBLIC HEALTH REGIONS



2

STANDARDS FOR CONFIDENTIALITY, DISCLOSURE OF DATA, AND QUALITY ASSURANCE

STANDARDS FOR CONFIDENTIALITY, DISCLOSURE OF DATA, AND QUALITY ASSURANCE

CONFIDENTIALITY

Data obtained under the *Texas Cancer Incidence Reporting Act* are for the confidential use of the Texas Department of State Health Services, including persons, and public or private entities that are necessary to carry out the public health interests of the Act. The data are privileged and may not be divulged or made public in a manner that discloses the individual identity of any patient. All reporting entities that are performing in compliance with the Act are immune from civil and criminal liability for furnishing the required information.

DISCLOSURE OF DATA

All data reported to the TCR are available for use in aggregate form for analysis by facility registry staff, physicians, health care workers, cancer researchers, and the public. Reports of cancer incidence are available on the TCR website under Cancer Statistics. A Web Query Tool which generates customized maps and tables of Texas cancer incidence and mortality rates is also available on the website at http://www.dshs.state.tx.us/tcr/data.shtm. Public access to aggregate data is available through published reports, or through the TCR, if in accordance with its data release policies and procedures.

The TCR **may** exchange patient-specific data with the reporting facility, any other cancer-control agency, clinical facility, pathology laboratories, or physician's offices for the purpose of obtaining information necessary to complete the abstract or follow-up information, provided that these agencies and facilities comply with the TCR's confidentiality policies. However, no facility-specific patient information can be released unless authorized under law. The TCR can contact the facility where the patient was seen and obtain consent to release information other than that authorized by law.

To achieve complete case ascertainment, the TCR **may** exchange patient-specific data with other state cancer registries if reciprocal data sharing agreements and confidentiality provisions are implemented.

The TCR **may** grant researchers access to confidential information concerning individual cancer patients, provided that those researchers comply with the provisions and confidentiality policies mandated by the Texas Department of State Health Services Institutional Review Board.

QUALITY ASSURANCE

The TCR implements an extensive series of quality assurance procedures that are based on the SEER Program, CDC recommendations, and NAACCR standards. These procedures, which consist of both internal and external processes, ensure the reliability, completeness, consistency and comparability of TCR data.

INTERNAL PROCESS

Submission Review:

The TCR's data upload system currently checks all submitted abstracts for errors.

As abstracts are uploaded into the system, they are intensely scrutinized for:

- Possible duplicate submission of existing abstracts.
- Unacceptable codes for any field or inter-field inconsistencies.
- Invalid or unusual site/sex, age/site, age/morphology or site/morphology combinations.

Currently, the TCR is not rejecting cases at upload, but this could change and you will be notified by TCR when this change is implemented.

Note: *Facilities* ***must*** *run their data through the appropriate NAACCR and TCR edits and make necessary corrections before submitting a file to the TCR.*

EXTERNAL PROCESS

Facility Training:

TCR staff provides technical assistance, training, and continuing education for cancer registrars and medical records personnel on standards and procedures for reporting. Requests for training and technical assistance should be directed to the Austin Central Office Training Team. To request training please submit your training needs using the online training request forms found in the Training Section of the TCR website: http://www.dshs.state.tx.us/tcr/training.shtm . Training staff contact information is also in the TCR Education and Training page of the TCR website.

Casefinding Data Quality Audits:

TCR staff or a TCR representative review casefinding sources such as disease indices, pathology reports (including cytology and autopsy reports), outpatient records, radiation therapy logs, and appropriate oncology logs for missing cases. Periodically, facilities are randomly selected for a casefinding audit. A casefinding audit is a systematic method of reviewing the facility's casefinding procedures and identifying all reportable cases in order to assess completeness and timeliness. The audit is a tool to improve a facility's casefinding process and is not a punitive measure. Sometimes chart review may be performed on records identified from the audit to determine case reportability. Casefinding procedures are located in the *Casefinding Section* beginning on page 16. Results from a specific facility's data quality audit are not shared with other entities without the facility's approval.

Reabstracting Data Quality Audits:

TCR staff, or a TCR representative, performs complete re-abstracting of a sample of reported cases without reference to the original abstract. If discrepancies are identified, they are used to assess the quality of the facility's cancer case reporting and training needs.

DEATH CLEARANCE

TCR staff performs additional checks of reporting completeness through the death clearance process. Each year the TCR electronically matches existing incidence cases in the cancer master file against the Vital Statistics Unit (VSU) death certificate records for the year. If a match is found, the date of death and the underlying cause of death is updated in the TCR's database patient's record. If no match is found, queries to facilities are made for patients who have a diagnosis of cancer on their death certificate, and expired at a reporting facility, but were not reported to the TCR. Facilities are required to submit abstracts for all missed cases. In some instances, there may not be evidence of active cancer. If there is no documented evidence of a reportable diagnosis on a queried case, please notify the Vital Statistics Specialist at the TCR central office using the Facility Death Clearance Report. If the facility is using the Web Plus follow-back system, the queried case can be rejected. Following a rejected case, the abstractor will add a note explaining the case.

3

CASEFINDING FOR COMPLETENESS OF REPORTING

CASEFINDING FOR COMPLETENESS OF REPORTING

The *Texas Cancer Incidence Reporting Act (Chapter 82, Health and Safety Code)* requires every health care facility, clinical laboratory, and health care practitioner center to submit cancer information for each reportable diagnosis.

Casefinding is a system used to identify all eligible cases to be reported to the TCR. Casefinding sources include disease indices, pathology and laboratory reports, patient logs, and similar resources specific to each facility. Refer to the Casefinding sources list on page 19 for a more detailed list. Every inpatient and/or outpatient with active disease and/or receiving cancer-directed therapy must be reported to the TCR regardless of the patient's state or country of residence. The requirements for reporting depend on the governing agencies of the registry. For example, hospitals participating in the Approvals Program of the Commissions on Cancer (CoC) of the American College of Surgeons follow the guidelines set forth by CoC; however, they must also adhere to the TCR reporting criteria. **Remember that cases diagnosed prior to 1995 are no longer required to be reported.**

REPORTABLE CANCER CASES

Cases of cancer to be reported to the TCR include:

1. All neoplasms with a **behavior code** of /2 (in situ) or /3 (malignant) in the *International Classification of Diseases for Oncology 3rd Edition (ICD-O-3)*, with some exceptions (see page 21).

2. All primary tumors with a **behavior code** of /0 (benign), /1 (borderline), or /3 (malignant) occurring in any of the following sites:

   a. Meninges (C700-C709), brain (C710-C719), spinal cord (C720), cauda equina (C721), cranial nerve or nerves (C722-C725), or any other part of the central nervous system (CNS) (C728-C729)

   b. Pituitary gland (C751), craniopharyngeal duct (C752), or pineal gland (C753)

Note: All diagnoses of the brain and CNS must have a morphology term and code listed in ICD-O-3 to be reportable. If there is no morphology term or code listed in the ICD-O-3 it is not reportable.

Note: According to MP/H rules (MP/H link: http://seer.cancer.gov/tools/mphrules/download.html), the terms tumor, mass, lesion and neoplasm are interchangeable for benign and malignant brain and CNS sites. Therefore, a diagnosis with these terms and no other information would be reportable for brain and CNS and the histology would be coded 8000/0 for benign tumor or 8000/1 for Neoplasm, NOS.

Note: Benign and borderline CNS cases diagnosed **prior to 2004** are no longer required to be submitted to the TCR.

Table 3.1 Required Sites for Benign and Borderline Primary Intracranial and Central Nervous System Tumors:

TERM	SPECIFIC SITES	ICD-O-3 TOPOGRAPHY CODE
Meninges	Cerebral meninges	C700
	Spinal meninges	C701
	Meninges, NOS	C709
Brain	Cerebrum	C710
	Frontal lobe	C711
	Temporal lobe	C712
	Parietal lobe	C713
	Occipital lobe	C714
	Ventricle, NOS	C715
	Cerebellum, NOS	C716
	Brain stem	C717
	Overlapping lesion of brain	C718
	Brain, NOS	C719
Spinal cord, cranial nerves, and other parts of the central nervous system	Spinal cord	C720
	Cauda equina	C721
	Olfactory nerve	C722
	Optic nerve	C723
	Acoustic nerve	C724
	Cranial nerve, NOS	C725
	Overlapping lesion of brain and central nervous system	C728
	Nervous system, NOS	C729
Pituitary, craniopharyngeal duct and pineal gland	Pituitary gland	C751
	Craniopharyngeal duct	C752
	Pineal gland	C753

Note: Benign and borderline tumors of the cranial bones (C410) are **not reportable.**

Cases Diagnosed Clinically are Reportable

In the absence of a histologic or cytologic confirmation of a reportable diagnosis, accession the case based on the **clinical diagnosis** (when a recognized medical practitioner states the patient has a reportable diagnosis). A clinical diagnosis may be recorded in the final diagnosis, in a clinic note, on an x-ray report, or in other parts of the medical record.

Note: A pathology report normally takes precedence over a clinical diagnosis. If the patient has a biopsy or fine-needle aspiration that disproves the clinical diagnosis the case is not reportable.

Exception: If the physician treats a patient for cancer in spite of a negative biopsy, accession the case.

Exception: If enough time has passed that it is reasonable to assume that the physician has seen the negative pathology report, and the clinician continues to call this a reportable disease, accession the case. A reasonable amount of time would be 6 months or more.

Example: In February 2013 a patient has a CT that shows possible lung cancer. The physician states this is probably lung cancer. A fine-needle aspiration is non-diagnostic and the physician advises the patient to have further tests. The patient refuses any further work-up or treatment. In September 2013 the physician sees the patient again and states that this is probable lung cancer based on previous x-rays, continued symptoms, and further decline in health.

CASEFINDING METHODS

There are two types of casefinding methods-**active** and **passive**:

1. Active casefinding: The personnel responsible for reporting obtain and review all sources for eligible cases. This method is more comprehensive and precise.

2. Passive casefinding: The personnel responsible for reporting rely on others to notify the reporter of possible eligible cases. There is a greater potential for missed cases using this method.

A combination of active and passive casefinding is a more effective method and ensures fewer missed cases. It is strongly recommended that every facility have a Casefinding Policy and Procedure in place. The procedures should be evaluated from time to time and amended as facility procedures or services change.

CASEFINDING SOURCES

1. Medical Records Department
   a. Disease index
   b. Admission and discharge reports
2. Pathology Department
   a. Histology reports
   b. Cytology reports
   c. Hematology reports
   d. Autopsy reports
3. Surgery Department
4. Outpatient Departments
5. Medical and Diagnostic Imaging
6. Radiation Oncology
7. Medical Oncology
8. Emergency Room reports
9. Lab reports

CASEFINDING PROCESS

Cooperation and a good working relationship between reporting personnel and other departments are essential for accurate case ascertainment. The reporter is responsible for identifying all casefinding sources under their facility licensure and arranging access to these sources, for example, rural health clinics, surgery centers across town or off campus.

Disease indices should be obtained after medical records are completed and coded (monthly or quarterly). The indices must include both **inpatient and outpatient** admissions **and must** be based on **year of admission.** It must be sorted **alphabetically** by last name and include the following: **last name, first name, medical record number, admission/discharge date, date of birth, social security number, all primary and secondary ICD-9 diagnosis codes and admission type.**

Attachment A *(*page 42) is an example of a disease index that can be modified for individual facilities. See page 22 for further instructions on disease index procedures.

The following list includes some helpful hints for the casefinding process:

- Review the disease index for reportable cancer codes to ensure the facility has reported all of its reportable cases to the TCR.

- Request a TCR Facility Data Report from your regional office when needed during the reporting year. A Facility Data Report is a complete listing of cases submitted by a facility.

- Compare the patients with reportable codes on the disease index to the TCR Facility Data Report.

- Review any patient charts with reportable codes that are missing from the TCR Facility Data Report for reportability.

- Prepare an abstract for each reportable case missing from the TCR Facility Data Report.

- If a previously reported patient is found to have a subsequent primary, assign the new primary the patient's original registry number. Change the sequence number to reflect the new primary and abstract the pertinent cancer information.

Note: If a facility uses an automated casefinding method (for example: the hospital's mainframe extracts possible reportable cases and places these into cancer registry software suspense file), a manual disease index should be run at the end of the reporting year. **Ensure that the ICD-9-CM codes used are the most current for the reporting year.** This disease index is then checked against the cancer registry database to ensure that all cases were either reported or clearly documented as non-reportable with the reason it is not reportable.

At the end of each reporting year, TCR requires that each facility send the disease index, non-reportable list, and the casefinding check-list (Attachment C, page 44) to the facility's health service region. Refer to page 10 for a list of all regional offices.

REPORTABLE NEOPLASMS

The following lists are intended to assist the cancer data reporter in identifying the reportable neoplasms.

- Malignant neoplasms *(exclusions noted on page 21)*

- Benign and borderline neoplasms of central nervous system (CNS) diagnosed 2004 and forward

- Pituitary adenomas diagnosed as of 2004

- *Carcinoma in-situ (*exclusions noted on page 21)*

- Carcinoid, NOS ***(excluding appendix,C181, unless stated to be malignant)***

Note: Extension into surrounding tissue does not make a carcinoid of the appendix reportable. Benign tumors can and do extend into surrounding tissue.

- Pilocytic/juvenile astrocytoma is reportable and should be coded to 9421/3 per ICD-O-3 errata

- Squamous intraepithelial neoplasia grade III (8077/2) of vulva **[VIN]**, vagina **[VAIN]**, and anus **[AIN] beginning with 2001 cases**

Note: According to AJCC high grade/severe dysplasia may be synonymous with in situ carcinoma within the gastrointestinal tract. However, they give no further instruction. Each facility should consult their cancer committee, physician advisor, and pathologists to determine how the phrase is used within the facility. This will determine whether or not a case diagnosed as high grade or severe dysplasia should be reported.

Note: All tumors and neoplasms of the brain and other CNS sites must have a morphology term and code in ICD-O-3. If there is no morphology term and code, it is not reportable. Tumors and neoplasms diagnosed prior to 2001 must have a morphology term and code in ICD-O-2 to be reportable.

Notes:
1. Malignant neoplasms of the skin of genital sites **are reportable.** These sites include: clitoris (C512), vulva (C519), vagina (C529), prepuce (C600), penis (C609), and scrotum (C632).

2. Reportable skin tumors such as adnexal carcinomas (carcinomas of the sweat gland, ceruminous gland, and hair follicle), adenocarcinomas, lymphomas, melanomas, sarcomas, and Merkel cell tumor **must be reported regardless of site**. Any carcinoma arising in a hemorrhoid is reportable since hemorrhoids arise in mucosa, not in skin.

NON-REPORTABLE NEOPLASMS (Exclusions)
- Basal cell carcinoma (8090–8110) of the skin (C440-C449) **except genital sites**
- Basal and squamous cell carcinoma (8070–8110) of skin of anus (C445)
- Epithelial carcinomas (8010–8046) of the skin (C440-C449)
- Papillary and squamous cell carcinomas (8050–8084) of the skin (C440-C449) **except genital sites**
- Malignant neoplasms, NOS (8000–8005) of the skin (C440-C449)
- In situ neoplasms of cervix regardless of histology (behavior of /2; C539)
- Intraepithelial neoplasms of the cervix (CIN) (8077/2; C539) or prostate (PIN)(8148/2; C619)
- Borderline cystadenomas (8442, 8451, 8462, 8472, 8473) of the ovaries (C569) with behavior code 1 are **not** collected as of January 01, 2001
- Cases diagnosed **prior to 1995** are no longer required to be reported.
- Benign and borderline CNS cases diagnosed **prior to 2004** are no longer required
- Benign and borderline tumors of the cranial bones (C410)
- Cysts or lesions of the brain or CNS diagnosed January 01, 2004 or later which have no ICD-O-3 morphology code

Example:
On 04/12/2013, a patient was diagnosed with cholesteatoma in the cerebral meninges. This is not a reportable CNS case since there is no code for cholesteatoma listed in *ICD-O-3.*

COMPREHENSIVE REPORTABLE LISTS

The following comprehensive lists are intended to aid appropriate staff (for example: Information

Services, Data Management) in creating the disease index (DI) with the required reportable neoplasms and ICD-9-CM codes.

Two separate DI's must be requested:
1. A DI with reportable ICD-9-CM codes - 100% review required. This DI will include the Inpatient and Outpatient admissions based on ICD-9-CM primary and secondary diagnosis codes. This list also includes some V-Codes.

2. A DI with supplementary ICD-9-CM codes - 5% review: The purpose of this review is to guarantee complete case ascertainment and improve casefinding outcomes. This can assist in determining codes requiring additional review for the facility. The 5% review of this list will be based on number of patients and not number of diagnosis codes. If a patient on this DI also appears on the DI with a reportable code, they may be crossed off this list to avoid duplicate reviews. After removing duplicate patients, review 5% of the total number of remaining patients. If cases for a particular code were identified as reportable, this information should be documented, and the following year this code should be reviewed 100%. If no reportable cases are identified after reviewing the supplementary list for a year then it may be acceptable to omit this process for the next 2 to 3 years. However, in the event that circumstances change (for example, new coders are hired or new codes are added to the list), then the supplementary list should be reviewed sooner to ensure complete casefinding. Some facilities may find that it works best to review the supplementary codes every 3 or every 6 months.

All admissions (inpatient and outpatient) with the following reportable diagnosis codes must be reviewed for reportability.

Note: Some of the codes contain conditions that are not reportable. The records need to be reviewed and evaluated separately to determine whether they are reportable to TCR.

Note: Some ranges of codes are expressed with only 1 decimal place (237.0-237.9) while some codes within that range may have two decimal places (237.71 and 237.72). All codes within the range are included and must be reviewed.

New reportable ICD-9-CM codes are marked with an asterisk and represent others reportable neuroendocrine tumors.

Table 3.2 Reportable ICD-9-CM Codes

ICD-9-CM CODE (100% Review Required)	DESCRIPTION
140.0 - 208.92	Malignant neoplasms
209.0 - 209.29	Malignant carcinoid tumors
209.30 - 209.36	Malignant poorly differentiated neuroendocrine carcinoma; Merkel cell carcinoma
209.70 - 209.79	Secondary neuroendocrine tumors
225.0 - 225.9	Benign neoplasms of brain and spinal cord

ICD-9-CM CODE (100% Review Required)	DESCRIPTION
227.3	Benign neoplasms of pituitary gland and craniopharyngeal duct (pouch) Reportable inclusion terms: Benign neoplasm of craniobuccal pouch, hypophysis, Rathke's pouch or sella turcica
227.4	Benign neoplasm of pineal gland
228.02	Hemangioma; of intracranial structures Reportable inclusion terms: Angioma NOS, Cavernous nevus, Glomus tumor, Hemangioma (benign)
228.1	Lymphangioma, any site This code includes Lymphangiomas of Brain, Other parts of nervous system and endocrine glands, which are reportable
230.0 - 234.9	Carcinoma in-situ (exclude 233.1, cervix)
236.0	Endometrial stroma, low grade (8931/1) Reportable inclusion terms: Stromal endometriosis (8931/3 per ICD-O-3) Stromal myosis (endolymphatic) (8931/3 per ICD-O-3) Stromatosis, endometrial (8931/3 per ICD-O-3)
237.0 - 237.1	Neoplasm of uncertain behavior (borderline) of pituitary gland, craniopharyngeal duct and pineal gland.
237.5 - 237.6	Neoplasm of uncertain behavior (borderline) of brain, spinal cord and meninges
237.72	Neurofibromatosis, type 2 (acoustic neurofibromatosis) **Note**: Acoustic neuromas growing along the acoustic nerve. See supplementary list for Neurofibromatosis, unspecified (237.70) and Neurofibromatosis, type 1 (237.71)
237.9	Neoplasm of other and unspecified parts of nervous system (cranial nerves)
238.4	Polycythemia vera (9950/3)
238.6	Neoplasms of uncertain behavior of other and unspecified sites and tissues, Plasma cells (Plasmacytoma, extramedullary, 9734/3) Reportable inclusion terms: Plasmacytoma NOS (9731/3) Solitary myeloma (9731/3)
238.7	Other lymphatic and hematopoietic tissues **Note**: This code was expanded 10/2006. It is now a subcategory and is no longer valid for use for coding purposes. It should be included in extract programs for quality control purposes.

ICD-9-CM CODE (100% Review Required)	DESCRIPTION
238.71	Essential thrombocythemia (9962/3) Reportable inclusion terms: Essential hemorrhagic thrombocythemia Essential thrombocytosis Idiopathic thrombocythemia Primary thrombocythemia Thrombocythemia vera ***Note:*** **Primary thrombocythemia, thrombocythemia vera and essential thrombocytosis are considered synonyms for essential thrombocythemia but are not listed in *ICD-O-3.* In the absence of a specific code for the synonym, code to the preferred term. Refer to *2012 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual.***
238.72	Low grade myelodysplastic syndrome lesions (includes 9980/3, 9982/3, 9983/3, 9985/3) Reportable inclusion terms: Refractory anemia (RA) (9980/3) Refractory anemia with excess blasts-1 (RAEB-1) (9983/3) Refractory anemia with ringed sideroblasts (RARS) (9982/3) Refractory cytopenia with multilineage dysplasia (RCMD) (9985/3) Refractory cytopenia with multilineage dysplasia and ringed sideroblasts (RCMD-RS) (9985/3)
238.73	High grade myelodysplastic syndrome lesions (includes 9983/3) Reportable inclusion terms: Refractory anemia with excess blasts-2 (RAEB-2)
238.74	Myelodysplastic syndrome with 5q deletion (9986/3) Reportable inclusion terms: 5q minus syndrome NOS
238.75	Myelodysplastic syndrome, unspecified (9985/3, 9987/3)
238.76	Myelofibrosis with myeloid metaplasia (9961/3) Reportable inclusion terms: Agnogenic myeloid metaplasia Idiopathic myelofibrosis (chronic) Myelosclerosis with myeloid metaplasia Primary myelofibrosis Excludes: myelofibrosis NOS myelophthisis anemia (not reportable) myelophthisis(not reportable)
238.77	Post-transplant lymphoproliferative disorder (9987/3)

ICD-9-CM CODE (100% Review Required)	DESCRIPTION
238.79	Other lymphatic and hematopoietic tissues (includes 9960/3, 9961/3, 9970/1, 9931/3) Reportable inclusion terms Lymphoproliferative disease (chronic) NOS (9970/1) Megakaryocytic myelosclerosis (9961/3) Myeloproliferative disease (chronic) NOS (9960/3) Panmyelosis (acute) (9931/3)
239.6	Neoplasms of unspecified nature, brain
239.7	Neoplasms of unspecified nature; endocrine glands, and other parts of nervous system
273.2	Other paraproteinemias Reportable inclusion terms: Franklin's disease (heavy chain) (9762/3) Heavy chain disease (9762/3) Mu heavy chain disease (9762/3)
273.3	Macroglobulinemia Reportable inclusion terms: Waldenstrom's macroglobulinemia (9761/3) Waldenstrom's (macroglobulinemia) syndrome
277.89	Other specified disorders of metabolism Hand-Schuller-Christian disease Histiocytosis (acute) (chronic) Histiocytosis (chronic)
288.4	Hemophagocytic Syndromes (9751/3, 9754/3) Reportable inclusion term: Histiocytic syndromes
V10.0-V10.89	Personal history of malignancy **Note**: Screen for recurrences, subsequent primaries, and/or subsequent treatment
V10.90	Personal history of unspecified malignant neoplasm Screen for recurrences, subsequent primaries, and/or subsequent treatment.
V10.91	Personal history of malignant neuroendocrine tumor, carcinoid tumor, Merkel cell carcinoma Screen for recurrences, subsequent primaries, and/or subsequent treatment.
V12.41	Personal history of benign neoplasm of the brain

SUPPLEMENTARY ICD-9-CM CODES

Many new codes and conditions have been added to the Supplementary ICD-9-CM Code List in order to improve casefinding outcomes for benign brain and CNS tumors, hematopoietic and lymphoid neoplasms, and other reportable diseases. Some codes represent neoplasm-related secondary conditions for which there should also be a primary diagnosis of a reportable neoplasm. There should be a 5% review of cases with the following codes. See Instruction 2 on page 22.

Table 3.3 Supplementary ICD-9-CM Code List

ICD-9-CM CODE (5% Review Required)	DESCRIPTION
042	Acquired Immunodeficiency Syndrome (AIDS) **Note**: This is not a malignancy. Medical coders are instructed to add codes for AIDS-associated malignancies. Screen 042 for history of cancers that might not be coded.
079.4	Human papillomavirus (HPV)
079.50-079.59	Retrovirus (HTLV, types I, II and 2)
209.40 - 209.69	Benign carcinoid tumors
210.0-229.9	Benign neoplasms (except for 225.0-225.9, 227.3, 227.4, 228.02, and 228.1, which are listed in the Reportable list) **Note**: Screen for incorrectly coded malignancies or reportable by agreement tumors.
235.0-236.7 236.90-236.99	Neoplasms of uncertain behavior (except for 236.0, which is listed in the Reportable list) **Note**: Screen for incorrectly coded malignancies or reportable by agreement tumors.
237.2-237.4	Neoplasm of uncertain behavior of adrenal gland, paraganglia and other and unspecified endocrine glands **Note**: Screen for incorrectly coded malignancies or reportable by agreement tumors.
237.70-237.71	Neurofibromatosis, unspecified and Type 1 **Note**: An inherited condition with developmental changes in the nervous system, muscles, bones and skin; multiple soft tumors (neurofibromas) distributed over the whole body. (See Reportable list for Neurofibromatosis, type 2, 237.72)
237.73	Schwannomatosis **Note**: Screen for incorrectly coded malignancies or reportable by agreement tumors.
237.79	Other neurofibromatosis **Note**: Screen for incorrectly coded malignancies or reportable by agreement tumors.
238.0-239.9	Neoplasms of uncertain behavior (except for 238.4, 238.6, 238.71-238.79, 239.6, 239.7, which are listed in the Reportable list.) **Note**: Screen for incorrectly coded malignancies or reportable by agreement tumors.

ICD-9-CM CODE (5% Review Required)	DESCRIPTION
249.20	Secondary diabetes with hypersmolarity
253.6*	Syndrome of inappropriate secretion of antidiuretic hormone
259.2*	Carcinoid Syndrome
259.8*	Other specified endocrine disorders
273.0	Polyclonal hypergammaglobulinemia (Waldenstrom) **Note**: Review for miscodes
273.1	Monoclonal gammopathy of undetermined significance (9765/1) **Note**: Screen for incorrectly coded Waldenstrom's macroglobulinemia or progression.
273.8	Other disorders of plasma protein metabolism
273.9	Unspecified disorder of plasma protein metabolism **Note**: Screen for incorrectly coded Waldenstrom's macroglobulinemia
275.42*	Hypercalcemia
277.88	Tumor lysis syndrome/Tumor lysis syndrome following antineoplastic drug therapy
279.02-279.06	Selective IgM immunodeficiency **Note**: Associated with lymphoproliferative disorders
279.2-279.9	Combined immunity deficiency-Unspecified disorder of immune mechanism
284.1	Pancytopenia
284.81	Red cell aplasia (acquired, adult, with thymoma)
284.89	Other specified aplastic anemias due to drugs (chemotherapy or immunotherapy), infection, radiation
284.9	Aplastic anemia, unspecified **Note**: Review for miscodes
285.0	Sideroblastic anemia
285.3	Antineoplastic chemotherapy induced anemia (Anemia due to antineoplastic chemotherapy)
287.39, 287.49, 287.5	Other primary, secondary and unspecified thrombocytopenia
288.03	Drug induced neutropenia
288.3	Eosinophilia **Note:** This is the code for eosinophilia (9964/3). Not every case of eosinophilia is associated with a malignancy. Diagnosis must be "Hypereosinophilic syndrome" to be reportable.
289.6	Familial polycythemia **Note:** This is a symptom of polycythemia vera.
289.89	Other specified diseases of blood and blood-forming organs **Note**: Review for miscodes
289.9	Unspecified diseases of blood and blood forming organs
323.81	Encephalomyelitis: specified cause NEC
337.9	Unspecified disorder of autonomic nervous system

ICD-9-CM CODE (5% Review Required)	DESCRIPTION
338.3	Neoplasm related pain (acute) (chronic)
352.9	Unspecified disorder of cranial nerves
353.8	Other nerve root and plexus disorders
379.5_	Nystagmus and other irregular eye movements
512.82	Secondary spontaneous pneumothorax
516.5	Adult pulmonary Langerhans cell histiocytosis (Effective 10/1/2011)
528.01	Mucositis due to antineoplastic therapy
630	Hydatidiform Mole (9100/0) **Note**: This is a benign tumor that can become malignant. If malignant, it should be reported as Choriocarcinoma (9100/3) and will have a malignancy code in the 140-209 range.
648.9_	Other current conditions classifiable elsewhere
686.01*	Pyoderma gangrenosum
694.4*	Pemphigus
695.89*	Other specified erythematous conditions
701.2*	Acquired Acanthosis nigricans
710.3*	Dermatomyositis
710.4*	Polymyositis
713.8	Arthropathy associated with other conditions classified elsewhere
728.9	Unspecified disorder of muscle, ligament, and fascia
731.1	Osteitis deformans in diseases classified elsewhere
731.3	Major osseous defect
733.10-733.16	Pathologic fracture **Note**: pathologic fractures can be due to bone structure weakening by pathological processes (e.g. osteoporosis, neoplasms and osteomalacia)
758.0	Down's Syndrome **Note**: Screen for myeloid leukemia associated with Down's Syndrome (9898/3)
780.79	Neoplastic (malignant) related fatigue
785.6	Enlargement of lymph nodes **Note**: Screen for large B-cell lymphoma arising in HHV8-associated multicentric Castleman disease (9738/3)
789.51	Malignant ascites **Note:** Code first malignancy
790.93	Elevated prostate specific antigen (PSA)
791.9	Other non-specific findings on examination of urine
792.0, 792.2, 792.4, 792.9	Non specified abnormal findings in specified and unspecified body structures
793.11	Solitary pulmonary nodule (Effective 10/1/2011)
793.8_	Non-specific (abnormal) findings on radiological and examination of body structure (breast)
795.0	Papanicolaou smear of cervix with cytologic evidence of malignancy

ICD-9-CM CODE (5% Review Required)	DESCRIPTION
795.1	Papanicolaou smear of anus with cytologic evidence of malignancy
795.4	Other nonspecific abnormal histological findings
795.8_	Abnormal tumor markers: Elevated tumor associated antigens (TAA); Elevated tumor specific antigens (TSA); Excludes: elevated prostate specific antigen (PSA) (790.93)
962.1, 963.1	Poisoning by hormones, antineoplastic, immunosuppressive drugs
990	Effects of radiation, unspecified
996.54	Mechanical complication of other specified prosthetic device, implant, and graft-due to breast prosthesis
796.7	Papanicolaou smear of anus with cytologic evidence of malignancy
996.85	Complication of transplanted organ
999.3_	Other infection due to central venous catheter, transfusion, infusion (Effective 10/1/2011
E858.0-E858.2	Accidental poisonings
E873.2	Failure in dosage, overdose of radiation in therapy
E878.0	Abnormal reaction of surgical operation with transplant of whole organ
E879.2	Adverse effect of radiation therapy
E930.7	Adverse effect of antineoplastic therapy
E932.1	Adverse reaction to antineoplastic therapy
E933.1	Adverse effect of immunosuppressive drugs
V07.5_	Prophylactic use of agents affecting estrogen receptors and estrogen levels
V13.89	Personal history of unspecified malignant neoplasm and history of in-situ neoplasm of other site
V15.22	Personal history of undergoing in utero procedure during pregnancy
V15.3	Irradiation: previous exposure to therapeutic or ionizing radiation
V16._	Family history of malignant neoplasm
V42.81	Organ or tissue replaced by transplant, Bone marrow transplant
V42.82	Transplant; Peripheral stem cells
V51.0	Encounter for breast reconstruction following mastectomy
V52.4	Breast prosthesis and implant
V54.2	Aftercare for healing pathologic fracture
V58.0	Encounter for radiation therapy
V58.1_	Encounter for antineoplastic chemotherapy and immunotherapy **Note**: This code was discontinued as of 10/2006 but should be included in extract programs for quality control purposes.
V58.11	Encounter for antineoplastic chemotherapy
V58.12	Encounter for antineoplastic immunotherapy

ICD-9-CM CODE (5% Review Required)	DESCRIPTION
V58.42	Aftercare following surgery for neoplasm
V66.1	Convalescence following radiotherapy
V66.2	Convalescence following chemotherapy
V66.7	Encounter for palliative care
V67.1	Radiation therapy follow up
V67.2	Chemotherapy follow up
V71.1	Observation for suspected malignant neoplasm
V72.83	Other specified pre-operative examination
V76.0-V76.9	Special screening for malignant neoplasm
V78.0-V78.9	Special screening for disorders of blood and blood-forming organs
V86._	Estrogen receptor positive status
V87.41, V87.43, V87.46	Personal history of antineoplastic chemotherapy, estrogen therapy and immunosuppression therapy

***Note**: These diseases are part of the paraneoplastic syndrome. Paraneoplastic syndrome is not cancer. It is a disease or symptom that is the consequence of cancer but is not due to the local presence of cancer cells. A paraneoplastic syndrome may be the first sign of cancer.

The codes in the following supplementary list are not reportable as such but they should alert registrars to look for the first malignant neoplasm associated with these codes.

Table 3.4 Non-Reportable Codes

ICD-9-CM CODE	DESCRIPTION
258.0	Multiple endocrine neoplasia (MEN) type IIA and IIB (rare familial cancer syndrome) **Note**: use additional codes to identify any malignancies and other conditions associated with the syndrome.
284.2	Myelophthisis
285.22	Anemia in neoplastic disease **Note**: Assign also a code for the neoplasm causing the anemia Excludes: anemia due to antineoplastic chemotherapy, new code 285.3
289.83	Myelofibrosis (NOS) (9961/3) **Note**: Not every case of myelofibrosis is associated with a malignancy. Review terms included in ICD-O-3 to determine if case is reportable. See the current ICD-9-CM.
331.7	Cerebral degeneration in diseases classified elsewhere
336.3	Myelopathy in other diseases classified elsewhere

ICD-9-CM CODE	DESCRIPTION
338.3	Neoplasm related pain (acute, chronic); Cancer associated pain; Pain due to malignancy (primary/secondary); Tumor associated pain
357.3	Polyneuropathy in malignant disease
358.1	Myasthenic syndromes in other diseases classified elsewhere
358.31	Eaton-Lambert syndrome in neoplastic disease (Effective 10/1/2011)
511.81	Malignant pleural effusion **Note**: Code first malignant neoplasm if known. If the primary site is not known, code 199.0, disseminated carcinomatosis, or code 199.1, malignancy NOS, should be assigned.
789.51	Malignant ascites **Note**: Code first malignant neoplasm if known. If the primary site is not known, code 199.0, disseminated carcinomatosis, or code 199.1, malignancy NOS, should be assigned

The following are **exclusions** and **do not** need to be reported to the TCR:

Table 3.5 Items Not Reportable To TCR

ICD-O-3 MORPHOLOGY CODES	DESCRIPTION
8000–8005	Neoplasms, malignant, NOS of the skin
8010/2	Carcinoma in-situ of cervix (CIN) **beginning with 1996 cases**
8010–8046	Epithelial carcinomas of the skin
8050–8084	Papillary and squamous cell carcinomas of the skin **except genital sites**
8077/2	Squamous Intraepithelial Neoplasia, grade III of cervix **beginning with 1996 cases; CIN**
8090–8110	Basal cell carcinomas of the skin **except genital sites**
8148/2	Prostatic Intraepithelial Neoplasia (PIN)

The following table shows newly reportable terms with new ICD-O codes that are documented in the 2008 *WHO Classification of Tumors of Hematopoietic and Lymphoid Tissues.*

2008 WHO CLASSIFICATION OF TUMORS OF HEMATOPOIETIC AND LYMPHOID TISSUES. Additional Hematopoietic and Lymphoid Codes and Terms - Numerical Order

This table contains a numeric list of hematopoietic and lymphoid neoplasm histology codes and terms documented in the *WHO Classification of Tumours of Haematopoietic and Lymphoid Tissues,* 4th Ed. published in 2008. These codes are not listed in ICD-O-3, but can be found in the *2012 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* at http://seer.cancer.gov/tools/heme/index.html. Column 1 is the more specific histology term; column 2 is the new code WHO proposed for that specific histology. These neoplasms are not newly reportable; they are more specific terms for diseases that would otherwise be coded in NOS categories. Do not use these codes for neoplasms diagnosed prior to 2010. The new codes went into

effect with cases diagnosed 1/1/2010 and after.

Table 3.6 2008 WHO Classification of Tumors of Hematopoietic and Lymphoid Tissues Additional Histology Terms and Codes - Numerical Order

DESCRIPTION	ICD-O CODE
Primary cutaneous follicle centre lymphoma	9597/3
T-cell/histiocyte rich large B-cell lymphoma	9688/3
Intravascular large B-cell lymphoma	9712/3
Systemic EBV positive T-cell lymphoproliferative disease of childhood	9724/3
Hydroa vaccinforme-like lymphoma	9725/3
Primary cutaneous gamma-delta T-cell lymphoma	9726/3
Plasmablastic lymphoma	9735/3
ALK positive large B-cell lymphoma	9737/3
Large B-cell lymphoma arising in HHV8-associated multicentric Castleman disease	9738/3
Fibroblastic reticular cell tumor	9759/3
Mixed phenotype acute leukemia with t(9;22)(q34;11.2); BCR-ABL1	9806/3
Mixed phenotype acute leukemia with t(v;11q23); MLL rearranged	9807/3
Mixed phenotype acute leukemia, B/myeloid, NOS	9808/3
Mixed phenotype acute leukemia, T/myeloid, NOS	9809/3
B lymphoblastic leukemia/lymphoma, NOS	9811/3
B lymphoblastic leukemia/lymphoma with t(9;22)(q34;q11.2); BCR-ABL1	9812/3
B lymphoblastic leukemia/lymphoma with t(v;11q23); MLL rearranged	9813/3
B lymphoblastic leukemia/lymphoma with t(12;21)(p13;q22); TEL-AML1 (ETV6-RUNX1)	9814/3
B lymphoblastic leukemia/lymphoma with hyperdiploidy	9815/3
B lymphoblastic leukemia/lymphoma with hypodiploidy (hypodiploid ALL)	9816/3
B lymphoblastic leukemia/lymphoma with t(5;14)(q31:q32); IL3-IGH	9817/3
B lymphoblastic leukemia/lymphoma with t(1;19)(q23;p13.3); E2A PPBX1 (TCF3 PBX1)	9818/3
T lymphoblastic leukemia/lymphoma	9837/3
Acute myeloid leukemia with t (6;9)(p23;q34) DEK-NUP214	9865/3
Acute myeloid leukemia with inv (3)(q21q26.2) or t(3;3)(q21;q26.2); RPN1EVI1	9869/3
Myeloid leukemia associated with Down Syndrome	9898/3
Acute myeloid leukemia (megakaryoblastic with t (1;22)(p13;q13); RBM15-MKL1	9911/3
Myeloid and lymphoid neoplasms with PDGFRB rearrangement	9965/3

DESCRIPTION	ICD-O CODE
Myeloid and lymphoid neoplasms with PDGFRB arrangement	9966/3
Myeloid and lymphoid neoplasm with FGFR1 abnormalities	9967/3
Polymorphic PTLD	9971/3
Refractory neutropenia	9991/3
Refractory thrombocytopenia	9992/3

Histologic Terms and Codes with Changes in Case Reportability
(Newly Reportable Conditions)

The following table shows existing ICD-O codes which changed from non-reportable (/1) to reportable (/3) for cases diagnosed January 1, 2010 and forward. Prior to 2010 these neoplasms were reported only if the physician stated they were malignant.

Table 3.7 Histologic Terms and Codes with Changes in Case Reportability

DESCRIPTION	ICD-O-3 CODE
Chronic lymphoproliferative disorder of NK-cells T-cell large granular lymphocytic leukemia	9831/3
Langerhans cell histiocytosis, NOS (previously 9751/1) Langerhans cell histiocytosis, unifocal (previously 9752/1) Langerhans cell histiocytosis, multifocal (previously 9753/1)	9751/3
Myelodysplastic/Myeloproliferative neoplasm, unclassifiable Myeloproliferative neoplasm, unclassifiable	9975/3

OTHER CASEFINDING METHODS

Other methods for identifying reportable cancer cases should be developed to assure complete case reporting. Since the patient's medical record is the primary source of information, arrangements should be made so the appropriate charts can be routed to the personnel responsible for reporting.

Pathology

The pathology department reports must be routinely checked. The best procedure is to have a copy of **all** pathology reports routed to the personnel responsible for reporting. All pathology reports (both positive and negative) must be reviewed by the reporter to ensure all eligible cases are identified. The reporter should request that all cytology, hematology, bone marrow biopsies, and autopsies be included. Both computerized and manual methods of reviewing pathology reports must include a way to track reports to ensure that every report has been included in the review. Facilities that send all pathology specimens to outside labs should keep a log of all specimens, to include date sent out, date received, and the diagnosis. The reporter should be given a copy of all reports.

Note: If a hospital sends a specimen to another hospital to be read, and the patient is never seen at the reading facility, only the hospital that performed diagnostic procedures or administered treatment for a cancer diagnosis is responsible for reporting the case. The reading facility should document this process in their policy and procedure for consistency.

Exception: To ensure complete reporting, if the specimen is sent from a **physician's office** to a reading facility, the reading facility would be responsible for reporting the case.

Radiation Oncology
For facilities with radiation oncology departments, a procedure must be established to identify patients receiving radiation therapy. This should include all inpatient and outpatient treatments.

Different options, such as providing copies of the treatment summary, a treatment card, or even a daily appointment book may be available to identify these cases. Many cancer patients are seen in the outpatient department, hematology clinic, laboratory, emergency room, nuclear medicine, and diagnostic radiology and oncology departments. A method to identify reportable cases from these departments must also be established.

Oncology/Hematology
Many facilities now have a designated oncology/hematology unit where patients receive chemotherapy treatments as an inpatient. In some cases, patients receive chemotherapy in an ambulatory setting, a freestanding facility, or a physician's office. The registrar/reporter must establish a policy and procedure for identifying patients who receive chemotherapy in these settings if affiliated with their facility.

Suspense File
A reportable case should be abstracted after review of the patient's complete record, not just from the unit record for the admission in question. If reportable cases are identified at the time of discharge, the complete medical record may not be available at the time the case is abstracted. A suspense file should be compiled of all cases identified as eligible or potentially eligible for abstracting. The suspense file can be something as simple as a manila folder to hold the various casefinding source documents (monthly disease index, pathology reports and outpatient log sheets and so forth) in alphabetical order and/or by date of diagnosis to assess timeliness of the abstracting process.

Non-Reportable List
Personnel responsible for reporting should review the table of terms that indicate a diagnosis of cancer on page 17. Upon review of the disease index, cases may be identified as TCR non-reportable cases. Examples of these would be basal and squamous cell carcinoma of the skin (173.0-9) (excluding genital sites), and CIN of the cervix (233.1). A list of these cases **must be kept each year**.

The TCR will review the disease index and the non-reportable list when it conducts casefinding audits after facilities have completed reporting for a given year (see page 14). The non-reportable list will answer any questions TCR staff may have regarding the non-reporting of these cases. The list should include patient name, date of birth, social security number, medical record number, admission date, casefinding source, and the reason the case was not reportable.

Attachment B (page 43) is a sample form that can be used as a history file of the non-reportable cases. Non-reportable cases can also be documented on the disease index. Place the notation "NR" next to the patient information and include a justification if the case is determined not reportable. Another method would be to develop an electronic spreadsheet that can be sorted alphabetically, such as Excel or Word. An alphabetical index card file can also be used.

Note: There is not a non-reportable log in the Web Plus system. Reporters using Web Plus may create and use a form such as the sample Attachment B, or make a not reportable notation for each case on the disease index. The non-reportable list must be submitted to TCR after reporting is complete for the year.

The following examples are a resource to determine if a case is reportable to the TCR. It is critical that these scenarios be applied appropriately. If a patient has active disease and/or is on cancer directed therapy, the case must be reported.

Examples:

a. The ICD-9-CM billing code indicates current disease. Reason for admission was radiology and laboratory testing. Radiology and laboratory findings do not indicate active disease. **This case is not reportable since there is no indication that the patient has current disease.**

b. Patient is admitted for staging procedures. Radiology reports no abnormal findings. The discharge summary states that the patient has recently been diagnosed with prostate cancer and is in the process of deciding treatment options. **This case is reportable because even though the radiology report shows no abnormal findings, the discharge summary states the patient has prostate cancer.**

c. The discharge summary and face sheet states history of cancer and there is no other information within the chart to indicate active or stable disease. **This case is not reportable because the patient has a history of cancer with no evidence of active disease.**

d. A patient is admitted for evaluation of congestive heart failure. The patient had a mastectomy for breast cancer 8 years ago and there is no evidence of recurrent or metastatic disease. **This case is not reportable because there is no indication that the patient has current disease.**

e. A patient comes in for lab work. Face sheet states lung cancer. No other information or documentation indicating active disease is available. **This case is not reportable because there is no information regarding whether the patient has current lung cancer.**

f. A patient was diagnosed with adenocarcinoma of the stomach in 1985 with no evidence of recurrent or metastatic disease. In 2013, the patient was admitted and diagnosed with small cell carcinoma of the lung. **The lung cancer is reportable for 2013 because the patient has active lung cancer.**

g. Discharge summary diagnosis states cancer and the ICD-9-CM billing code indicates current disease. All laboratory findings are negative for active disease, but one radiology report indicates active disease compatible with malignancy. **This case is reportable because according to the radiology report the patient has active disease.**

h. A patient is admitted to your facility with an acute cerebrovascular accident. The H&P states the patient was diagnosed with metastatic lung cancer four months prior to admission. He was treated with palliative care and referred to the Hospice program. All indications are that this patient still has active cancer. **This case is reportable because apparently the patient has active disease.**

i. A patient was diagnosed with cervical cancer in 2000 and has had no recurrence. She is now admitted and diagnosed with a second primary in the lung. **The lung case is reportable because the patient has active lung cancer.**

j. A patient comes to your facility for port-a-cath insertion to allow for chemotherapy for a malignancy. Documentation indicates the patient has active disease. **This case is reportable because the patient has active disease and is receiving cancer directed therapy, even though the therapy may be given at a different facility.**

k. Patient with a recent excisional biopsy for melanoma of skin of arm is admitted to your facility for a wide excision. The pathology report shows no residual melanoma. **This case is reportable because the wide excision is considered treatment for the melanoma.**

l. In 2013 a patient comes to your facility for a colonoscopy. The record states that the patient was diagnosed with breast cancer in 2007. She is still being treated with Tamoxifen which was part of the first course of treatment. It is unknown if the patient has evidence of disease at this time. **This case is reportable because the patient is still receiving hormone treatment.**

Note: When Tamoxifen is used as adjuvant therapy for breast cancer it is generally prescribed for 5 years. It has been shown that when taken for 5 years it reduces the chance of the original breast cancer coming back in the same breast or metastasizing. Therefore, if the patient has a history of breast cancer and is on Tamoxifen a*nd*

- it is known that the diagnosis was within the past 5 years, **report the case.**
- it is unknown how long ago the breast cancer was diagnosed, **report the case.**
- it is known that the diagnosis of breast cancer was greater than 5 years ago and there is no evidence of disease, and no evidence of other treatment being given at the time of admit, **it is not necessary to report the case.**

m. A patient is admitted to the hospital after a heart attack. The chart states the patient has a history of prostate cancer and is on Lupron. There is no other information regarding the patient's history. **Report this case because the patient is on treatment that could be related to the history of prostate cancer.**

n. A patient comes in for a bone scan. The physician orders state prostate cancer, but the bone scan report states no evidence of disease. There is no other information in the chart. **Do not report this case since there is no evidence of disease and no mention of current treatment.**

Summary: If there is any indication within the medical record that the patient has evidence of disease, or is on cancer directed treatment, the case is reportable. This would include but not limited to radiology reports, pathology reports, consults, history and physicals, and clinic notes.

Note: Refer to http://seer.cancer.gov/tools/mphrules/download.html to determine multiple primaries and histology for cases diagnosed on or after 1/1/2007.

Ambiguous Terminology for Casefinding:
In most cases, the patient's record clearly presents the diagnosis by use of specific terms which are synonymous with cancer. However, there will be times when a physician is not certain or the documented language is not definitive. Ambiguous terminology may originate from any source document, such as pathology report, radiology report or a clinical report. *The entire medical record should be reviewed before basing reportability on one of these terms*. The ambiguous terms listed below are reportable.

Ambiguous terms that are reportable (used to determine reportability only)

Apparent(ly)
Appears
Comparable with
Compatible with
Consistent with
Favor(s)
Malignant appearing
Most likely
Neoplasm (beginning with 2004 diagnosis and only for C700-C729, C751-C753)
Presumed
Probable
Suspect(ed)
Suspicious (for)
Tumor (beginning with 2004 diagnosis and only for C700-C729, C751-C753)
Typical (of)

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

Note: This list should be used only for determining case reportability. Do not use this list to determine the appropriate histology or stage. For histology always follow the Multiple Primary and Histology Rules (MPHR).

Example:
Pathology report states: "Prostate biopsy with markedly abnormal cells typical of adenocarcinoma."
Accession the case because "typical (of)" is an ambiguous term that is reportable.

Exception: If cytology is reported as "suspicious for malignancy" do not interpret this as a diagnosis of cancer. **Report the case only if a positive biopsy or a physician's clinical impression of cancer supports the cytology findings or if cancer directed therapy is administered.** Cytology is the examination of cells obtained by aspiration, washing, smear, or scraping.

As of January 2013, (SEER, Introduction SEER Program, page 1) a positive urine cytology is reportable (no ambiguous terminology used).

- If no information about primary site, code to C68.9.
- Do not report if subsequent biopsy of urinary site is negative
- Do not implement new/additional casefinding methods

Cytology using ambiguous terminology (only) remains not reportable.

Examples:

a. A patient with persistent hematuria has a urinalysis done in your facility and the cytology report states cells **suspicious** for malignancy. The patient does not return for any further work-up. Do not report this case based on the suspicious cytology alone.

b. A fine needle aspirate of a thyroid nodule is suspicious for follicular carcinoma. The patient has a thyroid biopsy which shows papillary follicular carcinoma. This case should be reported because the biopsy was positive for malignancy.

Note: When phrases such as strongly suspicious or highly favors are used, disregard the modifying term and refer to the guidelines above regarding the primary term. A patient stated to have "known" cancer should be reported to the TCR.

Note: If the word or an equivalent term does not appear on the reportable list and is not a form of a word on the reportable list, the term is not diagnostic of cancer. Do not accession the case. If forms of the word are used such as: "Favored" rather than "Favor(s)"; "appeared to be" rather than "appears", the case is reportable. Do not substitute synonyms such as "supposed" for presumed or "equal" for comparable.

Note: If one section of the medical record(s) uses a reportable term such as "apparently" and another section of the medical record(s) uses a term that is not on the reportable list, accept the reportable term and accession the case.

Exception: If the ambiguous diagnosis is proven to be not reportable by biopsy, cytology, or physician's statement, do not accession the case.

ADDITIONAL GUIDELINES FOR CASE REPORTING

- In some instances it is unclear whether cancer cases seen in a clinic are reportable through an associated facility. The cases **should be included** in the facility's caseload when:

a. The clinic is owned by the facility

b. The facility is legally responsible for the medical charts in the clinic

c. The facility receives revenue from the medical charts at the clinic

d. The clinical charts are filed in the same location as the facility charts, or

e. The facility pays the physicians to work in the clinic

- Cases diagnosed and/or treated for cancer prior to admission **should be reported** if there is evidence of **active disease**, whether or not diagnostic or therapeutic procedures were performed. *Stable disease indicates active disease.*

- Cases diagnosed at autopsy are reportable.

- Patients with active cancer coming into a facility for "consultation only" should be reported.

- Abstract cases with a reportable diagnosis using the medical record from the first admission (inpatient or outpatient) to your facility. Use information from subsequent admissions to supplement documentation and to include all first course treatment information. *Do not submit a report for each admission; submit one report per primary tumor.*

- Cases in which the disease is **no longer active** should only be reported if the patient is still receiving cancer-directed therapy. For instance, a patient with a history of leukemia in remission, but is still receiving chemotherapy.

Example:
A patient diagnosed 6 months ago with acute myelocytic leukemia is now in remission and on a maintenance dose of chemotherapy. The patient was admitted for evaluation of neutropenia following the most recent course of chemotherapy. If this is the first admission to your facility, this patient should be reported because cancer-directed treatment (chemotherapy) is being administered.

Note: Remember, physicians may refer to patients diagnosed with cancer prior to coming to a facility as having a "history of" cancer. These cases should be reviewed closely to determine if the patient has active disease and/or is receiving cancer-directed treatment. If you have any questions regarding the eligibility of a case, call your TCR health service region.

Examples for Determining Case Reportability:

a. A patient comes to a facility for a bone scan. The face sheet has been coded to prostate cancer. The bone scan is negative and there is no other information to indicate that this patient has active disease or is receiving cancer directed treatment. ***This case is not reportable because there is no information to indicate if this patient has active disease.***

b. A patient comes to the emergency room. He tells the attending physician that he had cancer years ago. There is no other information documented to indicate that he has active disease or is on cancer-directed therapy. ***This case is not reportable because there is no information confirming the patient has active disease***.

c. A patient comes into the emergency room for a broken wrist. The history/physical states that the patient is currently undergoing chemotherapy for lung cancer, but the facility does not render any treatment for the cancer; the patient is only treated for the broken wrist. ***This case is reportable because the patient is currently undergoing cancer directed treatment at another facility.***

d. A patient is admitted to a facility with a breast lump. The H&P states that the patient was diagnosed elsewhere with breast cancer seven years ago and treated with a lumpectomy. There is now recurrence of the disease and the patient was referred for a mastectomy. ***This case is reportable due to active disease.***

e. A patient comes to your facility for lab work only. The face sheet states "cancer". The only other information available is the lab results. ***This case is not reportable. A physician must state the patient has active disease, recurrence, or metastatic disease.***

Note: Every effort should be made to identify multiple primary tumors. Refer to the MP/H Rules and to the *2012 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* to prevent reporting the same primary twice for a patient, compare the patient name and primary cancer site from the registry database to the TCR facility data report. The TCR facility data report lists all the patients a facility has reported to TCR for multiple years.

Complete cancer reporting is an important element in a cancer registry quality assurance program. The TCR performs casefinding audits to determine the completeness of case ascertainment and timeliness of reporting at facilities across the state. These audits are a part of TCR's data quality procedures and are necessary to assure complete and accurate cancer information and to meet the state's federal funding obligations. The results of a casefinding audit are reported back to the facility. **The minimum acceptable completeness rate is 97%.**

HELPFUL HINTS TO CONDUCT CASEFINDING:

- All possible sources of cancer cases in a facility should be reviewed to achieve complete and accurate casefinding.
- Review pathology reports monthly.
- Review disease index monthly.
- Review radiation oncology logs weekly.
- Have coders route medical charts to the registrar/reporter on all identified cancer patients.
- Review outpatient and emergency room visits for reportability. Arrangements can be made to have these routed to the registrar/reporter, or the registrar/reporter can physically review them in the department.
- Maintain a list of non-reportable cases or document non-reportable cases on the disease index.

When reporting is complete for the year, send the following items to your TCR state health region:

- The disease index (see Attachment A, page 42) along with documentation of the parameters used to generate the index.
- The non-reportable list (see Attachment B, page 43).
- The casefinding checklist (see Attachment C, page 44).

Note: The Reporting Tools section is no longer located in the TCR Handbook. The instructions are located on the TCR website at http://www.dshs.state.tx.us/tcr/reporting.shtm.

Contact your health service region for an assessment of your casefinding procedures. This will better prepare you for an audit.

ATTACHMENT A

Sample Facility Disease Index

Cancer Cases with 2013 Admission Date

MR#	NAME	DOB	SS#	SEX	PT CLASS/ TYPE	ADMISSION DATE	DISCHARGE DATE	DIAGNOSIS/DESCRIPTION
123123	Roberts, Jim	2/10/1959	455-66-9090	M	IN, MCR	05/02/13	05/03/13	209.1 Mal Carcinoid Tumor Duodenum
431124	Smith, Bob	6/29/1938	422-23-2323	M	IN, MCR	04/05/13	04/07/13	V58.1 Chemo Encounter
C5412	Smith, Bob	6/29/1938	422-23-2323	M	SCD, MCR	05/11/13	05/11/13	189.0 Mal Neo Kidney
431124	Smith, Bob	6/29/1938	422-23-2323	M	IN, MCR	09/06/13	09/14/13	198.3 Sec Mal Neo Brain
MR421	Sun, Len	11/4/1980	566-66-6666	M	IN, OTH	10/16/13	10/20/13	285.22 Anemia in Neoplastic Disease
MR311	Timms, Emma	6/15/1959	500-00-5000	F	CLL, MCR	03/22/13	03/22/13	217 Benign Neo Breast
C1234	Timms, Emma	6/15/1959	500-00-5000	F	IN, MCR	05/29/13	06/02/13	174.4 Mal Neo Breast UOQ
C1234	Timms, Emma	6/15/1959	500-00-5000	F	IN, MCR	05/29/13	06/02/13	196.3 Mal Neo Lymph-Axilla
MR311	Timms, Emma	6/15/1959	500-00-5000	F	RCR, MCR	07/13/13	07/13/13	V58.0 Radiotherapy Encounter

ATTACHMENT B

Non-Reportable List

Facility Name: _____ Facility ID#___ Reviewed by: ___ Telephone: _____

PATIENT NAME	MED REC #	ADMIT DATE	DATE OF BIRTH	SS#	CASEFINDING SOURCE	N/R CODE

*****KEEP A COPY FOR YOUR RECORDS**

NON-REPORTABLE (N/R) CODES:
01 – Benign
02 – Non-Reportable Skin Cancer (Site=C44.*, Morph=8000-8110)
03 – No Evidence of Disease (NED) (History of Cancer but No Evidence of Treatment Currently and No Evidence of Cancer Currently)
04 – Cancer Not Proven
05 – Duplicate Case (This Cancer has already been reported to TCR)
06 – In situ Cancer of Cervix, CINIII
07 – No Cancer Mentioned in Record
08 – Diagnosed prior to 1995
09 – Lab only
10 – Other (Include Explanation)

ATTACHMENT C

A casefinding checklist must be used to document all sources utilized to achieve complete casefinding. Upon completion of abstracting for each year, the casefinding checklist must be completed and submitted to your regional TCR office. ***Keep a copy for your records.**

FACILITY NAME : FACILITY ID#: EXPECTED # CASES: YEAR:			
CASEFINDING SOURCE	**AVAILABLE Y/N OR NA**	**REVIEWED Y/N OR NA**	**COMMENTS**
Accession Register			
Ambulatory Setting			
Day Surgery			
Diagnostic Radiology & Oncology			
Emergency Room			
Free-standing facility			
Hematology Clinic			
Hospice			
Medical Records Disease Index			
Nuclear Medicine			
Outpatient Department			
Pathology Department			
Autopsy Reports			
Bone Marrow Biopsies			
Cytology			
Hematology			
Histology			
Physician's Office			
Radiation Oncology Dept.			
Daily Appointment Book			
Treatment Card			
Treatment Summary			

4

DEMOGRAPHICS AND PATIENT INFORMATION

DEMOGRAPHICS AND PATIENT INFORMATION

Reporting Facility Number (NAACCR Item #540)

Description
Identifies the facility or institution reporting the case.

Explanation
This data item is used for monitoring data submissions, ensuring the accuracy of data, and for identifying areas for special studies.

Coding Instructions
1. Enter the three-digit facility number assigned by the TCR.

2. If you do not know your facility number, contact your Health Service Region office or the Central Office in Austin. See page 10 for contact information.

Type of Reporting Source (NAACCR Item #500) (SEER pgs. 19-21)

Description
This data item identifies the source documents used to abstract the case being reported. This will not necessarily be the document that identified the case but the document that provided the best information.

Explanation
This field provides the source of the documents used to report the case, e.g., inpatient or outpatient charts, cases diagnosed in physician's offices, patients diagnosed at autopsy, pathology report only, or diagnosed by death certificate only.the source

Coding Instructions
1. Enter the code for the source of the facility and/or documents used to abstract the case.

Table 4.1 Type of Reporting Source Codes

CODE	LABEL	SOURCE DOCUMENTS	PRIORITY
1	Hospital inpatient; Managed health plans with comprehensive, unified medical records	-Hospital inpatient -Offices/facilities with unit record HMO physician office or group HMO affiliated free-standing laboratory, surgery, radiation or oncology clinic Includes outpatient services of HMOs and large multi-specialty physician group practices with unified records	1
2	Radiation Treatment Centers or Medical Oncology Centers (hospital-affiliated or independent)	-Facilities with a stand-alone medical record Radiation treatment centers Medical oncology centers (hospital-affiliated or independent) There were no source documents from code 1.	2
3	Laboratory Only (hospital-affiliated or independent)	-Laboratory with stand-alone medical record There were no source documents from codes 1, 2, 8, or 4.	5
4	Physician's Office/Private Medical Practitioner (LMD)	-Physician's office that is NOT an HMO or large multi-specialty physician group practice. There were no source documents from codes 1, 2 or 8.	4
5	Nursing/Convalescent Home/Hospice	-Nursing or convalescent home or a hospice. There were no source documents from codes 1, 2, 8, 4, or 3.	6
6	Autopsy Only	-Autopsy The cancer was first diagnosed on autopsy. There are no source documents from codes 1, 2, 8, 4, 3, or 5.	7
7	Death Certificate Only	-Death certificate is the only source of information; follow-back activities did not identify source documents from codes 1, 2, 8, 4, 3, 5 or 6. If another source document is subsequently identified, the Type of Reporting Source code must be changed to the appropriate code in the range of 1, 2, 8, 4, 3 or 6.	8
8	Other hospital outpatient units/surgery centers	-Other hospital outpatient units/surgery centers. Includes but not limited to, outpatient surgery and nuclear medicine services. There are no source documents from codes 1 or 2.	3

Note: Assign codes in priority order: 1, 2, 8, 4, 3, 5, 6, and 7 if more than one source is used

Definitions:

Comprehensive, unified medical record: A hospital or managed health care system that maintains a single record for each patient. That record includes all encounters in affiliated locations.

Stand-alone medical record: An independent facility; a facility that is not part of a hospital or managed care system. An independent medical record containing only information from encounters with that specific facility.

Managed health plan: Any facility where all of the diagnostic and treatment information is maintained in one unit record. The abstractor is able to use the unit record when abstracting the case.

Examples: HMOs or other health plans such as Kaiser, Veterans Administration, or military facilities.

Physician office: Examinations, tests and limited surgical procedures may be performed in a physician's office. If called a surgery center, but cannot perform surgical procedures under general anesthesia, code as a physician office.

Surgery center: Surgery centers are equipped and staffed to perform surgical procedures under general anesthesia. The patient usually does not stay overnight.

Unit record: The office or facility stores information for all of a patient's encounters in one record.

Examples:

a. A patient is admitted to your facility and expires before any treatment is rendered. An autopsy is performed and cancer is found in the lung. Code the reporting source to 6 (autopsy only). The autopsy report is the only document used for your cancer information. The patient was not known to have cancer prior to the autopsy.

b. A patient is admitted to your hospital and is diagnosed with lung cancer. Code the reporting source to 1 (Facility Inpatient/ Outpatient or Clinic). All documents in the medical record are used to gather the cancer information.

Date of Admit/Date of First Contact (NAACCR Item #580)

Description
The date of first admission/contact with the reporting facility for diagnosis and/or treatment of this cancer. If previously diagnosed/treated elsewhere, the date of first admission to your facility with diagnoses of active cancer.

Explanation
This data item allows the facility to document the first contact with the patient. It can be used to measure the time between admission and when the case is abstracted and the length of time between the first contact and treatment.

Coding Instructions

1. Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.

2. Enter the date of the first admission to your facility for a diagnosis and/or treatment of this reportable cancer or, if previously diagnosed/treated elsewhere, the date of the first admission to your facility with active cancer or receiving cancer treatment.

3. Date format is:

   a. YYYYMMDD

Example: The patient is first seen at this facility on January 4, 2013 with a diagnosis of cancer. Record the date of admit: 20130104

4. A date **must** be entered in this field. If the patient was never an inpatient, enter the date of the first outpatient visit e.g., biopsy, x-ray, laboratory test, or emergency room visit at your facility with active cancer.

5. For autopsy-only or death certificate-only cases, use the date of death as the date of first contact.

6. For "read only" or "pathology only" cases, enter the date the specimen was collected. These are cases where a specimen is sent to be read by the pathology department and the patient is never seen or admitted at the reporting facility. These cases are reportable if the pathology department generates revenue for the reporting facility and is **NOT** a free standing entity. The class of case should be coded to 43 and the reporting source would be 3.

Note: FORDS instructions (see FORDS pg 115) differ from TCR instructions. FORDS requires that for analytic cases *Date of First Contact* is the date the patient qualifies as an analytic case *Class of Case* 00-22. If the patient was admitted for non-cancer-related reasons, the *Date of First Contact* is the date the cancer was first suspected during the hospitalization. TCR will continue to instruct that the date be recorded as the admit date if the diagnosis is made at the reporting facility. It is understood that ACoS facilities will continue to follow the rules according to FORDS.

Examples:

a. A patient is admitted to the hospital on January 31, 2013, with chest pains. On February 2, 2013, a CT scan shows that the patient has a lung mass consistent with malignancy. Record the date of first contact as 20130131.

b. A patient has a biopsy in a staff physician's office on March 17, 2013, and the specimen is sent to the reporting facility's pathology department on that same day. The pathologist reads the specimen as malignant melanoma. The patient enters the same reporting facility on March 21, 2013, for a wide re-excision. Record the date of first contact as 20130317.

c. A patient has a lymph node biopsy at a small hospital on May 15, 2013. The specimen is sent to your hospital to be evaluated in your pathology department. The pathologist reports diffuse large b- cell lymphoma. The patient never enters your hospital. Record 20130515 as the date of first contact.

Registry/Accession Number (NAACCR Item #550) (FORDS pg. 34)

Description
A registry or accession number is a unique number assigned to identify each patient regardless of the number of primary cancers.

Explanation
This data item serves as a reference number to protect the identity of the patient.

Coding Instructions
1. The first four digits identify the calendar year the patient was first seen at the facility with a reportable diagnosis. The following five digits identify the numerical order in which the case was entered into the registry. Each year's accession/registry number will start with **00001**.

Example:
2013000001 would indicate the first 2013 case reported from a facility.

2. **Do not** assign a new registry number to a patient previously reported to the TCR with a new primary cancer. Within a registry, all primaries for an individual must have the same accession number.

Note: Web Plus does not auto populate Accession Number.

Medical Record Number (NAACCR Item #2300) (FORDS pg. 37)

Description
The number assigned to a patient's medical record by the reporting facility.

Explanation
This number identifies the individual patients within a reporting facility. It allows a reporting facility to easily locate a patient's health information. This health information is referenced when abstracting or updating a cancer case or to help identify multiple reports and primaries on the same patient.

Coding Instructions
1. Enter the eleven digit medical record number used to identify the patient's first admission with active cancer and/or on cancer treatment. Medical record numbers with less than 11 digits and alpha characters are acceptable.

2. If a number is not available (outpatient clinic charts or ER visit reports), enter OP followed by nine 0's in this field. See the list below for other optional medical record identifiers.

Table 4.2 Optional Medical Record Identifier Codes

CODE	DESCRIPTION
ER	Emergency Room patient without a medical record number
OP	Outpatient without a medical record number
RT	Radiation Therapy department patient without a medical record number
SU	One-day surgery unit patient without a medical record number
UNK	Medical record number unknown

Class of Case (NAACCR Item #610) (FORDS pgs. 100-112)

Description
Class of case identifies the role of the reporting facility in the patient's diagnosis and treatment.

Explanation
This data item divides case records into analytic and non-analytic categories. The class of case determines which cases should be included in the analysis of the facility's cancer experience.

Note: All reporting facilities must report their non-analytic cases to the TCR, regardless of their approval status with the ACoS.

A. **Analytical cases (codes 00-22):** Diagnosed at the reporting facility and/or received any of the first course treatment at the reporting facility. Abstracting for class of case 00 through 14 is to be completed within six months of diagnosis. This allows for treatment information to be documented in the patient's medical record. Abstracting for class of case 20 through 22 is to be completed within six months of first contact with the reporting facility. These cases are analyzed because the facility was involved in the diagnostic and therapeutic decision-making.

Note: A facility network clinic or outpatient center belonging to the facility is part of the facility.

B. **Non-analytical cases (codes 30-49 and 99):** Diagnosed and received all of the first course of treatment at another facility, or cases which were diagnosed and/or received all or part of the first course of treatment at the reporting facility prior to the registry's reference date (reference date applies to ACoS facilities, facilities striving for ACoS certification, or facilities that follow ACoS standards and do not seek certification). Abstracting for non-analytical cases should be completed within six months of first contact with reporting facility. Non-analytical cases (classes 30-49 and 99) are usually excluded from a facility's routine treatment or survival statistics.

Note: Per TCR reporting guidelines, non-analytical cases are reportable by all facilities for cases diagnosed January 1, 1995 and forward when there is documentation of active cancer or if the patient is receiving cancer directed therapy.

Note: Non-analytical cases, classes 49 and 99, are to be used solely by the central registry.

Coding Instructions

1. Code the *Class of Case* that most precisely describes the patient's relationship to the facility.

2. Code 00 applies only when it is known the patient went elsewhere for treatment. If that information is not available, code *Class of Case* 10.

3. Code 34 or 36 if the diagnosis is 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 (C751) craniopharyngeal duct (C752), and pineal gland (C753) that were diagnosed in 2004 or later.

Note: These types of cases are not required by TCR. This would be used for reportable by agreement cases.

4. 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).

5. A staff physician (codes 10-12, 41) is a physician who is employed by the reporting facility, under contract with it, or a physician who has routine practice privileges there. 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.

Table 4.3 Class of Case Definitions

ANALYTIC CASES	
Class 00*	Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done ELSEWHERE. Cases include: • Patients who choose to be treated elsewhere. • Patients referred elsewhere for treatment due to lack of special equipment; proximity of a patient's residence to the treatment center; financial, or rehabilitative considerations, etc.
Class 10*	Initial diagnosis AND PART OR ALL of first course treatment or a decision not to treat done at the reporting facility, NOS. **Note:** ACoS facilities should include cases in which patients are diagnosed at the reporting facility prior to the registry's reference date and all or part of the first course of treatment was received at the reporting facility after the registry's reference date.
Class 11	Initial diagnosis by staff physician AND PART of first course treatment was done at the reporting facility.
Class 12	Initial diagnosis by staff physician AND ALL first course treatment or a decision not to treat was done at the reporting facility.
Class 13*	Initial diagnosis AND PART of first course treatment was done at the reporting facility.
Class 14*	Initial diagnosis AND ALL first course treatment or a decision not to treat was done at the reporting facility.
Class 20*	Initial diagnosis elsewhere AND ALL OR PART of first course treatment was done at the reporting facility, NOS.
Class 21*	Initial diagnosis elsewhere AND PART of treatment was done at the reporting facility.
Class 22*	Initial diagnosis elsewhere AND ALL treatment or a decision not to treat was done at the reporting facility.

NON-ANALYTIC CASES Patient appears in person at 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.	
Class 30*	Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in DIAGNOSTIC WORKUP (for example, consult only, staging workup after initial diagnosis elsewhere).
Class 31*	Initial diagnosis and all first course treatment elsewhere AND reporting facility provided in-transit care. **Note:** In-transit care is given when a patient is temporarily away from the usual physician or treating facility. If the patient begins first course therapy in one location, then completes first course therapy at the reporting facility, this would not be considered in-transit care and the case would be analytic.
Class 32*	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease RECURRENCE OR PERSISTENCE.
Class 33*	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease HISTORY ONLY. **Note:** TCR required these cases only if the patient has active disease or is receiving cancer directed therapy at the time seen.
Class 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 done by reporting facility.
Class 35	Case diagnosed before program's Reference Date, AND initial diagnosis AND PART OR ALL of first course treatment by reporting facility.
Class 36	Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis elsewhere AND part or all of first course treatment by reporting facility.
Class 37	Case diagnosed before program's Reference Date, AND initial diagnosis elsewhere AND all or part of first course treatment by facility.
Class 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	
Class 40	Diagnosis AND all first course treatment given at the same staff physician's office.
Class 41	Diagnosis and all first course treatment given in two or more different staff physician offices.
Class 42	Non-staff physician or non-CoC approved 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).
Class 43*	Pathology or lab specimens only.
Class 49*	Death certificate only. **Note:** Used by central registries **only.**

UNKNOWN RELATIONSHIP TO REPORTING FACILITY	
Class 99	Case not required by CoC to be abstracted; Of unknown relationship to facility (not for use by CoC approved cancer programs for analytic cases). **Note**: Used by central registries **only**.

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

By using *Class of Case* codes in this manner for non-hospital sources, the central cancer registry is able to retain information reflecting the facility's role in managing the cancer consistent with the way it is reported from hospitals. Using C*lass of Case* in conjunction with *Type of Reporting Source* (500) which identifies the source documents used to abstract the cancer being reported, the central cancer registry has two distinct types of information to use in making consolidation decisions.

Table 4.4 Class of Case Examples

CODE	REASON
00	Reporting facility admits patient due to dizziness and falling. The patient receives clinical workup which includes CT and MRI of the brain. The results are positive for brain metastasis. The patient is discharged to another hospital for treatment for lung cancer with brain metastasis.
10	Patient is diagnosed with lung cancer at the reporting facility. Due to age and comorbidities the decision was made not to treat.
11	A patient is diagnosed with melanoma in a staff physician's office. He has a wide excision at the reporting facility, and then is treated with interferon at another facility.
12	A diagnosis of prostate cancer is made in a staff physician's office. The patient receives radiation therapy at the reporting facility, and no other treatment is given.
13	A patient is diagnosed with colon cancer at the reporting facility and undergoes a hemicolectomy there. She then receives chemotherapy at an outside clinic.
14	Reporting facility admits patient with hemoptysis. Workup reveals adenocarcinoma. The patient undergoes surgery followed by radiation therapy at the reporting facility. The patient did not receive any other treatment.
20	Patient was diagnosed with primary breast cancer at another facility. The patient then comes to the reporting facility for surgery. It is unknown if she received any other treatment.
21	Patient diagnosed at another facility with breast cancer and received neo-adjuvant chemotherapy. She now presents to the reporting facility for modified radical mastectomy.
22	Patient had a biopsy at another facility and the diagnosis was breast cancer. She underwent a mastectomy at the reporting facility and did not receive any further treatment.
32	Patient was diagnosed and treated for primary bladder cancer prior to admission to reporting facility. Reporting facility admits patient for cystectomy for recurrent bladder cancer.
38	Patient admitted to reporting facility with chest pain and expires. Autopsy performed at reporting facility identifies patient has pancreatic cancer.
43	A physician does a skin biopsy in his office and sends the biopsy specimen to a reading pathology/lab. The diagnosis is malignant melanoma. The pathology/lab facility is responsible for reporting the case.

Last Name (NAACCR Item #2230) (FORDS pg. 39)

Description
Identifies the last name of the patient.

Explanation
This data item is used as a patient identifier.

Coding Instructions
1. Enter the last name of the patient in **CAPITAL LETTERS.** Blanks, spaces, hyphens, apostrophes, and punctuation marks **are** allowed.

Examples:

a. Record De Leon with a space as DE LEON

b. Record O'Hara with an apostrophe as O'HARA

c. If Janet Smith marries Fred Jones and changes her name to Smith-Jones record SMITH-JONES with the hyphen.

2. Do not leave the data field blank. If the patient's last name is not known, enter UNKNOWN in this field. This should be done only as a last resort. Every resource should be exhausted to obtain this information.

Note: Document in *Text Remarks - Other Pertinent Information:* Last name unknown.

First Name (NAACCR Item #2240) (FORDS pg. 40)

Description
Identifies the first name of the patient.

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

Coding Instructions
1. Enter the first name of the patient in **CAPITAL LETTERS**.

2. Blanks, spaces, hyphens and apostrophes are not allowed. Do not use other punctuation.

3. This field may be updated if the name changes.

4. If the patient's first name is unknown, enter UNKNOWN. Do not leave the field blank. This should be done only as a last resort. Every resource should be exhausted to obtain this information.

Note: Document in *Text Remarks - Other Pertinent Information:* First name unknown.

Middle Name (NAACCR Item #2250) (FORDS pg. 41)

Description
Identifies the middle name or middle initial of the patient.

Explanation
This data item is used to differentiate between patients with identical first and last names.

Coding Instructions
1. Enter the middle initial if the complete middle name is not provided.

2. Blanks, spaces, hyphens and apostrophes are allowed. Do not use other punctuation.

3. This field may be updated if the name changes.

4. If the patient does not have a middle name or initial, or it is unknown, **leave blank**. Do not code UNK for unknown or NA for not applicable.

Maiden Name (NAACCR Item #2390)

Description
Identifies the female patients who are or have been married.

Explanation
This data item is useful for matching multiple records for the same patient and is useful in identifying Spanish/Hispanic origin.

Coding Instructions
1. Enter the maiden name of female patients who are or have been married if the information is available. Blanks, spaces, hyphens, apostrophes, and punctuation marks **ARE** allowed.

2. If the patient does not have a maiden name, or it is unknown, leave blank.

Alias Name (NAACCR Item #2280)

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 [2390].

Explanation
A patient may use a different name or nickname. These different names are aliases. This item is useful for matching multiple records on the same patient.

Coding Instructions
1. If the patient does not use an alias leave blank. Do not record the patient's first and last name again.

2. Record the **alias** last name followed by a blank space and then the **alias** first name.

3. Mixed case, embedded spaces, hyphens and apostrophes are allowed.

4. No other special characters are allowed.

Examples:

a. Ralph Williams uses the name Bud Williams. Record Williams Bud in the **NAME-ALIAS** field.

b. Janice Smith uses the name Janice Brown. Record Brown Janice in the **NAME-ALIAS** field.

c. Samuel Clemens uses the name Mark Twain. Record Twain Mark in the **NAME-ALIAS** field.

Street Address (NAACCR Item #2330) (FORDS pg. 42)

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

Explanation
Allows for the analysis of cancer clusters, environmental studies, or health services research and is useful for epidemiology purposes. A patient's physical address takes precedence over a post office box. If a patient has multiple primary tumors the address may be different if diagnosed at different times. Do not update this field if the patient moves after diagnosis.

Note: ACoS facilities **are** required to provide information for this field regardless of class of case.

Coding Instructions
1. Enter the number and street of the patient's residence at the time the cancer is diagnosed in **60 characters or less.** If the address contains more than 60 characters, omit the least important element, such as the apartment or space number.

2. Do not omit elements needed to locate the address in a census tract, such as house number, street, direction or quadrant, and street type (street, drive, lane, road, etc.).

3. Punctuation marks are limited to periods, slashes, hyphens and pound signs in this field.

4. Only use the post office box or the rural mailing address when the physical address is not available. Post office box addresses do not provide accurate geographical information for analyzing cancer incidence. Every effort should be made to obtain complete valid address information.

5. Abbreviate as needed using standard address abbreviations listed in the *U.S. Postal Service National Zip Code and Post Office Directory* published by the U.S. Postal Service (USPS). These include but are not limited to:

Table 4.5 Street Address Abbreviations

ABBREV.	DESCRIPTION	ABBREV.	DESCRIPTION	ABBREV.	DESCRIPTION
APT	Apartment	FL	Floor	S	South
AVE	Avenue	N	North	SE	Southeast
BLDG	Building	NE	Northeast	SQ	Square
BLVD	Boulevard	NW	Northwest	ST	Street
CIR	Circle	PLZ	Plaza	STE	Suite
CT	Court	PK	Park	SW	Southwest
DEPT	Department	PKWY	Parkway	UNIT	Unit
DR	Drive	RD	Road	W	West
E	East	RM	Room		

Example:
Patient's street address is 1232 Southwest Independence Apartment 400. Record: 1232 SW Independence Apt 400

Patients with an Unknown Address:

6. If the patient's address is not available in the medical record, record **NO ADDRESS** or **UNKNOWN. Do not** leave blank. These cases should be rare and every effort should be made to obtain a valid address. The address data fields for these cases should be recorded as the city **Unknown**, the state as **ZZ,** the zip code should be **99999** and the FIPS as **999**. **Do not record the reporting facility's city, state, zip and FIPS.**

Note: Document in *Text Remarks - Other Pertinent Information:* Patient address is unknown. Be aware that an excessive amount of unknown addresses will result in additional efforts by TCR staff to obtain a valid address which may include contacting the reporting facility or managing/following physician.

7. Log onto https://tools.usps.com/go/ZipLookupAction!input.action for help in completing address information,

Persons with More than One Residence:
These include snowbirds who live in the south for the winter months, sunbirds who live in the north during the summer months. This also includes persons with vacation residences which they occupy for a portion of the year.

8. Code the residence where the patient spends the majority of time (usual residence).

9. If the usual residence is not known or the information is not available, code the residence the patient specifies at the time of diagnosis.

Persons with No Usual Residence:
Homeless people and transients are examples of persons with no usual residence.

10. Code the patient's residence at the time of diagnosis as unknown.

Note: Under pertinent information document that patient is homeless. An unknown address is not the same as homeless.

Temporary Residents:

11. Code the place of usual residence rather than the temporary address for:
    a. Migrant workers
    b. Persons temporarily residing with family during cancer treatment
    c. Military personnel on temporary duty assignment
    d. Boarding school students below the college level (code the parent's residence)

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

13. Code the address of the institution for **Persons in Institutions**.
    a. Persons who are incarcerated
    b. Persons who are physically or mentally handicapped or mentally ill who are residents of homes, schools, hospitals, or wards.
    c. Residents of nursing and rest homes
    d. Long-term residents of other hospitals such as Veteran's Administration (VA) hospitals

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

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

15. **Personnel Assigned to Navy, Coast Guard, and Maritime Ships-**The US 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 US Census Bureau Publications for detailed rules at www.census.gov.

Address at Dx-Supplemental (NAACCR Item #2335) (FORDS pg. 43)

Description

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

Explanation

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

Coding Instructions
1. Do not use this data item to record the number and street address of the patient.

2. Do not update this data item if the patient's address changes.

3. If this address space is not needed, leave blank.

City (NAACCR Item #70) (FORDS pg. 44)

Description
Identifies the name of the city or town in which the patient resides at the time of diagnosis. Do not update this field if the patient moves after being diagnosed.

Explanation
Allows for the analysis of cancer clusters, environmental studies, or health services research and is useful for epidemiology purposes.

Coding Instructions
1. Enter the city of residence at the time the cancer is diagnosed. If the patient resides in a rural area, record the name of the city used in the mailing address.

2. 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.

3. If the patient has multiple primaries, the address may be different for subsequent primaries.

Note: Every effort should be made to record the patient's address from resources available in your facility. If the patient's address is not available **do not** leave blank. The address data fields for these cases should be recorded **Unknown** in the street address, **Unknown** in the city, **ZZ** in the state, **99999** in the zip code and **999** in the FIPS data field. **Do not record the reporting facility's city, state, zip and FIPS for unknown addresses.**

State (NAACCR Item #80) (FORDS pgs. 45-46)

Description
Identifies the patient's state of residence at the time of diagnosis/admission. This field should not be updated if the patient moves after being diagnosed.

Explanation
It allows for analysis of geographic and environmental studies and inclusion in state and national cancer publications/studies.

Coding Instructions
1. Record the appropriate **two-letter abbreviation** for state of residence at the time of diagnosis.

2. If the patient is a resident of Canada, record the appropriate **two-letter abbreviation** for the

country of residence at time of diagnosis/admission. If the province or territory of Canada is known, record the abbreviation. See page 64 for a list of Canadian Provinces/Territories.

3. If the patient is a foreign resident, other than Canada, record either **XX** or **YY** depending on the circumstance. Refer to the table below for specific instructions.

4. If the patient has multiple primaries, the state of residence may be different for subsequent cases. **Note:** Every effort should be made to record the patient's address from resources available in your facility. If the patient's address is not available **do not** leave blank. The address data fields for these cases should be recorded as **Unknown** in the street address, **Unknown** in the city, **ZZ** in the state, **99999** in the zip code and **999** in the FIPS data field. **Do not record the reporting facility's city, state, zip and FIPS for unknown addresses.**

Table 4.6 State Codes

CODE	DESCRIPTION
TX	If the state in which the patient resides at the time of diagnosis and treatment is Texas, then use the USPS code for the state of Texas.
US	Resident of United States, NOS (state/commonwealth/territory/possession unknown)
CD	Resident of Canada, NOS; Use the specific abbreviation of Canadian Provinces/Territories if this information is provided.
XX	Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) and Canada, and the country is **known.**
YY	Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) and Canada, and the country is **unknown.**
ZZ	Residence unknown.

Examples:

a. A patient's country of residence is documented as France; record XX in the state field.

b. Documentation in the patient's medical record states the patient is a resident of a foreign country and no other address documentation provided; record YY in the state field.

c. The patient's medical record states the patient lives in the United States or in a territory, commonwealth, or possession of the United States and no other address documentation is provided; record US in the state field.

d. If every valid attempt has been made to obtain the address and it is still unknown, record ZZ in the state field.

Table 4.7 Canadian Provinces/Territories

PROVINCE/TERRITORY	ABBREVIATION	PROVINCE/TERRITORY	ABBREVIATION
Alberta	AB	Nunavut	NU
British Columbia	BC	Ontario	ON
Manitoba	MB	Prince Edward Island	PE
New Brunswick	NB	Quebec	QC
Newfoundland and Labrador	NF	Saskatchewan	SK
Northwest Territories	NT	Yukon	YT
Nova Scotia	NS		

Table 4.8 State and Territory Abbreviations:
(Refer to the ZIP Code directory for further listings).

STATE		STATE		STATE	
Alabama	AL	Kentucky	KY	North Dakota	ND
Alaska	AK	Louisiana	LA	Ohio	OH
Arizona	AZ	Maine	ME	Oklahoma	OK
Arkansas	AR	Maryland	MD	Oregon	OR
California	CA	Massachusetts	MA	Pennsylvania	PA
Colorado	CO	Michigan	MI	Rhode Island	RI
Connecticut	CT	Minnesota	MN	South Carolina	SC
Delaware	DE	Mississippi	MS	South Dakota	SD
District of Columbia	DC	Missouri	MO	Tennessee	TN
Florida	FL	Montana	MT	Texas	TX
Georgia	GA	Nebraska	NE	Utah	UT
Hawaii	HI	Nevada	NV	Vermont	VT
Idaho	ID	New Hampshire	NH	Virginia	VA
Illinois	IL	New Jersey	NJ	Washington	WA
Indiana	IN	New Mexico	NM	West Virginia	WV
Iowa	IA	New York	NY	Wisconsin	WI
Kansas	KS	North Carolina	NC	Wyoming	WY

OTHER U.S. TERRITORIES	
American Samoa	AS
Guam	GU
Puerto Rico	PR
Virgin Islands	VI

Zip Code (NAACCR Item #100) (FORDS pg. 47)

Description
Identifies the postal code of the patient's address at the time of diagnosis/admission. If the patient has multiple tumors, the postal code may be different for each tumor.

Explanation
It allows for the analysis of cancer clusters, geographic or environmental studies and health services research.

Coding Instructions
1. Enter the patient's zip code at time of diagnosis/admission. Enter the nine-digit extended zip code if known. If recording the full nine-digit zip code, **no dash** should be placed between the first five and the last four digits. The five-digit zip code is allowed if this is all the information available. Blanks follow the five-digit code if the four-digit extension is not coded.

2. If the zip code is not available, refer to the *National Zip Code Directory* or to the USPS website: https://tools.usps.com/go/ZipLookupAction!input.action. This website is useful in obtaining missing address information in order to record a complete address.

3. If the patient is a resident of a foreign country at the time of diagnosis, record **88888** for the zip code.

Note: Every effort should be made to record the patient's address from resources available in your facility. If the patient's address is not available **do not** leave blank. The address data fields for these cases should be recorded as **Unknown** in the street address, **Unknown** in the city, **ZZ** in the state, **99999** in the zip code and **999** in the FIPS data field. **Do not record the reporting facility's city, state, zip and FIPS for unknown addresses.**

Table 4.9 Zip Code

CODE	DESCRIPTION
123456789	The patient's nine-digit U.S. extended postal code. Do not record dashes.
88888	Permanent address in a country other than Canada, United States, or U.S. possessions.
99999	Resident of the United States (including its possessions, etc.) or Canada and the postal code cannot be verified using the *National Zip Code Directory* or the USPS website.
99999	After every effort is made to obtain a valid address the information remains unknown.
M6G2S8	The patient's valid six character Canadian postal code left justified followed by three blanks.

Examples:

a. A patient's country of residence is documented as France; record 88888 in the zip code field.

b. A patient's address is in Canada and the zip code cannot be verified; record 99999 in the zip code field.

c. A patient's address is not documented in the medical record and remains unknown after researching all your facility's resources; record 99999 in the zip code field.

Fips County Code at Diagnosis (NAACCR Item #90) (FORDS pg. 49)

Description
Identifies the county of the patient's residence at the time of diagnosis. If the patient has multiple tumors, the county codes may be different for each tumor.

Explanation
This data item may be used for epidemiological purposes (for example: to measure the cancer burden in a particular geographical area).

Coding Instructions
1. Enter the appropriate three-digit code for the county of residence. 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 at: www.epa.gov/enviro/html/codes/state.html.

2. Refer to *Appendix C* for the list of Texas FIPS county codes.

3. If the patient has multiple tumors, the FIPS county codes may be different for each tumor.

4. Do not update this data item if the patient's county of residence changes after diagnosis.

5. ACoS facilities following the FORDS' guideline to code the country of residence in this data field for non-U.S. residents, **CD** and **XX** will be accepted by the TCR Edits.

Note: Every effort should be made to record the patient's address from resources available in your facility. If the patient's address is not available **do not** leave blank. The address data fields for these cases should be recorded as Unknown in the street address, **Unknown** in the city, **ZZ** in the state, **99999** in the zip code and **999** in the FIPS data field. **Do not record the reporting facility's city, state, zip and FIPS for unknown addresses.**

Table 4.10 Fips County Code at Diagnosis

CODE	DESCRIPTION	DEFINITION
001–507	County at diagnosis	Valid Texas FIPS code
998	Outside state/country & code is unknown	Known town, city, state, or country of residence, but county code not known **AND** a resident outside the state of Texas (must meet all criteria)
999	Unknown county	The county is unknown and not documented in the patient's medical record

Address at DX – Country (NAACCR Item #102) (FORDS pg. 48)

Description
Identifies the country of the patient's residence at the time of diagnosis. If the patient has multiple tumors, the country codes may be different for each tumor.

Explanation
This data item may be used for epidemiological purposes (for example: to measure the cancer burden in a particular geographical area).

Coding Instructions
1. Enter the appropriate alpha-3-digit code for the country of residence. Use codes issued by the United States Postal Service.

Table 4.11 Country Code Examples:

CODE	COUNTRY
USA	United States
CAN	Canada

Social Security Number (NAACCR Item #2320) (FORDS pg. 38)

Description
Identifies the patient by social security number.

Explanation
This item is used by the TCR in internal processes such as linking for resolution of duplicate primaries and consolidation.

Coding Instructions
1. Every effort should be made to obtain the social security number. Research all resources from your facility for this information.

2. Enter the patient's nine-digit social security number in this field.

3. If the social security number is unavailable or unknown, enter all 9's in this field. Document in *Text Remarks-Other Pertinent Information* that the social security information is unavailable.

4. A patient's Medicare number may not be identical to the person's social security number.

5. Do not put dashes or slashes in this field.

Note: Social security numbers are used for Medicare benefits. Suffix A on a social security number indicates the number is the patient's Medicare number. Other suffixes identify another person's Medicare number under which the patient may be entitled to receive benefits. **Take caution to enter the patient's social security number and not the spouse's or guardian's number.**
The following are not allowed:
- First 3 digits= 000 or 666
- Fourth and fifth digits= 00
- Last four digits= 0000
- First digit 9 (except for 9999999999)

Date of Birth (NAACCR Item #240) (FORDS pg. 60; SEER pgs. 34-35)

Description
Identifies the patient's century, year, month, and day of birth.
Explanation
This item is used by the TCR to match records, and to calculate age at diagnosis.

Coding Instructions
1. Punctuation marks (slashes, dashes, etc.) are not allowed.

2. The patient's date of birth **must be entered.** Cases cannot be processed without the date of birth.

3. Date format is:
   a. YYYYMMDD - when the complete date is known and valid

Example: The patient's date of birth is June 28, 1983. Code the date of birth as 19830628.

   b. YYYYMM - when the year and month are known and valid, and the day is unknown.

Example: The patient was born in November of 1981, but the day is unknown. Code 198111.

   c. YYYY when the year is known and valid but the month and day are unknown.

Example: The record indicates the patient was born in 1978 but no month or day is given.
Code 1978.

Note: If the complete date of birth is not available, documentation must be provided in *Other Pertinent Information.* For example: Medical records indicate only month and year of date of birth.

4. If only the age of the patient is known, calculate the year of birth from age and year of diagnosis and leave the day and month of birth unknown.

Example: A 50 year old patient diagnosed in 2010 is calculated to have been born in 1960.

5. The year of birth *must* be recorded. TCR will not accept unknown year of birth. Every effort must be made to obtain this information as it is critical for analysis.

Table 4.12 Date of Birth Code

CODE	DESCRIPTION
YYYYMMDD	The date of birth is the year, month and day the patient was born. The first four digits are the year, the third and fourth digits are the month, the fifth and sixth digits are the month, and the seventh and eighth digits are the day.

Birthplace – Country (NAACCR Item #254) (FORDS pg. 59; SEER pg. 33)

Description
Identifies the patient's country of birth.

Explanation
Birthplace is used to ascertain ethnicity, identify special populations at risk for certain types of cancers, and for epidemiological analyses.

Coding Instructions
1. Record the patient's country of birth (if available) using the US Postal Service. If the country of birth is unknown, code to ZZU.

2. Use the most specific code.

Table 4.13 Birthplace Country Examples

CODE	COUNTRY
USA	United States
CAN	Canada
ZZU	Place of birth is unknown, no mention in patient record

Birthplace - State (NAACCR Item #252) (FORDS pg. 58; SEER pg. 32)

Description
Identifies the patient's state of birth.

Explanation
Birthplace is used to ascertain ethnicity, identify special populations at risk for certain types of cancers, and for epidemiological analyses.

Coding Instructions
1. Record the patient's state of birth (if available) using the US Postal Service. If the state of birth is unknown, code to ZZ.

2. Use the most specific code.

Table 4.14 Birthplace - State Examples

CODE	DESCRIPTION
TX	If the state in which the patient resides at the time of diagnosis and treatment is Texas, then use the USPS code for the state of Texas.
US	Resident of United States, NOS (state/commonwealth/territory/possession unknown)
CD	Resident of Canada, NOS; Use the specific abbreviation of Canadian Provinces/Territories if this information is provided.
XX	Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) and Canada, and the country is **known.**
YY	Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) and Canada, and the country is **unknown.**
ZZ	Residence unknown.

Race 1 (NAACCR Item #160) (FORDS pgs. 63-64; SEER pgs. 38-42)

Description
Identifies the primary race of the person.

Explanation
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 accurate national comparisons. Race is defined by specific physical, hereditary and cultural traditions or origins, not necessarily by birthplace, place of residence, or citizenship.

Coding Instructions
1. Record the two-digit code to identify the primary race(s) of the patient in fields race 1, race 2, race 3, race 4, and race 5. The five race fields allow for coding of multiple races consistent with the Census 2000. **Refer to SEER Appendix D, Race and Nationality Descriptions from 2000 Census.**

2. Race is analyzed with *Spanish/Hispanic Origin.* Both items must be recorded. If the patient has multiple tumors, all records should have the same race code.

3. Race 1 is the field used to compare with race data on cases diagnosed prior to January 1, 2001.

4. If a person's race is a combination of white and any other race(s), code the appropriate other race(s) first and code white (01) in the next race field.

5. If a person's race is a combination of Hawaiian and any other race(s), code race 1 as 07, Hawaiian, and code the other race(s) in race 2, race 3, race 4, and race 5 as appropriate.

6. If no race is stated in the medical record or available from other sources in your facility, review the documentation for a statement of a race category such as patient described as a "Japanese female."

7. Persons of Spanish or Hispanic origin may be of any race, although persons of Mexican, Central American, South American, Puerto Rican, or Cuban origin are usually white. Do NOT code a patient

stated to be Hispanic or Latino as 98 (Other Race) in Race 1 and 88 in Race 2 - Race 5.

8. Code 03 should be used for any person stated to be Native American or (western hemisphere) Indian, whether from North, Central, South or Latin America.

9. Death certificate information may be used to supplement ante mortem race information only when race is unknown in the patient record or when the death certificate information is more specific.

10. In using the patient name to determine race:

a. Do not code race from name alone, especially for females with no maiden name given.

b. A Spanish name alone may not be used to determine the race code. A statement about race or place of birth must be documented.

11. If the patient's race is determined on the basis of the races of relatives, there is no priority to coding race, other than to code non-white first.

12. If only one race is reported for a person, Race 2- Race 5 must be coded to 88.

13. If Race 1 is coded to 99, unknown, Race 2- Race 5 must also be coded 99, unknown.

14. A unique race code (other than 88 or 99) can be coded only once in race 1 through race 5.

15. Document the specified race code in the *Text Remarks - Other Pertinent Information* field. A more specific race that is not included in the list of race codes such as 96 Other Asian, 97 Pacific Islander, or 98 Other Race should be documented as well.

16. If the face sheet states "Other race" and there is not more information about race in the medical record, if no further information is found, code Race 1 as 99, and code Race 2-5 as 99.

Table 4.15 Race Codes 1 - 5

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

- The **White** category usually includes Mexican, Puerto Rican, Cuban, Arab, and all other Caucasians including those from Europe and the Middle East.

- The **Black** category includes the designation African-American.

Table 4.16 Race Code 1 Examples

CODE	DESCRIPTION
01	-A patient was born in Mexico of Mexican parentage. -A patient stated to be German-Irish. -A person from Iran or Saudi Arabia. -An immigrant from Sweden.
02	A black female patient. **Note:** A specific 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.
04	A patient is of Chinese and Korean ancestry. Code 04, Chinese in Race 1. Code 08, Korean, in Race 2.
05	A patient has a Japanese father and a Caucasian mother. Code 05 Japanese in Race 1 and 01 White in Race 2.
07	A patient's race is a combination of Hawaiian and any other race(s). Code 07, Hawaiian, in Race 1 and Race 2–Race 5 as appropriate.
11	A patient is stated to be Asian. The place of birth is Laos. Code Race 1 as 11, Laotian, because it is more specific than 96, Asian, NOS.
99	A patient's race is unknown. Code Race 1 as Unknown, code 99. Race 2–Race 5 must also be coded 99. If a patient has a Spanish last name and she is stated to be a native of Indiana, code to 99, Unknown, because nothing is known about her race. Exception is done when Race is noted as "other" in face sheet; use code 99 for Race 1 and code 88 for Race 2-5.

Race 2, Race 3, Race 4, Race 5 (NAACCR Items #161, 162, 163, 164) (FORDS pgs. 63-68; SEER pgs. 38-42)

Description
Identifies the patient's additional races. Race is defined by specific physical, heredity, and cultural traditions or origins, not necessarily by birthplace, place of residence, or citizenship.

Explanation
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 accurate national comparisons.

Coding Instructions
1. Record the two-digit code to identify a multi-racial patient.

2. Race is analyzed with *Spanish/Hispanic Origin.* Both items must be recorded. All primaries for the same patient should have the same race code.

3. All resources in the facility must be used to determine the race of the patient.

4. If more than the *Race 1* code is entered, and if any race is **99**, then all race codes (*Race 1, 2, 3, 4* and *5*) must be **99**. If more than the *Race 1* code is entered, and if any race codes (for *Race 2, 3, 4* and *5*)

are **88** (no further race documented), then all **subsequent** race codes must also be **88**. The exception for this instruction when Race "other" is taken from face sheet, where Race 1 will be coded as 99 and Race 2-5 will be coded as 88.

5. If a person's race is a combination of Hawaiian and any other race(s), code *Race 1* as 07 Hawaiian and code the other race(s) in *Race 2*, *Race 3, Race 4*, and *Race 5* as appropriate.

6. If no race is stated in the medical record or available from other sources in your facility, review the documentation for a statement of a race category such as patient described as a "Hispanic female."

7. Persons of Spanish or Hispanic origin may be of any race, although persons of Mexican, Central American, South American, Puerto Rican, or Cuban origin are usually white. Do NOT code a patient stated to be Hispanic or Latino as 98 (Other Race) in *Race 1* and 88 in *Race 2–Race 5*.

8. Code 03 should be used for any person stated to be Native American or (western hemisphere) Indian, whether from North, Central, South, or Latin America.

9. Death certificate information may be used to supplement ante mortem race information only when race is coded unknown in the patient record or when the death certificate information is more specific.

10. In using the patient name to determine race:

a. Do not code race from name alone, especially for females with no maiden name given.

b. A Spanish name alone may not be used to determine the race code. A statement about race or place of birth must be documented.

11. If the patient's race is determined on the basis of the races of relatives, there is no priority to coding race, other than to code the non-white first.

12. If only one race is reported for a person, *Race 2–Race 5* must be coded to 88.

13. If race 1 is coded to unknown 99, *Race 2–Race 5* must also be coded unknown 99.

14. If Race 1 is taken from face sheet as "other", code Race 1 as 99, Race 2- Race 5 must be coded to 88.

15. A unique race code (other than 88 or 99) can be coded only once in *Race 1* through *Race 5*.

16. Document the specified race code in the *Text Remarks - Other Pertinent Information* text field. A more specific race that is not included in the list of race codes such as 96 Other Asian, 97 Pacific Islander, or 98 Other Race should be documented as well.

Spanish/Hispanic Origin (NAACCR Item #190) (FORDS pg. 69; SEER pg. 45)

Description
Identifies persons of Spanish or Hispanic origin. If a patient has multiple tumors, all records should have the same code.

Explanation
This is used 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.*

Coding Instructions
1. The information is coded from the medical record or is based on Spanish/Hispanic names.

2. Review all sources available to determine the correct code, including stated Hispanic ethnicity. Origin on the death certificate, birthplace and information about life history and language spoken should be considered.

3. Coding Spanish surname or origin is not dependent on race. A person of Spanish descent may be white, black, or any other race.

4. Portuguese, Brazilians and Filipinos are not presumed to be Spanish or non-Spanish.

   a. Assign code 7 when the patient is Portuguese, Brazilian, or Filipino and their name appears on a Hispanic surname list.

   b. Assign code 0 when the patient is Portuguese, Brazilian, or Filipino and their name does NOT appear on a Hispanic surname list.

Note: Refer to the list of Spanish/Hispanic surnames on the TCR website at:
http://www.dshs.state.tx.us/tcr/publications/2008crhb/web/2006HB-AppxM.pdf .

Table 4.17 Spanish/Hispanic Origin Codes

CODE	DESCRIPTION
0	Non-Spanish; non-Hispanic (includes Portuguese and Brazilian)
1	Mexican (includes Chicano, NOS)
2	Puerto Rican
3	Cuban
4	South or Central American (except Brazil)
5	Other specified Spanish/Hispanic (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 other information the person is not Hispanic. Ordinarily for central registry use only.
8	Dominican Republic (effective with diagnosis on or after 1/1/2005)
9	Unknown whether Spanish or not; not stated in patient record

Note: Use **code 0** if patient has a Spanish/Hispanic name and there is reason to believe he/she is **not** Hispanic, for example, patient is Filipino or patient is a woman with a Hispanic married name but she is known to be non-Hispanic.

5. Use codes 1–5 if specific ethnicity is known.

6. Use code 6 when you know the patient is Hispanic but cannot classify him/her to codes 1–5.

7. Use code 7 if race in the medical record is classified as White and he/she has a Spanish/Hispanic last name. Ordinarily used at the central registry level.

8. Use code 9 when Spanish/Hispanic origin is not documented or is unknown.

Examples:

a. Patient's last name is Gonzales and the medical record states the patient was born in Mexico; code to 1.

b. Patient's medical record states race as Hispanic, without mention of whether his/her origin was Mexico, Puerto Rico, Cuba, etc.; code to 6.

c. Patient's medical record states patient is White/Caucasian and the last name is Gonzales; code to 7.

Sex (NAACCR Item #220) (FORDS pg. 70; SEER pg. 49)

Description

Identifies the sex of the patient at the time of diagnosis.

Explanation

This data item is used to compare cancer rates and outcomes by site.

Coding Instructions
1. Record the patient's gender as indicated in the medical record.

2. The code must be gender-specific to the primary site.

Example: The patient must be coded as male for a prostate cancer, or female for ovarian primary. If the patient has multiple tumors the sex must be the same for all records.

Table 4.18 Patient Sex Codes

CODE	DESCRIPTION
1	Male
2	Female
3	Other (Hermaphrodite) (Intersexed)
4	Trans-sexual
9	Not Stated/Unknown

Note: Trans-sexual is defined as surgically altered gender.

Note: Transgendered is defined as a person who identifies with or expresses a gender identity that differs from the one which corresponds to the person's sex at birth. Assign code 4 for Transgendered.

Text Usual Industry (NAACCR Item #320)

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

Explanation
Used to identify work-related health hazards; identifies industrial groups or worksite-related groups in which cancer screening or prevention activities may be beneficial.

Definition
Type of business or industry where the patient worked in his or her usual occupation. Examples include manufacturing of tires, dry cleaning services, training of dogs, hospital.

Instructions
1. Document the patient's usual (longest held) industry to the extent that the information is available in the medical record.

2. Be descriptive and specific.

Examples

Inadequate: "Automobile industry"
Adequate: "Automobile manufacturing"

Inadequate: "Mine"
Adequate: "Copper mine"

Inadequate: "Retail"
Adequate: "Retail bookstore"

3. When recording government agencies record the level (federal, state, county, municipal) and the division.

Example
Inadequate: "Census"
Adequate: "U.S. Census Bureau"

4. Be complete. If the primary activity of the industry is unknown, record the name of the company (with city or town) in which the patient worked the most number of years before diagnosis.

Example
Inadequate: "ABC, Inc."
Adequate: "ABC, Inc., Kyle, TX"

5. If the patient's usual industry is unknown, document "Unknown" in the text field. This should be used only as a last resort.

Text Usual Occupation (NAACCR Item #310)

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

Explanation
Used to identify work-related health hazards; identifies occupational groups in which cancer screening or prevention activities may be beneficial.

Definition
Type of job the patient was engaged in for the longest time. It is not necessarily the highest paid job or the job considered the most prestigious, but the one that accounted for the greatest number of working years. Examples include police officer, bank teller, or nurse.

Exception
If a patient has been a homemaker for most of her adult life, but has ever worked outside the home, report the occupation held outside the home.

Coding Instructions
1. Document the patient's usual occupation, the kind of work performed during most of the patient's working life before diagnosis of this tumor, to the extent that the information is available in the medical record. Make sure the recorded usual occupation matches the recorded industry.

2. Be descriptive, specific and complete: Record the word or words which most clearly describe the kind of work or type of duties performed by the patient.

Examples
Inadequate: "Teacher"
Adequate: "Preschool teacher," "high school teacher"

Inadequate: "Laborer"
Adequate: "Residential bricklayer"

Inadequate: "worked in a warehouse," "worked in a shipping department"
Adequate: "warehouse forklift operator"

Inadequate: "Engineer"
Adequate: "Chemical engineer," "Railroad engineer"

Inadequate: "Self-employed"
Adequate: "Self-employed auto mechanic"

3. If the patient's usual occupation is not known, document "Unknown" in the text field. This should be used only as a last resort.

Commonly confused occupations
Contractor vs. skilled worker

a. A contractor mainly obtains contracts and supervises work
b. A "skilled worker" works with his or her own tools as a carpenter, plasterer, plumber or electrician.

Machine operator vs. machinist vs. mechanic

a. A "machine operator" operates machines.
b. A "machinist" sets up and operates machines.
c. A "mechanic" repairs, installs, and adjusts machines

Text Remarks - Other Pertinent Information (NAACCR Item #2680)

Description
Includes text area for information that is coded on the patient's disease and adequate or appropriate space is not provided for supporting text. Overflow or problematic coding issues can be documented in this text field.

Explanation
Information documenting the disease process should be entered manually from the medical record and not be generated from coded values. Such documentation should include additional staging information, additional treatment documentation, documentation of race and sex, history of the disease, comments regarding lack of information in the medical record and cause of death. The name of the following (Follow Up) physicians should also be noted here. See the Text Documentation Section for detailed instructions.

Physician Follow Up (NAACCR Item #2470)

Description
Identifies the physician currently responsible for the patient's medical care. The TCR requires the physician's state license number.

Explanation
The follow-up (or "following") physician is the first contact for obtaining information on the patient's status. This information may be used for outcome studies.

Coding Instructions
1. Record the state license number of the physician currently responsible for the patient's care. Physician license numbers for Texas can be found at the following website: www.docboard.org/tx/df/txsearch.htm

2. Cancer reporters using third party software must check with their vendor to ensure the physician's state license number transmits to the TCR.

3. This field must be populated for cases diagnosed 2006 and forward. If the information is unknown code 99999 and document in *Text Remarks - Other Pertinent Information* that the follow up physician is unknown.

Note: Beginning in 2011 CoC will no longer require data item 2470, *Following Physician.* TCR will continue to require this data item.

Sequence Number (NAACCR Item #560) (FORDS pgs. 35 - 36)

Description
Indicates the chronological sequence of all reportable neoplasms (malignant and non-malignant) over the lifetime of the patient regardless of when or where the case was diagnosed. Each neoplasm is assigned a different number. Sequence number 00 indicates patient has only one reportable malignant neoplasm. Reportable neoplasms not included in the facility registry are also allotted a sequence number. For example, an ACoS registry may contain a single record for a patient with a sequence number of 02 because the first reportable neoplasm occurred before the facility's reference date.

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

Coding Instructions
1. Codes 00–59 and 99 indicate reportable cases of malignant or in situ behavior.

2. Code 00 if the patient has a single reportable primary. If the patient develops a subsequent reportable primary, change the code for the first primary from 00 to 01, and number subsequent primaries sequentially.

3. If two or more reportable primaries are diagnosed simultaneously, assign the lowest sequence number to the diagnosis with the worst prognosis. If no difference in prognosis is evident, the decision is arbitrary.

a. Base the prognosis decision on the primary site, histology, and extent of disease for each of the primaries

b. If there is no difference in prognosis, the sequence numbers may be assigned in any order.

4. Codes 60–88 indicate non-malignant neoplasms (benign and borderline) that are reportable by agreement cases (e.g., those cases required by state registries). All benign or borderline neoplasms diagnosed/admitted to your facility should be sequenced according to this guideline. This includes benign and borderline CNS neoplasms.

5. Code 60 if the patient has a single non-malignant primary. If the patient develops a subsequent non-malignant primary, change the code for the first primary from 60 to 61, and number subsequent non-malignant primaries sequentially (62, 63…).

6. Sequence numbers should be reassigned in the database if the facility learns later of an unaccessioned tumor that would affect the sequence.

7. The *Sequence Number* refers to the number of malignant or non-malignant primaries **in the patient's lifetime**.

Table 4.20 Sequence Number: Malignant Neoplasms

ONE PRIMARY	MORE THAN ONE PRIMARY	SEQUENCE
00 One primary only	01 First of two or more primaries	99 Unspecified
	02 Second of two or more primaries	
	03 Third of three or more primaries	

Table 4.21 Sequence Number: Non-Malignant Neoplasms

ONE PRIMARY	MORE THAN ONE PRIMARY	SEQUENCE
60 One primary only	61 First of two or more primaries	88 Unspecified
	62 Second of two or more primaries	
	63 Third of three or more primaries	

Note: Squamous and/or basal cell carcinoma of the skin (except genital sites) **are no longer** considered when assigning the appropriate sequence number.

Examples:

a. A person is diagnosed with one malignant primary. Code the sequence number to 00.

b. A person was diagnosed with lung cancer in 2001. A colon cancer is diagnosed in 2012. Code the sequence number of the colon cancer to 02 and change the sequence number of the lung cancer to 01.

c. A person was diagnosed with breast cancer in April 2010 and metastasis to the lungs in June 2012. Since the lung is a metastatic site and not a second primary, it would not be abstracted. Code the sequence number of the breast cancer to 00.

d. A person was diagnosed with signet ring cell carcinoma of the bladder in 2004. In 2012, this person developed a benign meningioma in the temporal area of the brain. Code the bladder to sequence number 00, and code the brain to sequence number 60.

e. A person was diagnosed with carcinoma of the stomach in 2003, squamous cell carcinoma of the left forearm (a non-reportable neoplasm) in 2005, and non-Hodgkin's lymphoma in 2012. Code the sequence number of the stomach to 01. The sequence number of the left forearm would not be sequenced, abstracted or reported. Code the sequence number of the lymphoma to 02.

f. A person was diagnosed with a benign meningioma in June 2007. MRI at your facility in 2012 shows no change. *Code the sequence number to 60 for the benign meningioma.*

Other Primary Tumors (Site, Morphology, Date) NAACCR Item #2220)

Description

State-specific data field to capture information on other reportable tumors.

Explanation
Records tumor specific information on other reportable tumors in the patient's lifetime.

Coding Instructions
1. Record the site, morphology, and date of diagnosis of other primaries. **Do not** include metastatic lesions or the primary currently being reported in this field. **Do not** leave this area blank due to lack of specific information. Record the information you have available.

Examples:
a. The patient had a history of duct cell carcinoma of the left breast in 2005 and is admitted in 2012 for adenocarcinoma of the lung. Complete an abstract on the lung tumor, and document duct cell carcinoma of left breast in 2005 in this field.

b. The patient has a history of prostate cancer, no date or specific morphology is given. Patient is admitted in 2012 with a malignant melanoma of left leg. Document: history of prostate cancer, unknown date.

2. This field may be left blank if the sequence number is 00 for a malignant neoplasm or 60 for a non-malignant neoplasm.

Primary Payer at Diagnosis (NAACCR Item #630) (FORDS pgs. 71-72)

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

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

Coding Instructions
1. Record the type of insurance reported on the patient's admission page.

2. If more than one payer or insurance carrier is listed on the patient's admission page, record the first.

3. If the patient's payer or insurance carrier changes, do not change the initially recorded code.

4. Consult with your facility's billing department if the primary payer information is unclear.

Table 4.22 Primary Payer at Diagnosis Codes

CODE	LABEL	DESCRIPTION
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 types listed in codes 20, 21, 31, 35, 60-68
20	Private Insurance: Managed Care, HMO, or PPO	An organized system of prepaid care for a group of enrollees usually within a defined geographic area. Generally formed as one of four types: a group model, an independent physician association (IPA), a network, or a staff model. "Gate-keeper model" is another term for describing this type of insurance.
21	Private Insurance: Fee-for-Service	An insurance plan that does not have negotiated fee structure with the participating hospital. Type of insurance plan not coded as 20.
31	Medicaid	State government administered insurance for persons who are uninsured, below the poverty level, or covered under entitlement programs. Medicaid other than described in code 35.
35	Medicaid-Administered through a Managed Care plan	Patient is enrolled in Medicaid through a Managed Care program (e.g. HMO or PPO). The managed care plan pays for all incurred costs.
60	Medicare without supplement, Medicare, NOS	Federal government funded insurance for persons who are 62 years of age or older, or are chronically disabled (social security insurance eligible). Not described in codes 61, 62, or 63.
61	Medicare with supplement, NOS	Patient has Medicare and another type of unspecified insurance to pay costs not covered by Medicare.
62	Medicare-Administered through a Managed Care plan	Patient is enrolled in Medicare through a Managed Care plan (e.g. HMO or PPO). The Managed Care plan pays for all incurred costs.
63	Medicare with private supplement	Patient has Medicare and private insurance to pay costs not covered by Medicare.
64	Medicare with Medicaid eligibility	Federal government Medicare insurance with State Medicaid administered supplement.

CODE	LABEL	DESCRIPTION
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 treated at a military facility
67	Veterans Affairs	Veterans treated in Veterans Affairs facilities
68	Indian/Public Health Services	Patient who receives care at an Indian Health Services facility or at another facility and 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:

a. An indigent patient is admitted with no insurance coverage. Code the *Primary Payer at Diagnosis* as 01.

b. A patient is admitted for treatment and the patient admission page states the primary insurance carrier is an HMO. Code the *Primary Payer at Diagnosis* as 20.

c. 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. Code the *Primary Payer at Diagnosis* as 62.

d. Patient comes to your facility originally diagnosed with prostate cancer in 2000. Now he has bone metastasis. Code the *Primary Payer at Diagnosis* as 99 because the information from the facility where originally diagnosed is not available.

Comorbidities and Complications #1 - #10 (NAACCR Item #3110, 3120, 3130, 3140, 3150, 3160, 3161, 3162, 3163, and 3164) (FORDS pgs 73-83)

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.

Explanation

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.

Coding Instructions

1. Use only ICD-9-CM codes. These should be five characters. Be sure to omit decimal points.

2. Secondary diagnoses are found on the discharge abstract or coding summary. Information from the billing department at your facility may be consulted when a discharge abstract is not available.

3. 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.

4. Report the secondary diagnoses for this cancer using the following priority rules:

a. Surgically treated patients:

- Following the most definitive surgery of the primary site
- Following other non-primary site surgeries

b. Non-surgically treated patients:

- Following the first treatment encounter/episode

c. In cases of non-treatment:

- Following the last diagnostic/evaluative encounter

5. If there was an unplanned re-admission following surgical discharge, check for an ICD-9-CM "E" code and record, space allowing, as additional *Comorbidities and Complications*

6. If no secondary diagnoses were documented, then code 00000 in the first data item, and leave the remaining Comorbidities *and Complications* data items blank. **Do not leave the first data item blank.**

7. If fewer than 10 secondary diagnoses are listed, then code the diagnoses listed, and leave the remaining *Comorbidities and Complications* data items blank.

8. For non-analytic cases code the first data item 00000 and leave the remaining data items blank.

Table 4.23 Comorbidities and Complications Codes

ICD-9-CM or ICD-10-CM	CODE	DESCRIPTION, SPECIFIC INSTRUCTIONS
Both	00000	No comorbid conditions or complications. Code only the first field and leave the remaining fields blank.
ICD-9-CM	00100-13980, 24000-99990	Comorbid conditions: Omit the decimal point between the third and fourth characters.
ICD-9-CM	E8700-E8799, E9300-E9499	Complications: Omit the decimal point between the fourth and fifth characters
ICD-9-CM	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

Table 4.24 Comorbidities and Complications Code Examples

CODE	DESCRIPTION (ICD-9-CM)
49600	COPD (ICD-9-CM code 496)
25001	Type 1 diabetes mellitus (ICD-9-CM code 250.01)
E8732	The patient was inadvertently exposed to an overdose of external beam radiation
V1030	The patient has a personal history of breast cancer (ICD-9-CM code V10.3)

Source Comorbidity (Non-NAACCR Standard Data Item 9970) (Source CDC/NPCR-CER)

Description
This data item records the data source from which comorbidities/complications (NAACCR Data Items 3110, 3120, 3130, 3140, 3150, 3160, 3161, 3162, 3163, and 3164) were collected.

Coding Instructions
1. Do not leave this data item blank. If no comorbid condition or complications are identified in the patient's record use code 0.

Table 4.25 Source Comorbidity Codes

CODE	DESCRIPTION
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

Height (Non-NAACCR Standard Item 9960) (Source CDC/NPCR-CER)

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.

Coding Instructions
1. Different tumors for the same patient may have different values.

2. Height should be collected from source records once for each cancer.

3. 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.

4. The height entered should be that listed at or around the time of diagnosis. If no height was listed on the date of diagnosis, use the height recorded on the date closest to the date of diagnosis and before treatment was started.

5. Enter height as a 2 digit number measured in inches. Round all inches values to the nearest whole number; values with decimal place x.5 and greater should be rounded up (code 62.5 inches as 63 inches).
6. Do not leave this field blank. If the information is not available use code 99 (Unknown).
Note: An online conversion calculator is available at http://manuelsweb.com/ft_in_cm.htm.

Table 4.26 Height Codes

CODE	DESCRIPTION
XX	Exact number in inches (up to 98 inches)
98	98 inches or greater
99	Unknown height

Weight (Non-NAACCR Standard Data Item 9961) (Source CDC/NPCR-CER)

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.

Coding Instructions
1. Different tumors for the same patient may have different values.

2. Weight should be collected from source records once for each cancer.

3. Weight should be taken from the Nursing Interview Guide, Flow Chart, or Vital Stats section from the patient's medical record or physician office record.

4. 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.

5. Enter the weight as a 3 digits number measured in pounds. Round values to the nearest whole number. Values with decimal place x.5 should be rounded up (Code 155.5 pounds as 156). Code a weight of less than 100 pounds with a leading 0 (Code 95 pounds as 095).

6. Do not leave this field blank. If the information is not available use code 999 (Unknown).

Note: An online conversion calculator is available at http://manuelsweb.com/kg_lbs.htm.

Table 4.27 Weight Codes

CODE	DESCRIPTION
XXX	Exact weight in pounds
999	Unknown weight

Tobacco Use Cigarettes (Non-NAACCR Standard Data Item 9965) (Source CDC/NPCR-CER)

Description
Records the patient's past or current cigarette smoking. This data item is required for all sites/histologies as available. This should be recorded from sections such as the Nursing Interview, Guide, Flow Chart, Vital Stats, Nursing Assessment Section, or other available source from the patient's hospital medical record or physician office record.

Coding Instructions
1**.** If the medical record only indicates "No," use code 9 (Unknown/not stated/no smoking specifics provided) rather than code 0 (Never used).

2. If the medical record indicates "None," use 0 (Never used).

3. Do not leave this field blank. If there is no information use code 9 (Unknown).

Table 4.28 Tobacco Use Cigarettes Codes

CODE	DESCRIPTION
0	Never used
1	Current user (as of Date of diagnosis)
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

Tobacco Use Other Smoke (Non-NAACCR Standard Data Item 9966) (Source CDC/NPCR-CER)

Description
Records the patient's past or current use of smoking tobacco products other than cigarettes (pipes, cigars, and kreteks). This data item is required for all sites/histologies as available. This should be recorded from sections such as the Nursing Interview Guide, Flow Chart, Vital Stats, Nursing Assessment Section, or other available source from the patient's hospital medical record or physician office record.

Coding Instructions
1. If the medical record only indicates "No," use code 9 (Unknown/not stated/no smoking specifics provided) rather than code 0 (Never used).

2. If the medical record indicates "None," use 0 (Never used).

3. Do not leave this field blank. If there is no information use code 9 (Unknown).

Table 4.29 Tobacco Use Other Smoke Codes

CODE	DESCRIPTION
0	Never used
1	Current user (as of Date of Diagnosis)
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

Tobacco Use Smokeless (Non-NAACCR Standard Data Item 9967) (Source CDC/NPCR-CER)

Description
Records the patient's past or current use of smokeless tobacco products (chewing tobacco, snuff, etc.) This data item is required for all sites/histologies as available. This should be recorded from sections such as the Nursing Interview Guide, Flow Chart, Vital Stats, Nursing Assessment Section, or other available source from the patient's hospital medical record or physician office record.

Coding Instructions
1. If the medical record only indicates "No," use code 9 (Unknown/not stated/no smoking specifics

provided) rather than code 0 (Never used).

2. If the medical record indicates "None," use 0 (Never used).

3. Do not leave this field blank. If there is no information use code 9 (Unknown).

Table 4.30 Tobacco Use Smokeless Codes

CODE	DESCRIPTION
0	Never used
1	Current user (as of Date of Diagnosis)
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

Tobacco Use NOS (Non-NAACCR Standard Data Item 9968) (Source CDC/NPCR-CER)

Description
Records the patient's past or current use of tobacco when tobacco use is indicated but type is not specified. This data item is required for all sites/histologies as available. This should be recorded from sections such as the Nursing Interview Guide, Flow Chart, Vital Stats, Nursing Assessment Section, or other available source from the patient's hospital medical record or physician office record.

Coding Instructions
1**.** If the medical record only indicates "No," use code 9 (Unknown/not stated/no smoking specifics provided) rather than code 0 (Never used).

2. If the medical record indicates "None," use 0 (Never used).

3. Do not leave this field blank. If there is no information use code 9 (Unknown).

Table 4.31 Tobacco Use NOS Codes

CODE	DESCRIPTION
0	Never used
1	Current user (as of Date of Diagnosis)
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

5

CANCER INFORMATION

CANCER INFORMATION

Date of Initial Diagnosis (NAACCR Item #390) (FORDS pg. 117; SEER pgs. 54-58)

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

Explanation
The date of initial diagnosis is essential in the analysis of staging and treatment of the cancer, for epidemiology purposes, and for outcomes analysis.

Coding Instructions
1. Date format is:

a. YYYYMMDD - when the complete date is known and valid

Example: The patient has a CT on March 25, 2013 and the diagnosis is lung cancer. Code the diagnosis date as 20130325.

b. YYYYMM - when year and month are known and valid, and day is unknown.

Example:
A mammogram done in January 2013 shows that the patient has a malignancy in the upper outer quadrant of the right breast, but the day is unknown. Code the diagnosis date as 201301.

2. The initial diagnosis date may be from a clinical diagnosis, for example, when a radiologist views a chest x-ray and the diagnosis is lung carcinoma. If later confirmed by a pathology specimen, the diagnosis date remains the date of the initial clinical diagnosis.

Note: The Commission on Cancer does not recognize the BI-RADs schema for mammography as a case-finding source. However, if the radiologist states suspicious for malignancy (not neoplasm) in his/her impression, the case is reportable and the date of the mammogram would be considered the date of initial diagnosis for breast cancer.

3. The date of diagnosis based on a pathology report should be the date the specimen was taken, not the date the pathology report was read or created.

4 Refer to the *List of Ambiguous Terms* on page 37 for language that represents a diagnosis of cancer.

5. If a recognized medical practitioner states that, in retrospect, the patient had cancer at an earlier date, record the date of diagnosis as the earlier date. If later documentation shows the diagnosis was an earlier date, record the earlier date and document in the *Summary Stage Documentation* text field.

Examples:
a. The patient has an excision of a benign fibrous histiocytoma on January 3, 2013. Six months

later, a wide re-excision was positive for malignant fibrous histiocytoma. The pathologist reviews the original slides and documents that the previous tumor (benign fibrous histiocytoma) was malignant. Code the diagnosis date as 20130103.

Note: Do not back date if there is no review of previous slides with a revised physician statement of diagnosis of cancer or reportable tumor.

b. The patient had a total hysterectomy and bilateral salpingo-oophorectomy (BSO) in June 2013 with pathologic diagnosis of papillary cystadenoma of the ovaries. On December 6, 2013 the patient is diagnosed with widespread metastatic papillary cystadenocarcinoma. The slides from June 2013 are not reviewed and there is no physician statement saying the previous tumor was malignant. The date of initial diagnosis should be coded 20131206.

Note: Remember to check with your TCR health service regional office regarding the appropriate procedure to follow when there is updated information on an abstract already submitted to the TCR. **Do NOT resubmit the abstract**. These cases will result in duplicate records and require manual resolution.

6. For autopsy-only and death-certificate only cases the date of initial diagnosis will be the date of death.

7. Use the actual date of diagnosis for an in utero diagnosis (For cases diagnosed before January 1, 2009, assign the date of birth).

Example: An ultrasound done on 2/2/2013 to determine expected date of birth shows an unborn baby has a brain tumor. After the baby is born on 4/12/2013, resection shows malignant teratoma. Code the date of diagnosis 20130202.

8. Use the date therapy was started as the date of diagnosis if the patient receives first course of treatment before a definitive diagnosis.

9. Positive tumor markers alone are not diagnostic of cancer. Use the date of positive clinical, positive histologic, or positive cytologic confirmation as the date of diagnosis. Positive tumor markers alone are never used for case ascertainment.

10. Suspicious cytology alone is not diagnostic of cancer. Use the date of positive clinical, positive histologic, or positive cytologic confirmation as the date of diagnosis. Suspicious cytology alone is never used for case ascertainment.

Note: Cytology is the examination of cells rather than tissue. This would include sputum smears, bronchial brushings, bronchial washings, prostatic secretions, breast secretions, gastric fluids, spinal fluid, peritoneal fluid, urinary sediment, and cervical and vaginal smears.

11. In the absence of an exact date of initial diagnosis, record the best approximation. For vague dates, estimate the date of diagnosis for month and year using all available information. An approximate date is preferable to an unknown date of diagnosis. Refer to the table and examples below. Documentation that the exact date of diagnosis is not available in the medical record must be provided in *Summary Stage Documentation* text field.

12. Code the year and month of admission when there is no basis for estimation and document “Date of

DX unknown" in the *Summary Stage Documentation* text field. *This should be used only as a last resort.*

Note: Every resource available at the reporting facility must be reviewed in order to determine the date of diagnosis.

Example:
Patient admitted to your facility on April 26, 2013 with recurrent melanoma but the original date of diagnosis is unknown. Code the date of diagnosis as 201304. Record in the *Summary Stage Documentation* text field "Date of DX Unknown."

Table 5.1 Date of Initial Diagnosis – Date Estimates

DOCUMENTATION	DATE CODE/DESCRIPTION
Spring	Use April (04) for the month
Summer	Use July (07) for the month
Fall/Autumn	Use October (10) for the month
Winter	Determine if this means the beginning or the end of the year. Use December (12) or January (01) for the month as determined.
Early in Year	Use January (01) for the month
Middle of Year	Use July (07) for the month
Late in Year	Use December (12) for the month
Recently	Use the year and month of admission and leave the day blank. If patient was admitted during the first week of a month, use the previous month.
Several Months Ago	If the patient was not previously treated or if first course treatment started elsewhere was continued at the reporting facility, assume the case was first diagnosed three months before admission with day unknown (blank).
A Couple of Years	Code to two years earlier
A Few Years	Code to three years earlier

Examples:

a. A patient was admitted to your facility on March 15, 2013. The History and Physical states the patient has prostate carcinoma diagnosed about two months ago. Record the date of diagnosis as 201301.

b. A patient was admitted to your facility on September 10, 2013. The History and Physical states the patient has bone and brain metastasis from malignant melanoma diagnosed in the spring. Record the date of diagnosis as 201304.

c. On March 12, 2013, a mammogram reveals a mass in the upper outer quadrant of the patient's right breast. The radiologist's impression states: compatible with carcinoma. On March 20, 2013, the patient has an excisional breast biopsy that confirms infiltrating ductal carcinoma. Record the date of diagnosis as 20130312.

Morphology Type and Behavior (NAACCR Item #420, 430) **(ICD-O-2)** The International Classification of Diseases for Oncology, (ICD-O) 2nd Edition, is to be used for coding and reporting the

morphology and behavior of tumors diagnosed before January 1, 2001. **Adequate documentation of tumor cell type must be provided** in the **FINAL DIAGNOSIS** section of the reporting form. Use all pathology reports available; generally tissue from a resection or excision is most representative of the tumor's histology.

Morphology and Behavior (NAACCR Item #522, #523) (FORDS pgs. 120-121; SEER pgs. 75-77**) (ICD-O-3)**

Description
Identifies the microscopic structure of cells and the behavior of the tumor being reported.

Explanation
The histological (morphologic) type helps to determine staging and treatment options. It also assists in determining the disease course and prognosis, and in identifying multiple primaries. The behavior code is used by pathologists to describe whether tissue samples are benign (0), borderline (1), in situ (2), or malignant (3).

Coding Instructions

Morphology
1. Record the morphology code using the Alphabetic Index (ICD-O-3 pages 105–218) and the Numerical Index (ICD-O-3 pgs. 69–104). Review both of these sections of the ICD-O-3 to ensure accurate coding.

Note: For primaries diagnosed prior to January 1, 2001 use ICD-O-2.

2. Follow the coding rules outlined on pages 20–40 of ICD-O-3.

3. The term [obs] in ICD-O-3 indicates a diagnosis for which a better diagnostic term(s) is available, but which may still be used to code the cancer in certain circumstances. Obsolete terms are retained in ICD-O-3 for historical reference.

4. Adequate text documentation must be provided to support coding. Auto coding of the ICD-O-3 code description is not considered adequate text documentation.

Histology can be coded only after the determination of single vs. multiple primaries has been made. Refer to Multiple Primary and Histology (MP/H) rules to determine the number of primaries for solid tumors. For hematopoietic and lymphoid diseases refer to the *2012 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* at http://seer.cancer.gov/tools/heme/index.html.

MP/H Histology Coding Rules General Information

1. The 2007 histology coding rules replace all previous rules.

2. The rules are effective for cases diagnosed January 1, 2007 and after. Do not use these rules to abstract cases diagnosed prior to January 1, 2007.

3. The histology coding rules are available in the SEER website: http://seer.cancer.gov/tools/mphrules/download.html.

4. Rules are in hierarchical order within each section (Single Tumor and Multiple Tumors Abstracted as a Single Primary).

Note: Do not use these rules to determine case reportability, tumor grade, or behavior.

Note: For cases diagnosed prior to January 1, 2007 refer to Appendix D located on the TCR website: http://www.dshs.state.tx.us/tcr/2009crhb.shtm.

Coding Instructions for Hematopoietic Primaries
Beginning with cases diagnosed in 2012, use the *2012 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* at http://seer.cancer.gov/seertools/hemelymph/ for coding primary site, histology, and grade of hematopoietic and lymphoid tumors (M9590-9992). Use this manual to determine multiple primaries as well. For cases diagnosed between January 1, 2010 and December 31/2011 use the 2010 database at the same location.

For cases diagnosed prior to 2010 use the SEER table "Definitions of Single and Subsequent Primaries for Hematologic Malignancies" located in the 2009 TCR Cancer Reporting Handbook, Appendix E on the TCR website: http://www.dshs.state.tx.us/tcr/2009crhb.shtm#Appxonline.

Note: If the patient has a hematopoietic or lymphoid neoplasm diagnosed prior to 2010 and a new one diagnosed January 1, 2010 or later, use the 2010 or 2012 *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* as appropriate to determine multiple primaries.

Table 5.2 Behavior Codes

CODE	DESCRIPTION
0	Benign (Reportable for intracranial and CNS sites only)
1	Uncertain whether benign or malignant, borderline malignancy, low malignant potential, and uncertain malignant potential (Reportable for intracranial and CNS sites only)
2	Carcinoma in situ; intraepithelial; noninfiltrating; noninvasive
3	Malignant, primary and/or metastatic site (invasive)

Note: For cases diagnosed January 1, 2013 or later, gastrointestinal 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
Positive lymph nodes

Note: The TCR does not accept cases coded with a metastatic (/6) behavior code. If the only pathology specimen is from a metastatic site, code the appropriate histology code and the malignant behavior code /3. The primary site and its metastatic site(s) have the same basic histology. See *ICD-O-3*, pg 27.

Example:
A patient is diagnosed with metastatic brain tumors and a fine needle aspiration biopsy shows that the tumor is metastatic small cell carcinoma (8041/6). The pathology report indicates that the tumor originated in the lung. Code the primary site as lung and the morphology as small cell carcinoma (8041/3)

Behavior Coding Instructions

1. Behavior codes benign /0 and borderline /1 are reportable for intracranial and CNS sites only. These tumors are reportable to TCR for cases diagnosed in **2004** and forward. (C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753)

2. Clinical evidence alone cannot identify the behavior as in situ; the code must be based on pathologic examination and documentation.

3. Code the behavior as invasive /3 if any portion of the primary tumor is invasive no matter how limited.

4. Re-code the behavior as malignant (/3) when metastases are attributed to a tumor originally thought to be in situ (See page 77 of SEER Coding and Staging Manual 2013)

Example:
Pathology from mastectomy specimen: Large mass composed of intraductal carcinoma with a single focus of microinvasion. Code the behavior as infiltrating duct carcinoma (8500/3).

5. Code the behavior as in situ /2 if the pathology report describes the histology as in situ/2 and the ICD-O-3 histology is listed only with an invasive /3 behavior code.

6. Code the behavior as invasive /3 if the pathology report describes the histology as invasive /3 and the ICD-O-3 histology code is listed only with an in situ /2 behavior.

7. Certain histologies will never have in situ behaviors (8000–8005, 8020, 8021, 8331, 8332, 8800–9055, 9062, 9082, 9083, 9110–9493, 9501–9989).

8. If more than one behavior is reported, select the morphology code with the higher behavior code (the invasive tumor).

9. Refer to the following table.

Table 5.3 Behavior Codes

CODE	FIFTH DIGIT TERM	DESCRPIPTION
2	In situ and/or carcinoma in situ	Adenocarcinoma in an adenomatous polyp with no invasion of stalk
		Bowen disease (not reportable for C440–C449)
		Clark's Level I for melanoma (limited to epithelium)
		Comedocarcinoma, noninfiltrating (C50_)
2	Terms synonymous with in situ	Confined to epithelium
		AIN III (C211)
		Behavior code /2
		Hutchinson's melanotic freckle, NOS (C44_)
		Intracystic, non-infiltrating
		Intraductal
		Intraepidermal, NOS
		Intraepithelial, NOS
		Involvement up to, but not including the basement membrane
		Lentigo maligna (C44_)
		Lobular, noninfiltrating(C50_)
		Noninfiltrating
		Noninvasive
		No stromal invasion/involvement
		Papillary, non-infiltrating or intraductal
		Precancerous melanosis (C44_) Preinvasive
		Queyrat's erythroplasia (C60)
		Stage 0 (except Paget's disease (8540/3) of breast and colon or rectal tumors confined to the lamina propria)
		VAIN III (C529)
		VIN III (C51_)
3	Invasive	Invasive or microinvasive

Primary Site (NAACCR Item #400) (FORDS pg. 118; SEER pgs. 64-67)

Description
Identifies the primary site of the cancer.

Explanation
The primary site helps to determine stage and treatment options and shapes disease course and prognosis.

Refer to the Multiple Primary/Histology (MP/H) rules

http://seer.cancer.gov/tools/mphrules/download.html to determine the number of primaries for solid tumors. Use all of the available information to code the site.

Refer to the 2012 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual at *http://seer.cancer.gov/seertools/hemelymph/* for hematopoietic and lymphoid neoplasms diagnosed January 1, 2012 and forward. For cases diagnosed between January 1, 2010 and December 31, 2011 use the 2010 manual at the same location.

Adequate text documentation must be provided to support coding. Auto coding of the ICD-O-3 code description is not considered adequate text documentation. In general, when a primary site is preceded by carcinoma of…, or malignancy of…, code to that primary site.

See the *Coding Guidelines for Topography and Morphology* in the introduction of the ICD-O-3 for additional details. Primary site codes may be found in the *ICD-O-3 Topography*, *Numerical List Section* (*ICD-O-3*, page 43) and in the *Alphabetic Index* (*ICD-O-3*, page 105). The topography code consists of an initial character (the letter C) followed by two numeric digits, a decimal point, and one additional numeric digit. The decimal point is not entered as part of the code.

Example:
The pathology report says the primary site is the cardia of the stomach. The code (C160) is found in the *Alphabetic Index* under either "stomach" or "cardia." Enter the code as (C160); do not record the decimal point.

Note: The exact location of the primary tumor is not always stated in the pathology report or discharge diagnosis. It is necessary to review the entire medical record in order to obtain the most precise description of the primary site.

Example:
The pathology report states right breast resection specimen. The discharge diagnosis states carcinoma in the right breast. The History and Physical states examination of the right breast reveals a mass in the upper outer quadrant. **Code to the more detailed description from the History and Physical, upper outer quadrant of the right breast (C504).**

Coding Instructions
1. Code the site in which the primary tumor originated, even if it extends into an adjacent "subsite."

Examples:
a. Final diagnosis is adenocarcinoma of the upper lobe of the right lung. *Code the topography to lung, upper lobe (C341).*

b. Pathology report shows adenocarcinoma arising in an ectopic patch of endometriosis on the sigmoid colon. *Code primary site to sigmoid colon (C187) where the cancer originated.*

c. Patient has a right branchial cleft cyst; the pathology report identifies an adenocarcinoma arising in an ectopic focus of thyroid tissue within the branchial cleft cyst. Thyroidectomy pathology is negative. *Code primary site to branchial cleft (C104).*

d. The patient had a total hysterectomy with a bilateral salpingo-oophorectomy ten years ago for

non- cancer reasons. She now has widespread cystadenocarcinoma in the peritoneum. *Code the primary site to peritoneum, NOS (C482).* (The chart may or may not state that the patient has extra-ovarian or primary peritoneal carcinoma).

e. The patient has a 4 cm tumor in the right breast. The tumor originated in the upper inner quadrant and extends into the lower inner quadrant. *Code primary site to upper inner quadrant of breast (C502).*

2. Code the last digit of the primary site code to "8" when a single tumor overlaps an adjacent subsite(s) of an organ and the point of origin cannot be determined.

Example:
The patient has a 5 cm tumor overlapping the base of tongue and anterior 2/3 of tongue. Code the primary site to C028 (overlapping lesion of tongue).

Note: Do not use 8 when the primary site of origin is known or when more than one tumor is identified in different subsites.

Note: For lymphomas, if multiple lymph node chains are involved and the involved chains are in different lymph node regions, code C778 (lymph nodes of multiple regions). If the lymph nodes involved are in the same ICD-O-3 primary site code, code the primary site to lymph nodes of the specified nodal region. For example, if the only lymph node regions involved are the parotid, submandibular and supraclavicular lymph nodes, code the primary site C770.

3. Code the last digit of the primary site code to 9 for single primaries, when **multiple tumors arise in different subsites** of the same anatomic site and the point of origin cannot be determined.

Examples:

a. During a TURB, the physician describes multiple papillary tumors in the bladder neck (C675) and the lateral wall of the bladder (C672). *Code the primary site as bladder, NOS (C679).*

b. Patient has an infiltrating duct carcinoma in the upper outer quadrant (C504) of the right breast and another infiltrating duct carcinoma in the lower inner (C503) quadrant of the right breast. *Code the primary site as breast, NOS (C509).*

4. Some histology/behavior terms in *ICD-O-3* have **a related site code** in parenthesis; e.g., hepatoma (C220).

Note: Code the site as documented in the medical record and ignore the suggested ICD-O-3 code when a different primary site is specified in the medical record.

Example:
The pathology report says "infiltrating duct carcinoma of the head of the pancreas." The listing in *ICD-O-3* is infiltrating duct carcinoma 8500/3 (C50). Code the primary site to head of pancreas, C250, NOT to breast as suggested by the *ICD-O-3*.

Note: Use the site code suggested by ICD-O-3 when the primary site is the same as the site code suggested or the primary site is unknown.

Examples:

a. The biopsy is positive for hepatoma, but there is no information available about the primary site. *Code the primary site to liver (C220) as suggested by ICD-O-3.*

b. The patient has an excision of the right axillary nodes which reveals metastatic infiltrating duct carcinoma. The right breast is negative. The *ICD-O-3* shows duct carcinoma (8500) with a suggested site of breast (C50_). *Code the primary site as breast, NOS (C509).*

5. Code the primary site, not the metastatic site. If a tumor is metastatic and the primary site is unknown, code the primary site as unknown (C809).

Note: If at any time a specific primary site is identified, change the site code from Unknown Primary (C809) to the specified primary site. Check with the TCR regional office for the appropriate procedure if this case has already been submitted to the TCR.

6. When the medical record does **not** contain **enough information** to assign a primary site:

a. Consult a physician advisor to assign the site code.

b. Use the following table when the described histologies appear only with an ill-defined site description (such as "abdominal" or "arm"). Code to the tissue in which such tumors arise rather than the ill-defined region (C76_) of the body, which contains multiple tissues.

Table 5.4 Primary Site Codes

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

c. For other histologies use the NOS category for the organ system or the Ill Defined Sites (C760–C768) if the physician advisor cannot identify a primary site.

d. Code Unknown Primary Site (C809) if there is not enough information to assign an NOS or Ill-Defined Site Category.

Common Metastatic Sites

If the final diagnosis reflects carcinoma of one of the common metastatic sites listed below, carefully review documentation in the medical record to confirm the primary site.

- Bone
- CNS Sites (brain, spinal cord, meninges)
- Liver
- Lymph Nodes (excluding lymphoma)
- Pericardium (excluding mesothelioma)
- Pleura (excluding mesothelioma)
- Peritoneum
- Retroperitoneum

Leukemia and Lymphoma Guidelines

Refer to *2012 Hematopoietic and Lymphoid Neoplasms Case Reportability and Coding Manual* at http://seer.cancer.gov/seertools/hemelymph/ for cases diagnosed January 1, 2012 and forward. For cases diagnosed between January 1, 2010 and December 31, 2011 use the 2010 manual at the same location.

1. Code leukemia primaries to bone marrow (C421); blood cells originate in the bone marrow.

2. Malignant histiocytosis/Systemic histiocytosis is coded to bone marrow (C421).

Definitions:

Nodal lymphoma: A lymphoma originating in lymph nodes.

Extranodal lymphoma: Lymphoma originating in tissue or organ other than lymph nodes. Lymphatic system organs may be extranodal, for example, spleen is a lymphatic system organ and is also extranodal.

Extralymphatic: Originating in tissue or an organ that is not a part of the lymphatic system, for example, lymphoma of the stomach or colon.

Lymphatic system: An umbrella term that includes all lymphoid tissues: lymph nodes, spleen, thymus, tonsils, Waldeyer's ring, and Peyer's patches of the small intestine.

Lymphoma Coding Instructions

1. When a single lymph node chain is involved, code that chain as the primary site.

2. When multiple lymph node chains are involved at the time of diagnosis, do not simply code the lymph node chain that was biopsied.

a. If it is possible to determine where the disease originated, code the primary site to that lymph node chain.

b. If multiple lymph node chains are involved, and all involved chains are located in the same ICD-O-3 primary site code, code the primary site to lymph nodes of the specified nodal region (C77_).

c. If multiple lymph node chains are involved and the involved chains are in different lymph node regions, code C778 (lymph nodes of multiple regions).

3. When the lymphoma is **extranodal** and is:

a. Confined to the organ of origin, code the organ of origin.

Example:
Pathology from a stomach resection shows lymphoma. No other pathologic or clinical disease is identified. *Code the primary site as stomach, NOS (C16.9). Use the surgery codes for stomach (C16.9) and use the Lymphoma CS schema to code CS data items.*

b. Present in an **extranodal organ/site and** in that organ/site's **regional lymph nodes** code the extranodal organ/site as the primary site. (See Module 7, rule PH36 in the *2012 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual)*

Lymphomas that are primary in an extranodal organ/site may metastasize to that organ/site's regional lymph nodes. In rare cases a lymphoma may spread from the lymph node to an extranodal site or extralymphatic organ by direct extension.

Example: Lymphoma is present in the lung and hilar lymph nodes. *Code the primary site to lung (C34.9), use the surgery codes for lung (C34.9) and use the Lymphoma CS schema to stage.*

c. Present in **extranodal organ(s)/site and non-regional lymph nodes**, consult the physician to determine the primary site. If a site cannot be determined, code primary site to lymph nodes, NOS (C779). This situation will be very rare. (See Module 7, rule PH35 in the *2012 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual*)

Note: Approximately 25% of lymphomas originate in extra-nodal sites such as the stomach, intestine, or breast. A lymphoma primary originating in an organ or extra-nodal site should be coded to the organ or extra-nodal site and the surgery codes for that site should be used. The code for the primary site, in some cases, may not be the biopsy site. Always use the Lymphoma CS schema even if the lymphoma did not originate in the lymph nodes.

4. If the primary site is unknown or not given:

a. Code retroperitoneal lymph nodes if described as retroperitoneal mass (C772)

b. Code inguinal lymph nodes if described as inguinal mass (C774)

c. If the primary site is unknown code lymph nodes, NOS (C779)

Exception: Code unknown primary site (C809) only when there is no evidence of lymphoma in lymph nodes and/or the medical record documents that the physician suspects that it is an extranodal lymphoma. This situation will be very rare.

Esophagus Coding Instructions
See Appendix A for site-specific coding instructions for Esophagus.

Kaposi Sarcoma Coding Instructions:
Kaposi sarcoma is a rare condition. When not AIDS-related, it usually presents as localized disease with an easily recognized primary site. AIDS-related Kaposi sarcoma usually presents as a disseminated disease with involvement of **mucosal surfaces, visceral surfaces of organs, and skin**. It is important to review consecutive records carefully to determine the extent of involvement at diagnosis. Review of a single record may reveal only the site being treated during that admission.

1. Code Kaposi Sarcoma to the site in which it arises.

2. If the Kaposi Sarcoma is present in the skin and another site simultaneously, code to the specified skin site, (C44_).

3. If the primary site is unknown or cannot be determined, code skin, NOS (C449)**.**

Melanoma Coding Instructions
Code to Skin, NOS (C449) if a patient is diagnosed with metastatic melanoma and the primary site is not identified.

Sarcoma Coding Instructions:
The majority of sarcomas arise in mesenchymal or connective tissues that are located in the musculoskeletal system. The musculoskeletal system includes the fat, muscles, blood vessels, deep skin tissues, nerves, bones and cartilage. The default code for sarcomas of unknown primary site is **C499, soft tissue, NOS,** rather than C809.

Sarcomas may also arise in the walls of hollow organs and in the viscera covering an organ. Code the primary site to the organ of origin.

Example:
The pathology identifies a leiomyosarcoma of the uterus. Code the site to uterus, NOS (C559).

Additional Guidelines for Coding Primary Site:
A subareolar/retroareolar carcinoma is coded to the central portion of the breast (C501), which indicates that the tumor arose in the breast tissue beneath the nipple, not the nipple itself.

Mycosis Fungoides is coded to skin (C44_).

Intestinal type adenocarcinoma (8144) is a gastric histology term and is not listed in the WHO Histological Classification of Tumors of the Colon and Rectum. This code should not be used for colon and rectum primaries.

Grade of Tumor (NAACCR Item #440) (FORDS pgs. 123-124; SEER pgs. 78-81)

Description
Describes how much or how little the tumor cells resemble the parent tumor (organ of origin). It describes how well you can differentiate between normal cells and tumor cells. Well differentiated (Grade 1) is the most like normal tissue, and undifferentiated (Grade 4) is the least like normal tissue.

Explanation
Tumor grade is a system used to classify cancer cells in terms of how abnormal they look and how quickly they are likely to grow and metastasize.

Note: Terms such as "anaplastic", "well differentiated", and "undifferentiated" are sometimes essential parts of morphologic terms for neoplasms in ICD-O-3 (as well as the phenotype [T-cell and B-cell] for lymphomas and leukemias). These terms must be reported with the appropriate grade code.

Examples:

8020/3**4**	Carcinoma, undifferentiated
8021/3**4**	Carcinoma, anaplastic
8331/3**1**	Follicular adenocarcinoma, well differentiated
8332/3**1**	Follicular carcinoma, well differentiated
8332/3**2**	Follicular adenocarcinoma, moderately differentiated
8332/3**2**	Follicular carcinoma, moderately differentiated
8585/3**1**	Thymic carcinoma, well differentiated
8631/3**3**	Sertoli-Leydig cell tumor, poorly differentiated
8634/3**3**	Sertoli-Leydig cell tumor with heterologous elements, poorly differentiated
8805/3**4**	Sarcoma, undifferentiated
8851/3**1**	Liposarcoma, NOS, well differentiated
9062/3**4**	Seminoma, anaplastic
9082/3**4**	Malignant teratoma, undifferentiated
9082/3**4**	Malignant teratoma, anaplastic
9083/3**2**	Malignant teratoma, intermediate type
9187/3**1**	Intraosseous osteosarcoma, well differentiated
9362/3**2**	Pineal parenchymal tumor, intermediate differentiation
9382/3**4**	Oligoastrocytoma, anaplastic
9390/3**4**	Choroid plexus papilloma, anaplastic (synonym of malignant)
9392/3**4**	Ependymoma, anaplastic
9401/3**4**	Astrocytoma, anaplastic
9451/3**4**	Oligodendroglioma, anaplastic
9505/3**4**	Ganglioglioma, anaplastic
9511/3**1**	Retinoblastoma, differentiated type
9512/3**4**	Retinoblastoma, undifferentiated

Note: When coding the ICD-O-3 morphology code, do not code the 6th digit. This is coded in the data item *Grade of Tumor*.

Coding Instructions
1. Code grade/differentiation according to the rules in the *ICD-O-3,* (pages 30-31, 67).

2. For instructions to code grade for hematopoietic and lymphoid neoplasms diagnosed January 1, 2012 and later refer to the *2012 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* at http://seer.cancer.gov/seertools/hemelymph/. For cases diagnosed between January 1, 2010 and December 31, 2011 use the 2010 manual at the same location.

Note: Do not use Table 13 on pages 16-17 of ICD-O-3 to determine grade for Hematopoietic and Lymphoid neoplasms. The table is outdated.

3. For sites other than breast, prostate and kidney, code the tumor grade using the following priority order: 1) terminology; 2) histologic grade; 3) nuclear grade.

4. If grade is not stated in the final pathology diagnosis, use the information in the microscopic section, addendum, or comment to code grade.

5. If more than one grade is recorded for a single tumor, code the highest grade, even if it is a focus.

Example:
Pathology report reads: Grade II adenocarcinoma with a focus of undifferentiated adenocarcinoma. Code the tumor grade as grade 4.
6. Code the grade from the primary tumor only, never from a metastatic site or a recurrence.

7. Code the grade for all unknown primaries to 9 (unknown grade) unless grade is explicit by histology, for example, anaplastic carcinoma (grade = 4).

8. Code the grade of the invasive component when the tumor has both in-situ and invasive portions. If the invasive component grade is unknown, code the grade as 9 (unknown).

9. Code the information from the consult if the specimen is sent to a specialty pathology department for a consult.

10. If there are multiple pathology consults, ask the pathologist or physician advisor to determine which information should be used.

11. Do not code the grade assigned to dysplasia; for example high grade dysplasia (adenocarcinoma in situ) would be coded to 9 (unknown grade).

12. FIGO (International Federation of Obstetrics and Gynecology) grades are not coded. For a diagnosis that includes a commonly used differentiation term with a FIGO grade, such as moderately differentiated FIGO grade II, disregard the FIGO grade and code according to the term moderately differentiated.

13. Code the grade or differentiation from the pathology report prior to any neoadjuvant treatment. If there is no grade recorded prior to neoadjuvant treatment, assign code 9.

14. For the following sites see Appendix A for site specific coding instructions for grade. Site specific instructions take priority over general instructions.

- Colon
- Sarcoma
- Breast
- Kidney
- Prostate
- Brain (Astrocytoma)

Note: In 2013 CoC will not require coding of the field *Grade (Grade /Differentiation)* in some instances. TCR will continue to require coding of this field for all cases.

Coding Grade for Cases without Pathology or Cytology Confirmation
Code the grade of tumor stated on a Magnetic Resonance Imaging (MRI) or Positron Emission Tomography (PET) report if there is no tissue diagnosis (pathology or cytology report).

In situ Tumors
In situ tumors are not usually graded. Code the grade if it is specified for an in situ lesion unless there is an invasive component. Do not code the in situ grade if the tumor has both in situ and invasive components.

Table 5.5 Grade or Cell Indicator Codes

CODE	GRADE	DESCRIPTION
1	Grade I	Well differentiated; differentiated, NOS
2	Grade II	Moderately differentiated, moderately well differentiated, intermediate differentiation, partially well differentiated, partially differentiated, low grade NOS
3	Grade III	Poorly differentiated, dedifferentiated, moderately undifferentiated, relatively undifferentiated, slightly undifferentiated, medium grade NOS
4	Grade IV	Undifferentiated; anaplastic, high grade NOS
CELL INDICATOR FOR LEUKEMIAS AND LYMPHOMAS		
5		T-cell; T-precursor
6		B-cell; pre-B; B-precursor
7		Null cell; non T-non- B
8		NK (natural killer) cell
FOR USE IN ALL HISTOLOGIES		
9		Grade/differentiation not determined, not stated, not applicable; cell type not determined, not stated, not applicable

Table 5.6 Terminology Conversion Table

DESCRIPTION	GRADE	ICD-O-3 MORPHOLOGY 6TH DIGIT CODE
Differentiated, NOS	I	1
Well differentiated	I	1
Fairly well differentiated	II	2
Intermediate differentiation	II	2
Low grade	I–II	2
Mid differentiated	II	2
Moderately differentiated	II	2
Moderately well differentiated	II	2
Partially differentiated	II	2
Partially well differentiated	I–II	2
Relatively or generally well differentiated	II	2
Medium grade, intermediate grade	II–III	3
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
High grade	III–IV	4
Undifferentiated, anaplastic, not differentiated	IV	4
Non-high grade		9

Two-Grade System

Some cancers are graded using a two-grade system, for example, colon cancer. If the grade is listed as 1/2 or as low grade, assign code 2. If the grade is listed as 2/2 or as high grade, assign code 4.

Table 5.7 Two-Grade Conversion Table

DIFFERENTIATION/DESCRIPTION	GRADE	ICD-O-3 MORPHOLOGY 6TH DIGIT CODE
Low grade	1/2, I/II	2
High grade	2/2, II/II	4

Three-Grade System

There are several sites for which a three-grade system is used, such as peritoneum, endometrium, fallopian tube, prostate, bladder and soft tissue sarcoma. The patterns of cell growth are measured on a scale of 1, 2, and 3 (also referred to as low, medium, and high grade). This system measures the proportion of cancer cells that are growing and making new cells and how closely they resemble the cells of the host tissue. Thus, it is similar to a four-grade system, but simply divides the spectrum into 3 rather than 4 categories (see *Three-Grade Conversion Table* below). The expected outcome is more

favorable for lower grades.

If a grade is written as 2/3 that means this is a grade 2 of a three-grade system. Do not simply code the numerator. Use the following table to convert the grade to SEER codes:

Table 5.8 Three-Grade Conversion Table

DIFFERENTIATION/DESCRIPTION	GRADE	ICD-O-3 MORPHOLOGY 6TH DIGIT CODE
Low grade	1/3, I/III	2
Intermediate grade	2/3, II/III	3
High grade	3/3, III/III	4

Note: Do not use the Three-Grade Conversion Table for breast primaries.

Grade Path Value (NAACCR Item #441) (FORDS pg. 126)

Description
This field documents the numerator or first number of a tumor grade reported in a 2, 3, or 4 grade system. It supplements but does not replace the field *Grade/Differentiation* (NAACCR Item #440), which is part of the ICD-O-3 morphology code structure and may be converted from another grading system or coded by a different set of rules. *Grade Path Value* is paired with *Grade Path System* to describe the original grade of the tumor.

Coding Instructions
1. Code the histologic grade or differentiation reported in the pathology report or a physician's statement in the medical record, in that order.

a. Code this field from the same tissue used to code the sixth digit of the ICD-O-3 morphology code (*Grade/Differentiation*). This field identifies how the original grade of the tumor was described.

b. Do not convert the terms well, moderately, or poorly differentiated, low/high, or anaplastic into codes in this field.

c. Code the histologic grade/differentiation in priority over a nuclear or architectural grade.

d. If grade is described in the medical record as a fraction (x/y), this data field is the numerator. In other words, this field is the first or upper number of a grade expressed in two parts.

Examples:

- Synoptic report states grade ii of iii. *Code Grade Path Value as 2.*
- Final pathologic diagnosis listed as grade 1/4. *Code Grade Path Value as 1.*
- Microscopic description reports high grade III of III. *Code Grade Path Value as 3.*

e. Do not report grading systems such as Bloom-Richardson for breast or Fuhrman for kidney or Gleason for prostate or WHO grade as coded values in this field.

f. The code in this field cannot be greater than the corresponding code in *Grade Path System*.

g. For lymphomas and hematopoietic malignancies, this field is blank.

Table 5.9 Grade Path Value Codes

CODE	DESCRIPTION
1	Recorded as Grade I or 1
2	Recorded as Grade II or 2
3	Recorded as Grade III or 3
4	Recorded as Grade IV or 4
Blank	No 2, 3, or 4 grade system available. Unknown.

Grade Path System (NAACCR Item #449) (FORDS pg. 125)

Description
This field documents the denominator or second number of a tumor grade reported in a 2, 3, or 4 grade system. It supplements but does not replace the field Grade/Differentiation (NAACCR Item #440), which is part of the ICD-O-3 morphology code structure and may be converted from another grading system or coded by a different set of rules. Grade Path System is paired with Grade Path Value to describe the original grade of the tumor.

Explanation
This item is used to show whether a two, three or four grade system was used in the pathology report to describe the grade. This item is used in conjunction with Grade Path Value (NAACCR Item #441)

Coding Instructions
1. Code the grading system reported in the medical record. Do not convert the grade described in the pathology report.

a. Code this field from the same tissue used to code the sixth digit of the ICD-O-3 morphology code (*Grade/Differentiation*). This field identifies how the original grade of the tumor was described.

b. If grade is described in the medical record as a fraction (x/y), this data field is the denominator

Examples:

- Synoptic report states grade ii of iii. Code Grade Path System as 3.
- Final pathologic diagnosis listed as grade 1/4. Code Grade Path System as 4.
- Microscopic description reports high grade III of III. Code Grade Path System as 3.

c. Leave this field blank if another grading system in used in the pathology report. For example, do not report grading systems such a Bloom-Richardson for breast or Fuhrman for kidney or Gleason for prostate or WHO graded as coded values in this field.

d. For lymphomas and hematopoietic malignancies, this field is blank.

Table 5.10 Grade Path System Codes

CODE	DESCRIPTION
2	Recorded as Grade II or 2
3	Recorded as Grade III or 3
4	Recorded as Grade IV or 4
Blank	No 2,3, or 4 grade system available Unknown

Laterality (NAACCR Item #410) (FORDS pg. 119; SEER pgs. 68-70)

Description
Identifies the side of a paired organ or the side of the body where the tumor originated.

Explanation
Aids in staging and extent of disease information, and may indicate the number of primaries.

Coding Instructions
1. Starting with cases diagnosed January 1, 2004 and later, laterality is coded for specified invasive, benign, and borderline primary intracranial and CNS tumors. See Paired Organ Sites Table beginning on page 113.

2. Non-paired sites are coded to 0.

3. Unknown (C809) and Ill-defined (C760–C768) sites are coded to 0.

4. Assign code 9 when the disease originated in a paired site, but the laterality is unknown.

Example:
Admitting history says patient was diagnosed with lung cancer based on positive sputum cytology. Patient is treated for painful bony metastases. There is no information about laterality in the diagnosis of this lung cancer. Assign code 9.

5. **Do not** code metastatic sites as bilateral involvement.

Example:
Patient is diagnosed with adenocarcinoma of the left lung and the physician states patient has metastasis to the right lung. Assign laterality code 2, left origin of primary.

6. For primaries of in situ behavior, if laterality is not known, code to 3 (only one side involved, right or left origin of primary not indicated). Laterality for in situ behavior cannot be coded to 9 or 4.

7. Assign code 3 if laterality is unknown but the tumor is confined to a single side of a paired organ.

Example:
Pathology report: Patient has a 2 cm carcinoma in the upper pole of the kidney. Code laterality as 3 because there is documentation that the disease exists in only one kidney, but it is unknown if the disease originated in the right or left kidney.

8. Assign code 5 for a midline tumor of a paired site.

Note: Midline for code 5 refers to the point where the right and left sides of paired organs come into direct contact and a tumor forms at that point such as skin of trunk (C445). Most paired sites cannot develop midline tumors.

Example:
A melanoma of the skin of back is described as midline. Record laterality as 5.
Non-paired sites may be coded right or left, if appropriate. Otherwise, code non-paired sites 0.

Table 5.11 Laterality Codes

CODE	DESCRIPTION
0	Not a paired site
1	Right origin of primary
2	Left origin of primary
3	Only one side involved, right or left origin of primary not indicated
4	Bilateral involvement at time of diagnosis, lateral origin unknown for a single primary; or: Both ovaries simultaneously involved with a single histology Bilateral retinoblastomas Bilateral Wilms' tumors **Note**: If both lungs have nodules or tumors and the lung of origin is not known, assign code 4
5	Paired site: midline tumor
9	Unknown site; paired site, lateral origin unknown

Bilateral Sites
Laterality must be recorded for the following bilateral sites. Only major headings are listed. Laterality should be recorded for all anatomic sub-sites included in *ICD-O-3* unless specifically excluded. Such exclusions are coded 0.

Code laterality using codes 1–5 or 9 for all of the sites listed in the following table:

Table 5.12 Bilateral Site Codes

PAIRED ORGAN SITES - ALPHABETIC ORDER	
PRIMARY SITE	**ICD-O-3 CODE**
Acoustic nerve	C724
Adrenal gland [cortex, medulla]	C740–C749
Breast	C500–C509
Carotid body	C754
Cerebral meninges, NOS	C700
Cerebrum	C710
Conjunctiva, lacrimal gland, orbit, cornea, retina, choroid, ciliary body, iris, sclera, lens, eyeball	C690

PAIRED ORGAN SITES - ALPHABETIC ORDER	
PRIMARY SITE	**ICD-O-3 CODE**
Connective, subcutaneous and other soft tissues of lower limb & hip	C492
Connective, subcutaneous and other soft tissue of upper limb & shoulder	C491
Cranial nerve, NOS	C725
Epididymis	C630
Fallopian tube	C570
Frontal lobe	C711
Frontal sinus	C312
Kidney, NOS	C649
Long bones of upper limb, scapula and associated joints	C400
Long bones of lower limb and associated joints	C402
Lung	C341–C349
Main bronchus [excluding carina]	C340
Maxillary sinus [antrum]	C310
Middle ear [tympanic cavity]	C301
Nasal cavity [excluding nasal cartilage and nasal septum code 0]	C300
Occipital lobe	C714
Olfactory nerve	C722
Optic nerve	C723
Ovary	C569
Overlapping lesion of the eye and adnexa; Eye, NOS; Eye and lacrimal Gland	C690–C699
Parietal lobe	C713
Parotid gland	C079
Pelvic Bones and associated joints [excluding sacrum, coccyx and symphysis pubis - code 0]	C414
Peripheral nerves and autonomic nervous system of lower limb and Hip	C472
Peripheral nerves and autonomic nervous system of upper limb and shoulder	C471
Pleura	C384
Renal pelvis	C659
Rib, clavicle, and associated joints [excluding sternum - code 0]	C413
Short bones of upper limb and associated joints	C401
Short bones of lower limb and associated joints	C403
Skin of external ear	C442
Skin of eyelid	C441
Skin of other and unspecified parts of face [midline code 5]	C443
Skin of upper limb and shoulder	C446
Skin of lower limb and hip	C447
Skin of trunk [midline code 5]	C445

PAIRED ORGAN SITES - ALPHABETIC ORDER	
PRIMARY SITE	**ICD-O-3 CODE**
Spermatic cord	C631
Sublingual gland	C081
Submandibular gland	C080
Temporal lobe	C712
Testis	C620–C629
Tonsil, NOS and Overlapping lesion of Tonsil	C098–C099
Tonsillar fossa	C090
Tonsillar pillar	C091
Ureter	C669

Table 5.13 Bilateral Site Codes

PAIRED ORGAN SITES - NUMERICAL ORDER	
ICD-O-3 CODE	**PRIMARY SITE**
C079	Parotid gland
C080	Submandibular gland
C081	Sublingual gland
C090	Tonsillar fossa
C091	Tonsillar pillar
C098	Overlapping lesion of tonsil
C099	Tonsil, NOS
C300	Nasal cavity [excluding nasal cartilage and nasal septum code 0]
C301	Middle ear [tympanic cavity]
C310	Maxillary sinus [antrum]
C312	Frontal sinus
C340	Main bronchus [excluding carina]
C341–C349	Lung
C384	Pleura
C400	Long bones of upper limb, scapula, and associated joints
C401	Short bones of upper limb and associated joints
C402	Long bones of lower limb and associated joints
C403	Short bones of lower limb and associated joints
C413	Rib and clavicle [excluding sternum code 0]
C414	Pelvic bones [excluding sacrum, coccyx, and symphysis pubis code 0]
C441	Skin of eyelid
C442	Skin of external ear
C443	Skin of other and unspecified parts of face [midline code 5]

PAIRED ORGAN SITES - NUMERICAL ORDER	
ICD-O-3 CODE	**PRIMARY SITE**
C445	Skin of trunk [midline code 5]
C446	Skin of upper limb and shoulder
C447	Skin of lower limb and hip
C471	Peripheral nerves and autonomic nervous system of upper limb and shoulder
C472	Peripheral nerves and autonomic nervous system of lower limb and hip
C491	Connective, subcutaneous, and other soft tissues of upper limb and shoulder
C492	Connective, subcutaneous, and other soft tissues of lower limb and hip
C500–C509	Breast
C569	Ovary
C570	Fallopian tube
C620–C629	Testis
C630	Epididymis
C631	Spermatic cord
C649	Kidney, NOS
C659	Renal pelvis
C669	Ureter
C690–C699	Eye and adnexa
C700	Cerebral meninges , NOS
C710	Cerebrum [effective with cases diagnosed 01/01/2004]
C711	Frontal lobe [effective with cases diagnosed 01/01/2004]
C712	Temporal lobe [effective with cases diagnosed 01/01/2004]
C713	Parietal lobe [effective with cases diagnosed 01/01/2004]
C714	Occipital lobe [effective with cases diagnosed 01/01/2004]
C722	Olfactory nerve [effective with cases diagnosed 01/01/2004]
C723	Optic nerve [effective with cases diagnosed 01/01/2004]
C724	Acoustic nerve [effective with cases diagnosed 01/01/2004]
C725	Cranial nerve, NOS [effective with cases diagnosed 01/01/2004]
C740–C749	Adrenal gland [cortex, medulla]
C754	Carotid body

Notes:

a. A laterality code of 1–5 or 9 **must** be assigned for the above sites except as noted. If the site is not listed on the table, assign code 0 for laterality.

b. All malignant primary brain and CNS tumors diagnosed **prior to 2004** are coded laterality 0, not a paired site.

c. Never use code 4 for bilateral primaries for which separate abstracts are prepared, or when the side of origin is **known** and the tumor has spread to the other side. Code 4 is seldom used

EXCEPT for the following diseases:

- Both ovaries involved simultaneously, single histology
- Bilateral retinoblastoma
- Bilateral Wilms tumors

Example:
A left breast primary with metastasis to the right breast is coded to 2 (left). This would **not** be coded to 4 (bilateral).

Note: Sometimes the physician may describe the site of the tumor in an organ as right or left. This is a descriptive term and does not refer to a bilateral site or organ.

Example:
Patient admitted for surgical resection of tumor in right colon. Code to 0, not a paired site. Do not code to 1. Right colon refers to the ascending colon. The colon is not a paired site.

Final Diagnosis – Morphology/Behavior, Grade, Primary Site, and Laterality Documentation
(NAACCR ITEMS #2580 [Final Diagnosis (Primary, Laterality)], #2590 [Final Diagnosis (Morphology, Behavior, Grade)]

Text to support morphology/behavior, grade, primary site, and laterality codes **must** be provided.

Documenting Instructions
1. Record the morphology/behavior, grade, primary site, and laterality descriptions.

2. Do not use the generic ICD-9-CM code statement found on the face sheet.

Examples:

a. **Morphology:** Moderately well differentiated mucin-producing adenocarcinoma
Primary Site: Colon, ascending

b. **Morphology:** Grade 3, infiltrating ductal and lobular carcinoma
Primary Site: Right breast, upper outer quadrant

c. **Morphology:** Anaplastic astrocytoma
Primary Site: Brain, frontal-parietal lobe

d. **Morphology:** Intermediate grade large cell carcinoma
Primary Site: Left lung lower lobe

Lymph-Vascular Invasion (NAACCR Data Item 1182) (FORDS pg 127) (CS Manual Vs 02.04 Part 1 Section 1 pg 82)

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.

Explanation
Lymph-vascular invasion is an indicator of prognosis. This field is used by the CS algorithm to map AJCC T for some primary sites.

Note: TCR collects this data item only for Penis (C60) and Testis (C62)

Coding Instructions
1. Code from pathology report(s). Code the absence or presence of lymph-vascular invasion as described in the medical record.

a. The primary sources of information about lymph-vascular invasion are the pathology check lists (synoptic reports) developed by the College of American Pathologists. If the case does not have a checklist or synoptic report, code from the pathology report or a physician's statement, in that order.

b. Do not code perineural invasion in this field.

c. Information to code this field can be taken from any specimen from the primary tumor.

d. If lymph-vascular invasion is identified anywhere in the resected specimen, it should be coded as present/identified.

2. Use of codes:

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

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

Note: Synonyms for lymph-vascular invasion include LVI, lymphovascular invasion, vascular invasion, blood vessel invasion, and lymphatic invasion. Lymph node involvement is **not** the same as lymph-vascular invasion.

c. Use code 9 when:
- There is no microscopic examination of a primary tissue specimen.
- The primary site specimen is cytology only or a fine needle aspiration.
- The biopsy is only a very small tissue sample.

- It is not possible to determine whether lymph-vascular invasion is present.
- The pathologist indicates the specimen is insufficient to determine lymph-vascular invasion.
- Lymph-vascular invasion is not mentioned in the pathology report.

Table 5.14 Lymph-Vascular Invasion Codes

CODE	DESCRIPTION
0	Lymph-vascular invasion not present (absent)/Not identified
1	Lymph-vascular invasion present/Identified
8	Not applicable
9	Unknown if lymph-vascular invasion present Indeterminate

Diagnostic Confirmation (NAACCR ITEM #490) (FORDS pg. 128-130); SEER pgs. 71-73)

Description
Records the best method of diagnostic confirmation of the cancer being reported at any time in the patient's history.

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

Coding Instructions for Solid Tumors
1. 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.

2. Change to a lower code if at ANY TIME during the course of disease the patient has a diagnostic confirmation that has a higher priority. There is no time limit for this field.

3. If diagnosed elsewhere, copies of the previous pathology or radiology reports included in the medical record may be used to code this field.

4. All diagnostic reports in the medical record must be reviewed to determine the most definitive method used to confirm the diagnosis of cancer. This review must cover the entire medical history in regard to the primary tumor. If diagnosed prior to admission to the reporting facility, review the history section of the record to identify information regarding previous diagnostic tests and treatments.

5. If the information in the medical record indicates a biopsy or resection of the tumor has been performed, assume the diagnostic confirmation is histological even if the pathology report is not available.

Example:
A patient comes in for a bone scan for staging of a known prostate cancer. It is noted in the record that the patient had a prostate biopsy two weeks prior. Use diagnostic confirmation code 1, positive

histology.

6. Assign **code 1** when the microscopic diagnosis is based on:

   a. Tissue specimens from biopsy, surgery, autopsy or Dilatation & Curettage

   b. Bone marrow specimens (aspiration and biopsy)

7. Assign **code 2** when the microscopic diagnosis is based on:

   a. Examination of cells (rather than tissue) including but not limited to: 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.

   b. Paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid

8. Assign **code 4** when there is information that the diagnosis of cancer was microscopically confirmed, but the type of confirmation is unknown.

9. Assign **code 5** when the diagnosis of cancer is based on laboratory tests or marker studies **with** a clinical diagnosis for that specific cancer.

Examples:

   a. The patient has elevated alpha-fetoprotein **with** a clinical diagnosis of liver cancer.

   b. The workup for a prostate cancer patient is limited to a highly elevated PSA and the physician diagnoses and/or treats the patient based only on that PSA.

10. Assign **code 6** when the diagnosis is based only on:

   a. The surgeon's operative report from a surgical exploration or endoscopy such as colonoscopy, mediastinoscopy, or peritoneoscopy and no tissue was examined.

   b. Gross autopsy findings (no tissue or cytologic confirmation).

11. Assign **code 7** when the only confirmation of malignancy was diagnostic imaging such as computerized axial tomography (CT scans), magnetic resonance imaging (MRI scans), or ultrasounds/sonography.

12. Assign **code 8** when the case was diagnosed by any clinical method not mentioned in preceding codes.

13. Assign **code 9** when it is unknown how the diagnosis was confirmed. Death certificate only cases will be assigned **code 9**.

Note: The diagnostic code must be changed to the lower (more specific) code if a more definitive code confirms the diagnosis during the course of the disease, **regardless of time frame**.

Examples:

a. Mammography indicates a lesion suspicious for cancer. The diagnostic confirmation code is 7. Two weeks later a biopsy confirms infiltrating ductal carcinoma. **The correct diagnostic confirmation code is 1.**

b. MRI originally diagnosed a patient with a glioblastoma. The diagnostic confirmation code is 7. A year later a surgical biopsy is obtained**. The diagnostic confirmation code would be changed to 1.**

c. A thoracentesis is performed for a patient who is found to have a large pleural effusion. Cytology reveals malignant cells consistent with adenocarcinoma. **The diagnostic confirmation code is 2.**

d. CAT scan of abdomen reveals metastatic deposits in the liver and a large lesion in the ascending colon. Biopsy and later resection of the colon lesion revealed mucin-producing adenocarcinoma. **The diagnostic confirmation code is 1.**

e. Fine needle aspiration (FNA) is positive for malignant cells. **The diagnostic confirmation code is 2.**

Instructions for Coding Hematopoietic or Lymphoid Tumors (9590-9992)

1. There is no priority hierarchy for coding *Diagnostic Confirmation* for hematopoietic and lymphoid tumors. Usually the specific histologic type is diagnosed by immunophenotyping or genetic testing. For cases diagnosed January 1, 2012 and later see the *2012 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* at http://seer.cancer.gov/seertools/hemelymph/ for information on the definitive diagnostic confirmation code for specific types of neoplasm. For cases diagnosed between January 1, 2010 and December 31, 2011 use the 2010 manual at the same location.

2. **Code 1** when the microscopic diagnosis is based on tissue specimens from biopsy, surgery, or autopsy or bone marrow specimens from aspiration or biopsy.

3. 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.

4. 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.

5. 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.

Example: Bone marrow examination is positive for acute myeloid leukemia (9861/3). Genetic testing shows AML with inv (16) (p13.1q22) (9871/3). Code the Diagnostic Confirmation 3, positive histology and positive genetic testing.

6. 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.

7. 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.

8. Assign **code 8** when the case was diagnosed by any clinical method that cannot be coded as 6 or 7. 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.

Table 5.15 Diagnostic Confirmation Codes

CODE	DESCRIPTION	DEFINITION
MICROSCOPICALLY CONFIRMED		
1	Positive histology	Histological confirmation (tissue microscopically examined). In situ behavior must be microscopically confirmed.
2	Positive cytology, no positive histology	Cytological confirmation (no tissue microscopically examined; fluid cells microscopically examined). Includes pap smears, bronchial brushings, FNA and peritoneal fluid, cervical and vaginal smears, diagnoses based on paraffin block specimens from concentrated spinal, pleural or peritoneal fluid.
3	Positive histology PLUS - positive immunophenotyping AND/OR positive genetic studies (Used only for hematopoietic and lymphoid neoplasms 9590-9992)	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 (98613). Genetic testing shows AML with inv (16) (p13.1q22) (98713).
4	Positive microscopic confirmation, method not indicated	Diagnosis is stated to be microscopically confirmed but the method is not specified.
NOT MICROSCOPICALLY CONFIRMED		
5	Positive laboratory test/marker study	A clinical diagnosis of cancer is based on laboratory tests/marker studies that are clinically diagnostic for cancer but there is no histologic confirmation. This includes alpha-fetoprotein for liver cancer. Elevated PSA is non-diagnostic of cancer. If the physician uses the PSA as a basis for diagnosing prostate cancer with no other work-up, code to 5. (Adapted from SEER).
6	Direct visualization without microscopic confirmation	The tumor was visualized during a surgical/endoscopic procedure, with no specimen for microscopic exam.
7	Radiography and other imaging techniques without microscopic confirmation	The physician diagnosed the tumor from an imaging technique only.
8	Clinical diagnosis only (other than 5, 6, or 7)	The physician documented the tumor in the medical record. **Note:** Refer to the *Ambiguous Terminology List* in the MP/H Rules for cases diagnosed on or after 1/1/2007.
CONFIRMATION UNKNOWN		
9	Unknown whether or not microscopically confirmed	There is a statement of tumor in the medical record, but there is no indication of how it was diagnosed. Includes death certificate only cases.

Changing Abstract Information

There are some circumstances under which the information originally coded in the abstract should be updated.

1. To correct coding or abstracting errors when identified.

2. When better information is available at a later date.

- Earlier or more specific diagnosis date
- Better histology or grade
- More specific primary site
- Lower diagnostic confirmation code

Example: At the time of diagnosis a patient is diagnosed with liver metastasis but primary site cannot be determined and the abstract is submitted as an unknown primary. At a later date the physician determines that the patient has a colon primary. Change the primary site from unknown to colon. Be sure to make any necessary changes in *Collaborative Stage* and *Surgery Codes*. Document the new information in the appropriate text fields.

Example: A patient is diagnosed with lung cancer by CT exam alone. An abstract is submitted with the histology of cancer (8000/3) and diagnostic confirmation code 7. At a later admit the H&P states that the patient has squamous cell carcinoma of the lung diagnosed by fine needle aspiration. The *Histology* should be changed from cancer to squamous cell carcinoma (8070/3), and the *Diagnostic Confirmation* should be changed to 2, cytology. These findings should also be documented in the text fields

Note: Contact the TCR health service regional office regarding the appropriate procedure to follow when there is updated information on an abstract already submitted to the TCR. **Do NOT resubmit the abstract.** These cases will result in duplicate records and require manual resolution.

6

STAGING

SUMMARY STAGE DOCUMENTATION

Summary Stage Documentation (NAACCR Item #2600)

Description
Additional text area for staging information not already entered in other Text fields.

Explanation
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 abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values.

Coding Instructions
1. Prioritize entered information in the order of the fields listed below.

2. Text automatically generated from coded data is not acceptable.

3. NAACCR-approved abbreviations should be utilized

4. Do not repeat information from other text fields.

5. 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.

6. If information is missing from the record, state that it is missing.

7. Do not include irrelevant information.

8. Do not include information that the registry is not authorized to collect.

Suggestions for text:

- Date(s) of procedure(s), including clinical procedures, which 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

Summary Stage Documentation - PE (NAACCR Item #2520)

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.

Explanation
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 abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values.

Coding Instructions
1. Prioritize entered information in the order of the fields listed below.

2. Text automatically generated from coded data is not acceptable.

3. NAACCR-approved abbreviations should be utilized

4. Do not repeat information from other text fields.

5. 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.

6. If information is missing from the record, state that it is missing.

7. Do not include irrelevant information.

8. Do not include information that the registry is not authorized to collect.

Suggestions for text:
- Date of physical exam
- Age, sex, race/ethnicity
- History that relates to cancer diagnosis
- Primary site
- Histology (if diagnosis prior to this admission)

- Tumor location
- Tumor size
- Palpable lymph nodes
- Record positive and negative clinical findings. Record positive results first.
- Impression (when stated and pertains to cancer diagnosis)
- Treatment plan

Summary Stage Documentation - Xray/Scan (NAACCR #2530)

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

Explanation
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 abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values.

Coding Instructions
1. Prioritize entered information in the order of the fields listed below.

2. Text automatically generated from coded data is not acceptable.

3. NAACCR-approved abbreviations should be utilized

4. Do not repeat information from other text fields.

5. 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.

6. If information is missing from the record, state that it is missing.

7. Do not include irrelevant information.

8. Do not include information that the registry is not authorized to collect.

Suggestions for text:

- Date(s) and type(s) of X-ray/Scan(s).
- Primary site.
- Histology (if given).
- Tumor location.
- Tumor size.
- Lymph nodes.
- Record positive and negative clinical findings. Record positive results first.
- Distant disease or metastasis

Summary Stage Documentation-Scopes (NAACCR Item #2540)

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

Explanation
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 abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values.

Coding Instructions
1. Prioritize entered information in the order of the fields listed below.

2. Text automatically generated from coded data is not acceptable.

3. NAACCR-approved abbreviations should be utilized

4. Do not repeat information from other text fields.

5. 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.

6. If information is missing from the record, state that it is missing.

7. Do not include irrelevant information.

8. Do not include information that the registry is not authorized to collect.

Suggestions for text:

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

Summary Stage Documentation - Lab tests (NAACCR Item # 2550)

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

Explanation
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 abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values.

Coding Instructions
1. Prioritize entered information in the order of the fields listed below.

2. Text automatically generated from coded data is not acceptable.

3. NAACCR-approved abbreviations should be utilized

4. Do not repeat information from other text fields.

5. 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.

6. If information is missing from the record, state that it is missing.

7. Do not include irrelevant information.

Do not include information that the registry is not authorized to collect.

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)

Summary Stage Documentation - OP (NAACCR Item # 2560)

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

Explanation
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 abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values.

Coding Instructions
1. Prioritize entered information in the order of the fields listed below.

2. Text automatically generated from coded data is not acceptable.

3. NAACCR-approved abbreviations should be utilized

4. Do not repeat information from other text fields.

5. 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.

6. If information is missing from the record, state that it is missing.

7. Do not include irrelevant information.

8. Do not include information that the registry is not authorized to collect.

Suggestions for text:

- Dates and descriptions of biopsies and all other surgical procedures from which staging information was derived
- Number 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

Summary Stage Documentation - Path (NAACCR Item # 2570)

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

Explanation
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 abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values.

Coding Instructions

1. Prioritize entered information in the order of the fields listed below.

2. Text automatically generated from coded data is not acceptable.

3. NAACCR-approved abbreviations should be utilized

4. Do not repeat information from other text fields.

5. 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.

6. If information is missing from the record, state that it is missing.

7. Do not include irrelevant information.

8. Do not include information that the registry is not authorized to collect.

Suggestions for text:

- Date(s) of procedure(s)
- Anatomic source of specimen
- Type of tissue specimen(s)
- Tumor type and grade (include all modifying adjectives, i.e., predominantly, with features of, with foci of, elements of, etc.)
- Gross tumor size
- Extent of tumor spread
- Involvement of resection margins
- Number 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. Record any additional comments from the pathologist, including differential diagnoses considered and any ruled out or favored.

COLLABORATIVE STAGE 2004 AND LATER

For Collaborative Stage Description, Explanation, and Coding Instructions click on the following link.

Collaborative Stage Version 2: http://web2.facs.org/cstage0204/schemalistnat.html

The following link includes the Site Specific Factors required by the Texas Cancer Registry.

2010-2013 SSFs Required by TCR:
http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589981967

See Appendix A for an explanation of certain Site-Specific Factors.

SEER STUMMARY STAGE 2003 AND EARLIER

EOD-Tumor Size (NAACCR Item #780)

Description
Part of the 10-digit EOD [779]. Detailed site-specific codes for anatomic EOD used by SEER for tumors diagnosed from January 1, 1988 through December 31, 2003.

Explanation
Site-specific EOD codes provide extensive detail describing disease extent. The EOD codes can be grouped into different stage categories for analysis (e.g., historical summary stage categories consistent with those used in published SEER data since 1973, or more recently, AJCC stage groupings). The codes are updated as needed, but updates are usually backward compatible with old categories. See *Comparative Staging Guide for Cancer*.

Coding Instructions
See *SEER Extent of Disease, 1988: Codes and Coding Instructions*, Third Edition, for site-specific codes and coding rules for all EOD fields. The CoC codes for Tumor Size are in the *FORDS* manual.

Note: See Chapter V, Unresolved Issues, for a discussion of coding differences between CoC and SEER.

SEER Summary Stage 1977 (NAACCR Item #760)

Description
Code for summary stage at the initial diagnosis or treatment of the reportable tumor. This has traditionally been used by central registries to monitor time trends. For hospital registries, CoC requires its use in the absence of defined AJCC classification. For site-specific definitions of categories, see the SEER Summary Staging Guide.

SEER Summary Stage 1977 is limited to information available within 2 months of the date of diagnosis.NAACCR approved extension of this time period to 4 months for prostate tumors diagnosed beginning January 1, 1995.

Explanation
Stage information is important when evaluating the effects of cancer control programs. It is crucial for 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.

To study historical trends in stage, the coding system must be relatively unchanged (stable) over time. AJCC‘s TNM system is updated periodically to maintain clinical relevance with changes in diagnosis and treatment. The surveillance registries often rely on the Summary Stage, which they consider to be more ―stable.‖ Summary Stage has been in widespread use, either as the primary staging scheme or a secondary scheme, in most central and hospital registries since 1977.

Table 6.1 SEER Summary Stage 1977 Codes

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

Note*:* Code 8 has been added in Version 10.1 to be used when there is not an applicable code to reflect stage (e.g., benign brain, borderline ovarian).

Note*:* See also the item Derived SS1977 [3010] for the value of SEER Summary Stage 1977 as generated by the Collaborative Staging algorithm.

Note: Summary stage is required. The correct data item to use (and corresponding code manual) is determined by the year in which the cancer was diagnosed. Tumors diagnosed on or after January 1, 2004, should be assigned a summary stage based upon the Collaborative Stage data item algorithms and retained in Derived SS2000 [3020].Tumors diagnosed on or after January 1, 2001, should be assigned a summary stage according to the SEER *Summary Staging Manual 2000*, and the code should be reported in SEER Summary Stage 2000 [759]. Tumors diagnosed before January 1, 2001, should be assigned a summary stage according to *SEER Summary Stage Guide 1977*, and the code should be reported in SEER Summary Stage 1977 [760].

SEER Summary Stage 2000 (NAACCR Item #759)

Description

Code for summary stage at the initial diagnosis or treatment of the reportable tumor. For hospital registries, CoC requires its use in the absence of a defined AJCC classification. For site-specific definitions of categories, see SEER *Summary Staging Manual 2000.*

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.

Explanation

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.

Table 6.2 SEER Summary Stage 2000 Codes

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

Note*:* Code 8 has been added in Version 10.1 to be used when there is not an applicable code to reflect stage (e.g., benign brain, borderline ovarian).

Note*:* See also the item Derived SS2000 [3020] for the value of SEER Summary Stage 2000 as generated by the Collaborative Staging algorithm.

Note: Summary stage is required. The correct data item to use (and corresponding code manual) is determined by the year in which the cancer was diagnosed. Tumors diagnosed on or after January 1, 2004, should be assigned a summary stage based upon the Collaborative Stage data item algorithms and retained in Derived SS2000 [3020].Tumors diagnosed on or after January 1, 2001, should be assigned a summary stage according to the SEER *Summary Staging Manual 2000*, and the code should be reported in SEER Summary Stage 2000 [759]. Tumors diagnosed before January 1, 2001, should be assigned a summary stage according to *SEER Summary Stage Guide 1977*, and the code should be reported in SEER Summary Stage 1977 [760].

7

TREATMENT INFORMATION

TREATMENT INFORMATION

***2013 Drug Category Changes**
Changes from chemotherapy to BRM/Immunotherapy to make consistent with FDA guidelines effective 1/1/2013. Please refer to page 170 for Table with 2013 Drug Category Changes.

First Course of Treatment
Cancer-directed therapy or definitive treatment is limited to procedures that normally affect, control, change, remove, or destroy cancer tissue of the primary or metastatic site, and administered to the patient before disease progression or recurrence. The **first course** of treatment can be defined as cancer-directed treatment that begins **within four months** of initial diagnosis. This could be over a year for some cancer sites (see examples below). Any and all types of first course treatment administered at the reporting facility or elsewhere must be coded in the appropriate treatment field and documented in the *Treatment Documentation* field. First course ends when the treatment plan is completed, or there is disease progression, recurrence or treatment failure.

Examples:

a. The planned first course treatment for a breast primary could include surgery, chemotherapy, radiation, and hormone therapy.

b. First course for childhood leukemia typically spans two years from induction, and consolidation, to maintenance.

c. In the **absence of documentation** of a treatment plan, disease progression or recurrence, or treatment failure in the medical record, first course ends one year after the date of diagnosis. Any treatment given after one year is second course of therapy in the absence of a documented treatment plan.

d. "Watchful waiting" is a treatment option for patients with slow, indolent diseases such as prostate cancer and chronic lymphocytic leukemia. It is considered first course treatment and the appropriate treatment data fields should be coded to 00, not done. Document "Watchful waiting" in the appropriate treatment text field. The field *RX Summ-Treatment Status* should be coded as 2, Active surveillance (watchful waiting)

e. When the patient refuses treatment the appropriate treatment fields should be coded to patient refused. If the patient changes his/her mind and decides to have the prescribed treatment:

   - Code and document the treatment as first course of therapy if it has been less than one year since the cancer was diagnosed and there has been no documented disease progression.

   - If time lapsed has been more than a year or there is documented disease progression, all therapy thereafter should be considered second course of therapy.

f. Code and document all treatment that was started even if it is not completed.

Example: The patient completed only the first dose of a planned 30 day chemotherapy regimen. Code chemotherapy as administered.

g. If a patient has multiple primaries and the treatment given for one primary also affects/treats the other primary, code the treatment for both primaries.

Example: The patient had prostate and bladder cancer. The bladder cancer was treated with a TURB. The prostate was treated with radiation to the prostate and pelvis. The pelvic radiation includes the regional nodes for the bladder. Code and document the radiation as treatment for both the bladder and the prostate cases.

h. If a patient has multiple primaries and the treatment given affects only one of the primaries, code the treatment(s) only on the site that is affected.

Example: The patient has colon and tonsil primaries. The colon cancer is treated with a hemicolectomy and the tonsil primary is treated with radiation to the tonsil and the regional nodes. Do not code the radiation to the tonsil and regional nodes for the colon primary. Do not code the hemicolectomy for the tonsil.

i. If a patient is diagnosed with an unknown primary, code and document the treatment given as first course even if the correct primary is identified later.

Example: A patient is diagnosed with metastatic carcinoma, unknown primary site. After a full course of chemotherapy, the primary site is identified as prostate. Hormonal treatment is started. Code and document the chemotherapy as first course treatment. The hormone therapy is considered second course and not coded.

All Malignancies Except Leukemia

The first course of treatment includes all treatment planned and administered by the physician(s) from the initial diagnosis of cancer. Treatment can include multiple methods and may last a year or more. Any treatment delivered after the first course is considered subsequent treatment.

Note: Should there be a change of therapy due to apparent failure of the originally delivered treatment or because of the progression of the disease, the later therapy is not considered first course.

Leukemia:
Leukemia is grouped or typed by how quickly the disease develops and gets worse. Chronic leukemia gets worse slowly. Acute leukemia gets worse quickly. Leukemias are also grouped by the type of white blood cells affected. There are lymphoid and myeloid leukemias.

Treatment for leukemias is divided into three phases:

1. Remission induction (chemotherapy and/or biological response modifiers)

2. CNS prophylaxis or consolidation (irradiation to brain, chemotherapy)

3. Remission continuation or maintenance (chemotherapy or bone marrow transplants)

Definitions

Induction: Initial intensive course of chemotherapy.

Consolidation: Repetitive cycles of chemotherapy given immediately after remission.

Maintenance: Chemotherapy given for a period of months or years to maintain remission.

Remission: the bone marrow is normocellular with less than 5% blasts, there are no signs or symptoms of the disease, no signs or symptoms of central nervous system leukemia or other extramedullary infiltration, and all of the following laboratory values are within normal limits: white blood count and differential, hematocrit/hemoglobin level, and platelet count.

Coding Guidelines for First Course Therapy for Leukemia and Hematopoietic Diseases:

1. If a patient has a partial or complete remission during the first course therapy:

    a. Code and document all therapy that is "remission-inducing" as first course.

    b. Code and document all therapy that is "consolidation" as first course.

    c. Code and document all therapy that is "remission-maintaining" as first course.

Note: Do not code the treatment given after the patient relapses (is no longer in remission).

2. Some patients do not have a remission. A change in the treatment plan indicates a failure to induce remission. If the patient does not have a remission:

    a. Code and document the treatment given in an attempt to induce a remission.

    b. Do not record treatment administered after the change in treatment plan.

Other Treatment for Hematopoietic Diseases:

1. Record all treatment as described above. The following treatments are coded as "other" in Other Treatment even though they do not "modify, control, or destroy proliferating cancer tissue."

    a. Collect phlebotomy for polycythemia vera ONLY. Phlebotomy also may be referred to as blood removal, bloodletting or venisection.

    b. Collect blood thinners, anticoagulants and/or anticlotting agents for:

        - Mast cell sarcoma, mast cell leukemia, systemic mastocytosis
        - Chronic Myelogenous Leukemia BCR/ABL-positive
        - Polycythemia vera

- Primary myelofibrosis
- Essential thrombocythemia
- Chronic neutrophilic leukemia
- Myelodysplastic/myeloproliferative neoplasm

Note: Blood thinner examples include heparin, warfarin, Coumadin, Plavix, Pradaxa and Brilinta

Note: Blood transfusions and aspirin therapy are no longer collected as treatment.

Refer to the 2013 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual at **http://seer.cancer.gov/seertools/hemelymph/** to determine the correct coding of treatment for hematopoietic diseases.

Date of Initial Treatment (NAACCR Item #1260) (SEER pg. 108-110)

Description
The date the first course of treatment (surgery, radiation, systemic or other) started at any facility.

Explanation
This field is used to measure the delay between diagnosis and onset of treatment. A secondary use is as a starting point for survival statistics. This date cannot be calculated from the respective first course treatment dates if no treatment was given. Therefore, providing information about these instances is important when a physician decides not to treat a patient or the patient, patient's family or guardian declines treatment.

Note: This field will no longer be derived.

Instructions
1. Record the earliest date of the following treatment in this field:

- RX Date-Surgery NAACCR Data Item #1200
- RX Date-Radiation NAACCR Data Item #1210
- RX Date-Chemotherapy NAACCR Data Item #1220
- RX Date-Hormone Therapy NAACCR Data Item #1230
- RX Date Immunotherapy NAACCR Data Item #1240
- RX Date-Other NAACCR Data Item #1250
- RX. Summary- Scope of Reg Ln Surgery NAACCR Item #1292

- RX Summ– Surg Other Reg/Dist RX NAACCR Item #1294
- RX Summ– Transplant/Endocrine NAACCR Item #3250

2. Code the date of **excisional biopsy** as the date therapy initiated when it is the first treatment. Code the date of a biopsy documented as incisional if further surgery reveals no residual or only microscopic residual.

Example*:* Breast core needle biopsy with diagnosis of infiltrating duct carcinoma; subsequent re-excision with no residual tumor noted. Code the date of the needle biopsy as the excisional biopsy date.

3. Date format is:

   a. YYYYMMDD - when the complete date is known and valid.

   Example: A patient was found to have a large polyp during a colonoscopy on January 8, 2013. A polypectomy on that date confirmed adenocarcinoma of the descending colon. The polypectomy is considered cancer directed surgery, so code the *Date of Initial Treatment* 20130108.

   b. YYYYMM - when year and month are known and valid, and day is unknown.

   Example: Patient had pre-op chemo in March 2013 followed by a mastectomy. The exact chemo start date is unknown. Code the *Date of Initial Treatment* as 201303.

   c. YYYY - when year is known and valid, and the month and day are unknown.

Note: Treatment dates for a fetus prior to birth are to be assigned the actual date of the event. Record the type of treatment in the appropriate date item, for example, *Surgery of Primary Site.*

   Example: On 1/3/2013 a fetus is diagnosed with malignant teratoma. The teratoma is resected in utero 1/10/2013. Live birth is on 3/8/2013. Code the surgery date 20130110.

4. Leave blank:

   a. When no treatment is given during the first course

   b. When Treatment Status is coded 2, Active surveillance (watchful waiting)

   c. When it is known the patient had first course therapy, but it is impossible to estimate the date

   d. When it is unknown whether the patient had treatment

   e. Autopsy only cases

Date of Initial RX Flag (NAACCR Item #1261) (SEER pg 111)

Description
This flag explains why there is no appropriate value in the corresponding date field, Date of Initial RX-SEER (1260).

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

Coding Instructions
1. Leave this item blank if *Date of Initial Treatment* has a full or partial date recorded.

2. Assign code 10 when it is unknown whether any treatment was administered.

3. Assign code 11 when no treatment is given during the first course, the first course is active surveillance (watchful waiting) or the initial diagnosis was at autopsy

Table 7.1 Date of Initial RX Flag Codes

CODE	DESCRIPTION
10	No information whatsoever can be inferred from this exceptional value (unknown if therapy was administered)
11	No proper value is applicable in this context (for example, no treatment given or autopsy only)
(blank)	A valid date value is provided in item *Date of Initial Treatment* (NAACCR Item #1260).

RX. Summary- Scope of Reg Ln Surgery (NAACCR Item #1292) (FORDS pg. 219-222; SEER pgs. 115-119)

Description
Indicates the removal, biopsy, or aspiration of **regional** lymph nodes at the time of surgery of the primary site or during a separate surgical procedure.

Explanation
This information is used to compare and evaluate the extent of surgical treatment.

Coding Instructions
1. Record all surgical procedures that remove, biopsy, or aspirate regional lymph nodes even if surgery of the primary site is not performed. Codes 0–7 are hierarchical. Code the procedure that is numerically higher.

2. Information to be coded for this data field is **cumulative**. It is appropriate to add the number of all the lymph nodes removed during each surgical procedure performed as part of the first course treatment.

3. Code only regional lymph node procedures in this data item. Record distant lymph node removal in *Surgical Procedure of Other Site*. Include lymph nodes that are coded as regional in the Collaborative Stage Data Collection System.

Example: Melanoma with no primary skin site identified. One axillary lymph node removed revealing melanoma. No other tumors found. The axillary lymph node is coded as regional for CS lymph node coding. Include this lymph node in *Scope of Regional LN Surgery*.

4. If the operative report lists a lymph node dissection but no nodes were found by the pathologist, code the *SCOPE OF REG LN SURGERY* to 0 (No lymph nodes removed).

5. If the patient has two primaries with common regional lymph nodes, code and document the removal of regional nodes for both primaries.

Example: Patient has a cystoprostatectomy and pelvic lymph node dissection for papillary transitional cell cancer of the bladder. Pathology identifies prostate adenocarcinoma as well as the bladder cancer and 4/21 nodes positive for metastatic adenocarcinoma. Code *Scope of Regional Lymph Node Surgery* to 5 (4 or more regional lymph nodes removed) for both primaries.

6. Code to 9 for:

   a. Primaries of the meninges, brain, spinal cord, cranial nerves, and other central nervous system (C700–C709, C710–C719, C720–C729).

   b. Lymphomas (M-9590–9726, 9728-9732, 9734-9740, 9750-9762, 9811-9831, 9940, 9948, and 9971) with a lymph node primary site (C770–C779).

   c. Hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease

      - Primary sites: C420, C421, C423, or C424 (all histologies)

      - Histologies: 9727, 9750, 9760–9764, 9800–9820, 9823, 9826, 9831–9920, 9931–9992 (all sites)

      - Unknown or ill-defined sites (C809, C760–C768) (all histologies)

   d. Pituitary Gland (C751), Craniopharyngeal Duct (C752), and Pineal Gland (C753)

7. Refer to the Collaborative Stage Data Collection System Coding Instructions, version 02.04.40 for site specific instructions.

Note: This table is also available in the Quick Reference, Standard Tables Section.

Note: See Appendix A for additional instructions specific to Breast Surgical Codes (RX Summary-Scope of Reg Ln Surgery).

Table 7.2 RX. Summary- Scope of Reg Ln Surgery Codes

CODE	DESCRIPTION	DEFINITION	GENERAL INSTRUCTIONS
0	None	No regional lymph node surgery. No lymph nodes found in the pathologic specimen. Diagnosed at autopsy.	
1	Biopsy or aspiration of regional lymph nodes, NOS	Biopsy or aspiration of regional lymph node(s) regardless of the extent of involvement.	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.
2	Sentinel lymph node biopsy (only)	Biopsy of the first lymph node or nodes that drain a defined area of tissue within the body. Sentinel node(s) are identified by the injection of a dye or radio label at the site of the primary tumor.	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 nonsentinel nodes may be discovered by the pathologist or selectively removed 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 nonsentinel nodes may be discovered by the pathologist or selectively removed (or harvested) as part of the SLNBx procedure by the surgeon. Code this as a SLNBx (code 2). If review of the operative report confirms that a regional lymph node dissection followed the SLNBx, code these cases as 6.
3	Number of regional lymph nodes removed unknown or not	Sampling or dissection of regional lymph node(s) and the number of nodes removed is unknown or not stated. The procedure is not specified	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	DESCRIPTION	DEFINITION	GENERAL INSTRUCTIONS
	stated; regional lymph nodes removed, NOS	as sentinel lymph node biopsy.	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 SLN Bx only. Code 5 (4 or more regional lymph nodes removed). If a relatively small number of nodes were examined pathologically, review the operative report to confirm the procedure was not a SLNBx only (code 2). If a relatively large number of nodes were 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.
4	1–3 regional lymph nodes removed	Sampling or dissection of regional lymph node(s) with fewer than four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.	
5	4 or more regional lymph nodes removed	Sampling or dissection of regional lymph nodes with at least four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.	
6	Sentinel lymph node biopsy and code 3, 4, or 5 at same time, or timing not stated	Code 2 was performed in a single surgical procedure with code 3, 4, or 5; or code 2 and 3, 4, or 5 were performed, but timing was not stated in patient record.	SNLBx and regional lymph node dissection (code 3, 4, or 5) during the same surgical event, or timing not known. Generally, SLNBx followed by a regional lymph node completion will yield a relatively large number of nodes. However it is possible for these procedures to harvest only a few nodes. If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only. Infrequently, a SNLBx is attempted and the patient fails to map (i.e. no

CODE	DESCRIPTION	DEFINITION	GENERAL INSTRUCTIONS
			sentinel lymph nodes are identified by the dye and/or radio label injection.) When mapping fails, the surgeon usually performs a more extensive dissection of regional lymph nodes. Code these cases as 6.
7	Sentinel node biopsy and code 3, 4, or 5 at different times	Code 2 was followed in a subsequent surgical event by procedures coded as 3, 4, or 5.	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.
9	Unknown or not applicable	It is unknown whether regional lymph node surgery 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.	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:

a. Patient has a radical neck dissection and the number of lymph nodes removed is not stated. The appropriate code would be 3.

b. The patient has modified radical mastectomy with sentinel lymph node biopsy and axillary lymph node dissection. The final diagnosis is infiltrating ductal carcinoma with 2/12 axillary lymph nodes positive. The appropriate code would be 6, sentinel lymph node biopsy and code 3, 4, or 5 at same time, or timing not stated.

c. Transverse colon: Adenocarcinoma with extension into subserosa, 3/10 pericolic lymph nodes are positive. The appropriate code would be 5, four or more regional lymph nodes removed.

Rx Date– Surgery (NAACCR ITEM #1200) (FORDS pg. 209)

Description
The date of the first cancer-directed surgical procedure performed at any facility.

Explanation
Documents the date of the first cancer-directed surgical procedure. This date may or may not reflect the date of the most definitive surgical procedure.

Coding Instructions
1. Record the date of the first surgical procedure of the types coded as *Surgical Procedure of Primary Site, Scope of Regional Lymph Node Surgery,* or *Surgical Procedure/Other Site.*

2. Date format is:

a. YYYYMMDD - when the complete date is known and valid.

Example: A patient was found to have a large polyp during a colonoscopy on January 8, 2013. A polypectomy on that date confirmed adenocarcinoma of the descending colon. The polypectomy is considered cancer directed surgery, so the date of first surgery should be coded 20130108.

b. YYYYMM - when year and month are known and valid, and day is unknown.

Example: Patient is seen for treatment recommendations following a mastectomy in March 2013. The exact day of surgery is unknown. Code the date of surgery as 201303.

c. YYYY - when year is known and valid, and the month and day are unknown.

Example: A patient had a radical prostatectomy in 2013 and is now seen with bone mets. The month and day of the surgery are unknown. Code the date of surgery as 2013.

d. Blank - when no known date applies (no surgery was done or it is unknown if surgery was done).

3. Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.

4. If two or more cancer-directed surgeries are performed, enter the date for the first cancer-directed surgery.

5. If surgery was done do not leave this field blank. If the date is unknown record the year of diagnosis as the surgery date and leave the month and day blank. Document in the text field that the date of surgery is unknown.

Examples:

a. An incisional biopsy is performed on March 3, 2013 followed by a resection on March 17, 2013. Record the date of the resection (20130317) as the date of the first surgical procedure. An incisional biopsy is a diagnostic procedure, not a cancer-directed surgery.

b. February 1, 2013 a patient had a fine needle aspiration of a right breast mass, consistent with

infiltrating ductal carcinoma. On February 15, 2013, the patient underwent a right modified radical mastectomy. The date of surgery would be recorded as 20130215.

c. Patient had a lumpectomy as part of first course of treatment for breast cancer in 2013, but the date is unknown. On June 3, 2013 she comes to your facility to begin chemotherapy. Record the date of surgery as 2013.

RX Date Surgery Flag (NAACCR Data Item #1201) (FORDS pgs.210-211)

Description
This flag explains why there is no appropriate value in the corresponding date field, *RX Date Surgery*, NAACCR Item 1200.

Explanation
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
1. Leave this item blank if *Surgical Procedure of Primary Site* (NAACCR Item #1200) has a full or partial date recorded.

2. Code 10 if it is unknown whether any surgery was performed.

3. Code 11 if no surgical procedure was performed.

Table 7.3 RX Date Surgery Flag Codes

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).
(blank)	A valid date value is provided in item *Date of First Surgical Procedure* (NAACCR Item #1200).

Surgical Procedure of Primary Site (NAACCR Item #1290) (FORDS pg. 215; SEER pgs.113–114)

Description
Cancer-directed surgery is an operative procedure that actually removes, excises, or destroys cancer tissue of the primary site. Code the most definitive surgical procedure of the primary site performed at any facility as part of the first course of treatment. This field is for surgery of primary site only.

Explanation
Identifies the specific cancer-directed surgery of the primary site.

Coding Instructions
1. Code the type of surgery the patient received as part of the **first course of treatment** at any facility.

2. Refer to the Site-specific Surgery Codes can be found in Appendix B of the FORDS Manual on page 357: http://www.facs.org/cancer/coc/fords/fords-manual-2013.pdf

Table 7.4 Surgical Procedure of Primary Site Codes

CODE	TYPE	DESCRIPTION
00	None	No surgical procedure of primary site. Diagnosed at autopsy.
10–19	Site-specific codes; tumor destruction	Tumor destruction, no pathologic specimen produced. Refer to *Appendix A* for correct site-specific procedure code.
20–80	Site-specific codes; resection	Refer to *Appendix A* for correct site-specific procedure code.
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 surgery codes; special	Special codes. Refer to *Appendix A* for correct site-specific procedure code.
99	Unknown	Medical record does not state whether a surgical procedure of the primary site was performed and no information is available. Death certificate only.

3. Code the most invasive, extensive, or definitive surgery if the patient has multiple surgical procedures of the primary site even if there is no tumor found in the pathologic specimen. Codes 00–80 are listed in **hierarchical** but **not necessarily numerical order**. Code the procedure listed furthest down the list within the codes 10–80.

Example: Patient has excisional breast biopsy that is positive for carcinoma. The patient chooses to have a modified radical mastectomy. The pathologic examination of the mastectomy specimen shows no residual tumor. Code the modified radical mastectomy.

4. Code 98 takes precedence over code 00 for hematopoietic, reticuloendothelial, immunoproliferative or myeloproliferative disease and for unknown or ill-defined sites unless the case is death certificate only.

   a. Primary Sites: C420, C421, C423, or C424 (all histologies)

   b. Histologies 9750, 9760-9764, 9800-9820, 9826, 9831-9920, 9931-9964, 9980-9989 (all sites)

   c. Unknown or ill-defined sites: C760-C768, C809 (all histologies)

5. Excisional biopsies that remove the entire tumor and/or leave only microscopic margins are coded in this field if no further more definitive surgery is done.

Note: Code an **excisional biopsy**, even when documented as **incisional,** when:

   a. All disease is removed (margins free) OR

   b. All gross disease is removed and there is only **microscopic residual at the margin.**

Note: Do not code an excisional biopsy when there is macroscopic residual disease.

6. Surgery to remove regional or distant tissue or organs is coded in this field only if the tissue or

organs are removed in continuity with the primary site (en bloc), except where noted in *Appendix A.* Specimens from an en bloc resection may be submitted to pathology separately.

SEER Note: In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily as a single specimen.

Example: Code an en bloc removal when the patient has a hysterectomy and an omentectomy.

7. Surgery performed solely for the purpose of establishing a diagnosis/stage (exploratory surgery), the relief of symptoms (bypass surgery), or reconstruction is **not** considered cancer-directed surgery. Brushings, washings, and aspiration of cells are not surgical procedures.

8. 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, code the total or final results.

Example: Patient has a partial mastectomy with positive margins. Two weeks later the patient has a modified radical mastectomy. Code the modified radical mastectomy.

9. For bladder, when only random biopsy procedures are performed, code surgery of primary site field to 00. [None; no surgery of primary site.]

10. For brain tumors, gross total resection (of tumor or mass) should be coded to 20, and not 55. Code 55 would indicate total resection of a lobe of the brain.

11. Code surgery for extra-lymphatic lymphoma using the site-specific surgery coding scheme (not lymph node scheme) for the primary site.

Reason for No Surgery of Primary Site (NAACCR Item #1340) (FORDS pg. 234; SEER pgs. 121-123)

Description
Records the reason that no surgery was performed on the primary site. This field applies only to surgery of primary site.

Explanation
This data item provides information related to quality of care.

Coding Instructions
1. Assign code 0 when *Surgery of Primary Site* is coded in the range of 10-90 (surgery of the primary site was performed.

2. Assign a code in the range of 1-8 if *Surgery of Primary Site* is coded 00 or 98.Code 1 if the treatment plan offered multiple alternative treatment options and the patient selected treatment that did not include surgery of primary site, or if the option of "no treatment" was accepted by the patient.

Note: Referral to a surgeon is equivalent to a recommendation for surgery.

a. Assign code 1 when:

- There is no information in the patient's medical record about surgery AND:
- It is known that surgery is not usually performed for this type and/or stage of cancer OR
- There is no reason to suspect that the patient would have had surgery of primary site.
- The treatment plan offered multiple treatment options and the patient selected treatment that did not include surgery of the primary site.
- The option of "no treatment" was accepted by the patient.
- When no surgery is done, and surgery is not normally performed for site/histology.

Example: Prostate cancer patient is offered three treatment options: a. Radical prostatectomy, b. Radiation therapy, or c. Hormone therapy. The patient chose radiation therapy. Assign code 1. Surgery of the primary site was not performed because it was not part of the planned first-course treatment. The treatment plan was for the patient to receive ONE of three treatment modality options. At no time did the physician recommend that the patient have all three treatments.

- Patient elected to pursue no treatment following the discussion of surgery. Discussion does not equal a recommendation
- Watchful waiting/active surveillance (prostate).

b. Assign code 6 when it is known that surgery was recommended AND it is known that surgery was not performed AND there is no documentation explaining why surgery was not done.

c. Assign code 7 when the patient refuses recommended surgery OR makes a blanket statement that he/she refused all treatment when surgery is a customary option for the primary site/histology.

Note: Coding *Reason for No Surgery of Primary Site* as "refused" does not affect the coding of the other treatment fields. Code 7 means surgery is exactly what was recommended by the physician and the patient refused. If two treatment alternatives were offered and surgery was not chosen, code *Reason for No Surgery of Primary Site* as 1.

d. Assign code 8 when surgery is recommended, but it is unknown if the patient had the surgery.

Example: There is documentation in the medical record that the primary care physician referred the patient to a surgical oncologist. Follow-back to the surgical oncologist and primary care physician yields no further information. Assign code 8.

3. Code 1 if *Surgical Procedure of Primary Site* (NAACCR Item #1290) is coded 98.

4. Code 9 if the treatment plan offered multiple choices, but it is unknown which treatment, if any, was provided.

Note: This table is also available in the Quick Reference, Standard Tables Section.

Table 7.5 Reason for No Surgery Codes

CODE	DESCRIPTION
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. Diagnosed at autopsy
2	Surgery of the primary site was not recommended/performed because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, etc.)
5	Surgery of the primary site was not performed because the patient died prior to planned or recommended surgery.
6	Surgery of the primary site was not performed; it was recommended by the patient's physician, but was not performed as part of the first course of therapy. No reason was noted in the patient record.
7	Surgery of the primary site was not performed: it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in the patient's 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:

a. A patient with primary tumor of the liver is not recommended for surgery due to advanced cirrhosis. The reason for no primary site surgery is 2, not recommended due to comorbid conditions.

b. A patient is referred to another facility for recommended surgical resection of a non-small cell lung carcinoma. There is no further information from the facility to which the patient was referred. The reason for no surgery of primary site is 8, recommended but unknown if performed.

RX Summ– Surg Other Reg/Dist RX Code (NAACCR Item #1294) (FORDS pgs. 227-228; SEER pg. 120)

Description

Indicates the surgical removal of other regional site(s), distant site(s), or distant lymph node(s) beyond the primary site. Code the surgical procedure of other sites the patient received, at any facility, as part of the first course of treatment.

Explanation

Documents the extent of surgical treatment and is useful in evaluating the extent of metastatic disease.

Coding Instructions

1. The codes are **hierarchical.** Record the **highest numbered code** that describes the surgical resection of *distant lymph nodes or regional/distant tissues or organs* the patient received as part of the **first course of treatment** at any facility.

2. Do not code tissues or organs such as an appendix that were removed incidentally, and the organ was not involved with cancer.

Note: Incidental removal of organs means that tissue was removed for reasons other than removing cancer or preventing the spread of cancer. Examples of incidental removal of organ(s) would be removal of appendix, gallbladder, etc., during abdominal surgery.

3. Codes 1-5 have priority over codes 0 and 9.

Note: This table is also available in the Quick Reference, Standard Tables Section.

Table 7.6 RX Summ– Surg Other Reg/Dist RX Codes

CODE	DESCRIPTION	DEFINITION
0	None	No surgical procedure of non-primary site was performed. Diagnosed at autopsy.
1	Non-primary surgical procedure performed	Non-primary surgical procedure to other site(s), unknown if the site(s) is regional or distant.
2	Non-primary surgical procedure to other regional sites	Resection of regional site that is not included in combination surgery codes of the primary site.
3	Non-primary surgical procedure to distant lymph node(s)	Resection of distant lymph node(s).
4	Non-primary surgical procedure to distant sites	Resection of distant site.
5	Combination of codes	Any combination of surgical procedures 2, 3, or 4.
9	Unknown	It is unknown whether any surgical procedure of a non-primary site was performed. Death certificate only.

Examples:

a. The incidental removal of the appendix during a surgical procedure to remove a primary malignancy in the right colon is coded to 0.

b. Surgical biopsy of metastatic lesion from liver with an unknown primary is coded to 1.

c. Surgical ablation of solitary liver metastasis with a hepatic flexure primary is coded to 2.

d. Excision of distant metastatic lymph nodes with a rectosigmoid primary is coded to 3.

e. Removal of a solitary brain metastasis with a lung primary is coded to 4.

f. Excision of a solitary liver metastasis and hilar lymph node with a rectosigmoid primary is coded to 5.

g. For unknown or ill-defined primary sites (C760-C768, C809) or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease (C420, C421, C423, C424 or M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992) treated with any surgery to treat tumors, code Surgical Procedure of Other Site to 1

[Non-primary surgical procedure to other site(s) or node(s), NOS; unknown if regional or distant].

RX Text Surgery (NAACCR Item #2610)

Description
Text area for information describing all surgical procedures performed as part of treatment.

Explanation
Text documentation is an essential component of a complete abstract and used extensively for quality assurance, consolidation of information from multiple sources, and special studies.

Coding Instructions
1. Text information **MUST BE PROVIDED BY ALL FACILITIES.**

2. Document all first course surgery regardless of where it was done, in date order.

3. Document if no surgery was done, or if it cannot be determined if intended surgery was done.

Example: 5/1/13 patient had a right lobe thyroidectomy. On 6/8/13 patient had completion thyroidectomy.

Note: See the Text Documentation section of the 2013 TCR CRH for further explanation and examples.

Date Radiation Started (NAACCR Item #1210) (FORDS pg. 235)

Description
The date the radiation therapy began at any facility as part of the first course of treatment.

Explanation
Identifies the date radiation therapy was initially started.

Coding Instructions
1. Record the date of the first cancer-directed radiation therapy.

2. Date format is:

   a. YYYYMMDD - when the complete date is known and valid

   Example: A patient with breast cancer begins external beam radiation therapy on April 10, 2013. Code the date of radiation therapy as 20130410.

   b. YYYYMM - when year and month are known and valid, and day is unknown.

   Example: A patient was diagnosed with prostate cancer and underwent brachytherapy in January 2013, but the day is not known. Record date of radiation therapy as 201301.

c. YYYY - when year is known and valid, and the month and day are unknown.

Example: A patient is seen with brain cancer in July 2013. It is known that the patient had radiation therapy earlier in the year, but the month and day are unknown. Record the date of radiation therapy as 2013.

d. Blank - when no known date applies (no radiation therapy was given or it is unknown if radiation was given).

Example: A patient with a malignant brain tumor has refused all therapy including radiation therapy. Leave the date of radiation therapy blank.

3. Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.

4. If two or more types of radiation therapy are delivered, (for example: beam and isotopes; beam and implants) enter the date for the **first** type of radiation therapy.

5. If radiation therapy is given do not leave this field blank. If the date is not known record the year of diagnosis as the start date and leave the month and day blank. Document in the text field that the date of radiation therapy is unknown.

RX Date Radiation Flag (NAACCR Item #1211) (FORDS pg. 236-237)

Description
This flag explains why there is no appropriate value in the corresponding date field *Date Radiation Started.*

Explanation
As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information previously transmitted in date field

Coding Instructions
1. Leave this item blank if *Date Radiation Started* has a full or partial date recorded.

2. Code 10 if it is unknown whether any radiation was given.

3. Code 11 if no radiation is planned or given.

4. Code 15 if radiation is planned, but has not yet started and the start date is not yet available.

Table 7.7 RX Date Radiation Flag Codes

CODE	DESCRIPTION
10	No information whatsoever can be inferred from this exceptional value (unknown if any radiation was given)
11	No proper value is applicable in this context (for example, no radiation given)
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).

Radiation– Regional Treatment Modality (NAACCR Item #1570) (FORDS pgs. 243-245)

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

Explanation
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.

Coding Instructions
1. 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.

2. In the event multiple radiation therapy modalities were employed in the treatment of the patient, record only the dominant modality (the greatest dose of radiation). It may be necessary to consult with the radiation oncologist to determine the dominant modality.

3. Note that in some circumstances the boost treatment may precede the regional treatment. Record only the dominant modality.

4. For purposes of this data item, photons and x-rays are equivalent.

5. Radioembolization is defined as embolization combined with injecting small radioactive beads or coils into an organ or tumor. Code as brachytherapy when the tumor embolization is performed using a radioactive agent or radioactive seeds. Use code 50.

6. Tomotherapy is a form of intensity modulated radiation therapy (IMRT). Use code 31.

7. MammoSite radiation therapy is accomplished by the placement of wires with a radioactive bead attached. The MammoSite devise is the applicator with a balloon tipped end that is inserted into the surgical cavity which results from the removal of the tumor. MammoSite would be coded as brachytherapy, intracavitary, as there is no direct insertion into tissue.

8. Record all radiation therapy given as first course of treatment, even if it is palliative.

Note: This Table is also available in the Quick Reference, Standard Tables Section.

Table 7.8 Radiation– Regional Treatment Modality Codes

CODE	TYPE	DESCRIPTION
00	No radiation treatment	Radiation therapy was not administered to the patient.
20	External beam, NOS	The treatment is known to be 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 to 50 or 51.
23	Photons (2-5 MV)	External beam therapy using a photon-producing machine with beam energy in the range of 2-5 MV.
24	Photons (6-10 MV)	External beam therapy using a photon-producing machine with beam energy in the range of 6-10 MV.
25	Photons (11-19 MV)	External beam therapy using a photon-producing machine with beam energy in the range of 11-19 MV.
26	Photons (> 19 MV)	External beam therapy using a photon-producing machine with beam energy more than 19 MV.
27	Photons (mixed energies)	External beam therapy using more than one energy over the course of treatment.
28	Electrons	Treatment delivered by electron beam.
29	Photons and electrons mixed	Treatment delivered using a combination of photon and electron beams.
30	Neutrons with or without photons/electrons	Treatment delivered using neutron beam.
31	IMRT	Intensity modulated radiation therapy, an external beam technique that should be clearly stated in medical 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 medical record.
40	Protons	Treatment delivered using proton therapy.
41	Stereotactic radiosurgery, NOS	Treatment delivered using stereotactic radiosurgery, type not specified in medical 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 with a gamma knife machine.

CODE	TYPE	DESCRIPTION
50	Brachytherapy, NOS	Brachytherapy, interstitial implants, molds, seeds, needles, or intracavitary applicators of radioactive materials not otherwise specified.
51	Brachytherapy, intracavitary, low dose rate (LDR)	Intracavitary (no direct insertion into tissues) radioisotope treatment using LDR applicators and isotopes (Cesium-137, Fletcher applicator).
52	Brachytherapy, intracavitary, high dose rate (HDR)	Intracavitary (no direct insertion into tissues) radioisotope treatment using HDR after-loading applicators and isotopes.
53	Brachytherapy, Interstitial, LDR	Interstitial (direct insertion into tissues) radioisotope treatment using LDR sources.
54	Brachytherapy, Interstitial, HDR	Interstitial (direct insertion into tissues) radioisotope treatment using HDR sources.
55	Radium	Infrequently used for 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	Same as above.
80*	Combination modality, specified	Combination of external beam radiation and either radioactive implants or radioisotopes. *Do not use for cases diagnosed on or after January 1, 2003.
85*	Combination modality, NOS	Combination of radiation treatment modalities not specified in code 80. *Do not use for cases diagnosed on or after January 1, 2003.
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.

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

RX Summ-Radiation (NAACCR Item #1360) (SEER pgs. 124-126)

Description
Codes for the type of radiation therapy performed as part of the first course of treatment.

Explanation
Identifies the type of radiation therapy administered from either external or internal.

Coding Instructions

1. Assign code 0 when:

   a. There is no information in the patient's medical record about radiation AND:
      - It is known that radiation is not usually performed for this type and/or stage of cancer OR
      - There is no reason to suspect that the patient would have had radiation

   b. The treatment plan offered multiple treatment options and the patient selected treatment that did not include radiation

   c. Patient elected to pursue no treatment following the discussion of radiation treatment. Discussion does not equal a recommendation.

   d. Watchful waiting/active surveillance (prostate)

   e. Patient diagnosed at autopsy

   f. Radiotherapy recommended, but patient died before receiving radiotherapy.

2. Assign code 1 for:

   a. Beam radiation directed to cancer tissue. The source of the beam radiation is not coded. Sources may include, but are not limited to: X-ray, cobalt, linear accelerator, neutron beam, betatron, spray radiation, stereotactic radiosurgery such as gamma knife, and proton beam.

   b. Total body irradiation (TBI) prior to a bone marrow transplant.

3. Assign code 2 when the radiation is delivered by interstitial implant, molds, seeds, needles or intracavitary applicators. The radioactive material used in implants includes, but is not limited to: cesium, radium, radon, radioactive gold, and iodine.

Example: Brachytherapy with 125 seeds. Assign code 2. Seeds are always low dose therapy because they are left in place and the radioactivity decays over time.

4. Assign code 3 when radioactive isotopes are given orally, intracavitary or by intravenous injection. Radioactive isotopes include but are not limited to: I-131 or P-32.

5. Assign code 3 for 90-yttrium and for I-131 Iodine when given with Rituxan as treatment for lymphoma. (Code Rituxan as chemotherapy).

Note: Rituxan is given in combination with the monoclonal antibody Zevalin conjugated to 90-Yttrium or the monoclonal antibody Bexxar conjugated to I-131-Iodine in the treatment of NHL. The monoclonal antibody is only the delivery agent for radioisotope. Do not code Zevalin or Bexxar as chemotherapy. See the definition of Monoclonal Antibodies.

6. Assign code 4 when the patient has beam radiation **and** either radioactive implants or radioisotopes.

7. Assign code 8 when:

a. Radiation has been recommended, but there is no confirmation of its actually being delivered.

b. The only information available is that the patient was referred to a radiation oncologist.

Note: Review cases coded 8 periodically for later confirmation of radiation therapy.

Example: MammoSite intracavitary radiation therapy was placed in the breast, but there is no documentation of radiation actually being given. Assign code 8. Check this case periodically and update the code when further information becomes available.

8. Assign code 9 when there is no documentation that radiation was recommended or performed.

Table 7.9 RX Summ-Radiation Codes

CODE	DESCRIPTION
0	None; Diagnosed at autopsy
1	Beam radiation
2	Radioactive implants
3	Radioisotopes
4	Combination of 1 with 2 or 3
5	Radiation, NOS-method of source not specified
7	Patient or patient's guardian refused radiation therapy
8	Radiation recommended, unknown if administered
9	Unknown if radiation administered

RX Text Radiation (NAACCR Item #2620 and 2630)

Description
Text area for manual documentation of information regarding treatment of the tumor being reported with beam radiation and/or other radiation therapy.

Explanation
Text documentation is an essential component of a complete abstract and used extensively for quality assurance, consolidation of information from multiple sources, and special studies.

1. Text information to support radiation treatment **MUST BE PROVIDED BY ALL FACILITIES.**

2. Document all first course therapy radiation treatment regardless of where it was done, in date order.

3. Document if no radiation therapy was done, or if it cannot be determined if intended radiation therapy was done.

Example: External beam radiation therapy completed on 6/15/13, start date not given. Estimate start

date 5/2013.

Note: See the Text Documentation section of the 2013 TCR CRH for further explanation and examples.

RX Summary-Surgery/Radiation Sequence (NAACCR Item #1380) (FORDS pgs. 252-253; SEER pgs.129-130)

Description
Records the sequencing of radiation and surgical procedures given as part of the first course of treatment.

Explanation
The sequence of radiation and surgical procedures given as part of the first course of treatment cannot always be determined using the date on which each modality was started or performed. This data item can be used to more precisely evaluate the timing of delivery of treatment to the patient.

Coding Instructions
1. For the purpose of coding radiation sequence with surgery, "Surgery" is defined as a surgical procedure to the primary site (codes 10–90) or scope of regional lymph node surgery (codes 1–7) or surgical procedure of other site (codes 1–5). If all of these procedures are coded 0, then this item should be coded 0.

2. If a 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 of another site, then code this item 2–9 as appropriate.

3. Assign code 0 when:

   a. The patient did not have either surgery or radiation.

   b. The patient had surgery but not radiation.

   c. The patient had radiation but not surgery.

4. 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.

Note: This table is also available in the Quick Reference, Standard Tables Section.

Table 7.10 RX Summary-Surgery/Radiation Sequence Codes

CODE	LABEL	DESCRIPTION
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 was 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 after any 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, but both surgery and radiation were given	Administration of radiation therapy and surgery to primary site, scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s) were performed and the sequence of the treatment is not stated in the patient record.

Examples:

a. Due to other medical conditions surgery was not performed. The patient received palliative radiation therapy to alleviate pain. Use code 0.

b. Patient received radiation therapy prior to resection of a lung lesion. Use code 2.

c. A patient underwent excisional biopsy of a right breast mass followed by radiation therapy to breast. Use code 3.

d. Preoperative radiation therapy was given to a large bulky vulvar lesion, followed by a lymph node dissection. Radiation therapy was then given to treat positive lymph nodes. Use code 4.

e. A cone biopsy of the cervix was followed by intracavitary implant for IIIB cervical carcinoma. Use code 5.

f. 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. Use code 6.

g. A primary of the head and neck was treated with surgery and radiation prior to admission, but the sequence is unknown. Use code 9.

h. Patient has an unknown primary. A radical neck dissection is done followed by radiation therapy. Use code 3.

Reason For No Radiation (NAACCR Item #1430) (FORDS pg. 257)

Description
Records the reason that no regional radiation therapy was administered to the patient.

Explanation
When evaluating the quality of care, it is useful to know the reason that various methods of therapy were not used, and whether the failure to provide a given type of therapy was due to the physician's failure to recommend that treatment, or due to the refusal of the patient, a family member, or the patient's guardian.

Coding Instructions
1. If *Regional treatment Modality* (NAACCR Item #1570) is coded 00, then record the reason based on documentation in patient record.

2. Code 1 if the treatment plan offered multiple alternative treatment options and the patient selected treatment that did not include radiation therapy.

Example: A patient with Stage I prostate cancer is offered either surgery OR brachytherapy to treat his disease. The patient elects to be surgically treated. Code *Reason for No Surgery* 1.

3. 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.

4. Code 8 if it is known that a physician recommended radiation treatment, but no further documentation is available yet to confirm its administration.

5. Cases coded 8 should be followed and updated to a more definitive code as appropriate.

6. Code 9 if the treatment plan offered multiple alternative treatment options, but it is unknown which treatment, if any, was provided.

Table 7.11 Reason for No Radiation Codes

CODE	DESCRIPTION
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).
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.

Date Chemotherapy Started (NAACCR Item 1220) (FORDS pg. 261)

Description
The date of initiation of chemotherapy that is part of the first course of treatment.

Explanation
Collecting dates for each treatment modality allows the sequencing of multiple treatments and aids in the evaluation of time intervals from diagnosis to treatment and from treatment to recurrence.

Coding Instructions
1. Record the first or earliest date on which chemotherapy was administered by any facility.

2. Date format is:
   a. YYYYMMDD - when the complete date is known and valid.

      Example: A patient with colon cancer begins 5-FU on February 5, 2013. Record the date as 20130205.

   b. YYYYMM - when year and month are known and valid, and day is unknown.

      Example: A patient started chemotherapy in March 2013 but the exact day is not known. Record 201303.

   c. Blank - when no known date is applicable (no chemotherapy was given or it is unknown if chemotherapy was given).

3. Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.

4. Do not leave the date blank if chemotherapy was administered. If the date is unknown code the year of diagnosis as the start date and leave the day and month blank. Document in the text field that the complete first date of chemotherapy is not known.

> **Example:** The patient had breast cancer diagnosed in April 2013. She has completed chemotherapy and now comes to your facility for radiation therapy. Record the date of chemotherapy as 2013.

RX Date Chemo Flag (NAACCR Item #1221) (FORDS pgs. 262-263)

Description
This flag explains why there is no appropriate value in the corresponding date field.

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

Instructions
1. Leave this item blank if *Date Chemotherapy Started* has a full or partial date recorded.

2. Code 10 if it is unknown whether any chemotherapy was given.

3. Code 11 if no chemotherapy is planned or given.

4. Code 15 if chemotherapy is planned, but not yet started.

Table 7.12 RX Date Chemo Flag Codes

CODE	DESCRIPTION
10	No information whatsoever can be inferred from this exceptional value (unknown if chemotherapy was given)
11	No proper value is applicable in this context (no chemotherapy given)
15	Information is not available at this time, but it is expected that it will be available later (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).

Chemotherapy (NAACCR Item #1390) (FORDS pg. 264-265; SEER pgs. 131-135)

Description
Chemotherapy is a chemical (or group of chemicals) administered to treat cancer. Chemotherapy consists of a group of anti-cancer drugs that inhibit the reproduction of cancer cells. Chemotherapeutic agents may be administered by intravenous infusion or given orally.

Explanation
This data item allows for the evaluation of the administration of chemotherapeutic agents as part of the first course of therapy.

Coding Instructions

1. Refer to *SEER*RX Version 2.0.1* located at: **www.seer.cancer.gov/tools/seerrx/** for direction on coding systemic therapy appropriately.

2. Code the type of chemotherapy the patient received as part of the **first course of treatment** at any facility. Chemotherapy may involve the delivery of one or a combination of chemotherapeutic agents.

3. Chemoembolization is a procedure in which the blood supply to the tumor is blocked surgically or mechanically and anticancer drugs are administered directly into the tumor. This permits a higher concentration of drug to be in contact with the tumor for a longer period of time. Code as chemotherapy when the embolizing agent(s) is a chemotherapeutic drug(s). Use *SEER*Rx Version 2.0.1 to* determine whether the drugs used are classified as chemotherapeutic agents. Use codes 01, 02, 03 as specific information regarding the agent(s) is documented in the medical record.

4. Code 00 if chemotherapy was not administered to the patient, and it is known that it is not usually delivered for this type and stage of cancer, or 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.

5. Code to 82, 85, 86, or 87 if it is known that chemotherapy is usually administered for this type and stage of cancer, but it was not delivered.

6. Code to 87 if the patient refused the recommended chemotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.

7. Assign code 88 when the only information available is that the patient was referred to an oncologist.

Note: Review cases coded 88 periodically for later confirmation of chemotherapy. If follow-up indicates the patient was never seen by the oncologist, change the code to 00

8. If the physician changes one of the agents in a combination regimen and the replacement agent is in a different group (chemotherapeutic agents are grouped as alkylating agents, antimetabolites, natural products, or other miscellaneous) than the original agent, the new regimen is the beginning of subsequent treatment and is **not** recorded as first course treatment.

Note: This table is also available in the Quick Reference, Standard Tables Section.

Table 7.13 Chemotherapy Codes

CODE	DESCRIPTION
00	None; chemotherapy was not part of the first course of therapy.
01	Chemotherapy administered as first course of therapy, but the type and number of agents is not documented in the patient record.
02	Single-agent chemotherapy administered as first course of therapy.
03	Multi-agent chemotherapy was delivered as first course of therapy.
82	Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors i.e., comorbid conditions, advanced age.
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 the patient record.
87	Chemotherapy was not delivered. 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:

a. A patient with primary liver cancer is known to have received chemotherapy. The type(s) of agent(s) delivered is not documented in the medical record. Record **code 01** and document the information in the treatment documentation text field.

b. A patient with Stage III colon cancer is treated with a combination of fluorouracil and levamisole. Code the fluorouracil as a single agent and the levamisole as an immunotherapeutic agent. Record **code 02** and document the information in the treatment documentation data field.

c. A patient with early stage breast cancer receives chemotherapy. The medical record indicated a **combination regimen** containing doxorubicin is to be administered. Record **code 03** and document the information in the treatment documentation data field.

d. Following surgical resection of an ovarian mass the physician recommends chemotherapy. The medical record states chemotherapy was not delivered and the reason is not documented. Record **code 86** and document that the medical record states chemo not delivered but no reason given.

e. Patient has hepatocellular carcinoma. Under x-ray guidance, a small catheter is inserted into an artery in the groin. The catheter's tip is threaded into the artery in the liver that supplies blood flow to the tumor. A chemotherapy agent is injected through the catheter into the tumor and mixed with particles that embolize or block the flow of blood to the diseased tissue. Record **code 02** and document that chemoembolization was done.

Table 7.14 Drug Category Changes

DRUG NAME(S)	PREVIOUS CATEGORY	NEW CATEGORY	EFFECTIVE DATE
Alemtuzumab/Campath	Chemo	BRM/Immuno	1/1/2013
Bevacizumab/Avastin	Chemo	BRM/Immuno	1/1/2013
Rituximab	Chemo	BRM/Immuno	1/1/2013
Trastuzumab/Herceptin	Chemo	BRM/Immuno	1/1/2013
Pertuzumab/Perjeta	Chemo	BRM/Immuno	1/1/2013
Cetuximab/Erbitux	Chemo	BRM/Immuno	1/1/2013

RX Text Chemo (NAACCR Item # 2640)

Description
Text area for documentation of information regarding chemotherapy treatment of the reported tumor.

Explanation
Text documentation is an essential component of a complete abstract and used extensively for quality assurance, consolidation of information from multiple sources, and special studies.

Coding Instructions
1. Text information to support chemotherapy treatment information **MUST BE PROVIDED BY ALL FACILITIES.**

2. Document all first course therapy chemotherapy information regardless of where it was done, in date order.

3. Document if no chemotherapy was given, or if it cannot be determined if intended chemotherapy was given.

Example: 3/15/13 Oncologist recommends 4 cycles adjuvant taxol and carboplatin. PT wants treatment closer to home, referred to oncologist in his area. PT seen on 10/4/13 and physician notes pt has completed 4 cycles of taxol and carboplatin.

Note: See the Text Documentation section of the 2013 TCR CRH for further explanation and examples.

Date Hormone Therapy Started (NAACCR Item #1230) (FORDS pg. 268)

Description
Records the date of initiation of hormone therapy that is part of the first course of treatment.

Explanation
Collecting dates for each treatment modality allows the sequencing of multiple treatments and aids in the evaluation of time intervals from diagnosis to treatment and from treatment to recurrence.

Coding Instructions
1. Record the first or earliest date on which hormone therapy was administered by any facility.

2. Date format is:
   a. YYYYMMDD - when the complete date is known and valid.

      Example: A patient with recently diagnosed prostate cancer begins Lupron therapy on January 21, 2013. Record the date as 20130121.

   b. YYYYMM - when year and month are known and valid, and day is unknown.

      Example: A patient with breast cancer completed chemotherapy and then began Tamoxifen in April 2013, but the exact day is not known. Record the start date as 201304.

   c. YYYY - when the year is known and valid, and the month and day are unknown.

      Example: A patient with prostate cancer started Lupron therapy earlier this year, but there is no information regarding the month and day. Record 2013 as the start date.

   d. Blank - when no known date applies (no hormone therapy was given, or it is unknown if anyhormone therapy was given).

3. Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.

4. If hormone therapy was administered do not leave the date blank. If the start date is not known, record the year of diagnosis as the start date and leave the month and day blank. Document in the text field that the date of hormone treatment is unknown.

RX Date-Hormone Flag (NAACCR ITEM #1231 (FORDS pg. 269-270)

Description
This flag explains why there is no appropriate value in the corresponding date field *Date Hormone Therapy Started*.

Explanation
As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information previously transmitted in the date field.

Instructions
1. Leave this item blank if *Date Hormone Therapy Started* has a full or partial date recorded.

2. Code 10 if it is unknown whether any hormone therapy was given.

3. Code 11 if no hormone therapy is planned or given.

4. Code 15 if hormone therapy is planned, but not yet started.

Table 7.15 RX Date-Hormone Flag Codes

CODE	DESCRIPTION
10	No information whatsoever can be inferred from this exceptional value (unknown if any hormone therapy was given).
11	No proper value is applicable in this context (no hormone therapy given).
15	Information is not available at this time, but it is expected that it will be available later (hormone therapy is planned as part of first course treatment, but had not yet started at the time of the last follow-up).
(blank)	A valid date is provided in item *Date Hormone Therapy Started* (NAAACCR Item #1230).

Hormone Therapy (Hormone/Steroid Therapy) (NAACCR Item #1400) (FORDS pg. 271-272; SEER pg. 136-137)

Description
Hormone therapy is a drug or group of drugs that is delivered to change the hormone balance. Hormone therapy may affect a long-term control of the cancer growth. It is not usually curative.

Note: Hormone therapy is administered to treat cancer tissue and is considered to achieve its effect through change of the hormone balance. Some cancers, such as prostate or breast, depend upon hormones to develop. When a malignancy arises in these tissues, it is usually hormone-responsive. Other primaries and histologic types may be hormone-responsive, such as melanoma and hypernephroma.

Explanation
This data item allows for the analysis of hormone treatment as part of the first course of therapy.

Coding Instructions
1. Code the type of hormone therapy the patient received as part of the **first course of treatment** at any facility. Hormone therapy may involve the delivery of one or a combination of agents.

2. Refer to *SEER*Rx Version 2.0.1* located at: **www.seer.cancer.gov/tools/seerrx/** for direction on coding hormone therapy appropriately.

3. Code prednisone as hormone therapy when it is administered in a combination chemotherapy regimen, such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone), or COPP (cyclophosphamide, vincristine, procarbazine, prednisone).

4. Some types of cancers are slowed or suppressed by hormones. These cancers are treated by administering hormones and should be coded in this data field.

Example: Endometrial cancer may be treated with progesterone. Even if the progesterone is given for menopausal symptoms, it has an effect on the growth or recurrence of endometrial cancer and should be coded.

5. Code to 00 if hormone therapy was not delivered to the patient and it is known that it is not usually administered for this type and stage of cancer, or 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.

6. Code to 01 for thyroid replacement therapy, which inhibits the thyroid stimulating hormone (TSH). TSH is a product of the pituitary gland that stimulates tumor growth.

7. Code to 82, 85, 86, or 87 if it is known that hormone therapy is usually delivered for this type and stage of cancer, but it was not delivered.

8. Code to 87 if the patient refused recommended hormone therapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.

9. Code 88 when the only information available is that the patient was referred to an oncologist.

Note: Review cases coded 88 periodically for later confirmation of hormone therapy. If follow-up with the oncologist indicates that the patient was never there, change to code to 00.

10. Do not code as hormone replacement therapy when it is given because it is necessary to maintain normal metabolism and body function.

11. If prednisone or other hormone is delivered for other reasons, **do not** code as hormone therapy.

Examples:

a. A patient is given prednisone to stimulate the appetite and improve nutritional status. Prednisone is not coded as hormone therapy. Code to 00.

b. 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 hormone therapy. Code to 00.

Exception: Decadron is coded as hormonal treatment **for lymphoid leukemias, lymphomas, and multiple myelomas only.** It is delivered to achieve its effect on cancer tissue through change of the hormone balance.

Note: This table is also available in the Quick Reference, Standard Tables Section.

Table 7.16 Hormone Therapy Codes

CODE	DESCRIPTION
00	None; hormone therapy was not part of the planned first course of therapy.
01	Hormone therapy was delivered as first course of therapy.
82	Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age).
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 treatment. 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:

a. A patient diagnosed with metastatic prostate cancer is administered flutamide (an anti-androgenic agent) as part of the first course of therapy. Code to 01 and document the information in the Treatment Documentation data field**.**

b. A patient with metastatic prostate cancer declines the administration of Megace (a progestational agent) as part of the first course of therapy and the refusal is documented in the medical record. Code to 87 and document the information in the Treatment Documentation data field**.**

c. Patient with endometrial cancer is treated with progesterone. Even if the progesterone is given for menopausal symptoms, it has an effect on the growth or recurrence of endometrial cancer. Code to 01 and document the information in the Treatment Documentation data field.

d. A patient with follicular or papillary cancers of the thyroid is treated with thyroid hormone to suppress serum thyroid stimulating hormone (TSH). Code to 01 and document the information in the Treatment Documentation data field**.**

Note: Surgical removal of organs for hormone manipulation (such as orchiectomy for prostate cancer) is not coded in this data item. Code these procedures in the data field Hematologic Transplant and Endocrine Procedures.

RX Text Hormone (NAACCR Item #2650)

Description

Text area for information about hormonal treatment.

Explanation
Text documentation is an essential component of a complete abstract and used extensively for quality assurance, consolidation of information from multiple sources, and special studies.

Coding Instructions
1. Text information to support hormone therapy **MUST BE PROVIDED BY ALL FACILITIES.**

2. Document all first course hormone therapy regardless of where it was done.

3. Document if no hormone therapy was given, or if it is unknown if intended hormone therapy was given.

Example: After being diagnosed with adenocarcinoma of the prostate on 1/11/13, the patient opted for hormonal treatment and started Lupron on 2/1/13.

Date Immunotherapy Started (NAACCR Item #1240) (FORDS pg. 275)

Description
Records the date of initiation of immunotherapy or a biologic response modifier (BRM) that is part of the first course of treatment.

Explanation
Collecting dates for each treatment modality allows the sequencing of multiple treatments and aids in the evaluation of time intervals from diagnosis to treatment and from treatment to recurrence.

Coding Instructions
1. 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.*

2. Date format is:

a. YYYYMMDD - when the complete date is known and valid.

Example: A patient with multiple myeloma begins treatment with interferon on March 12, 2013. Record the date as 20130312.

b. YYYYMM - when the month and year are known and valid and the day is unknown.

Example: A patient with melanoma received lymphokine-activated killer cells in January 2013 the day is not known. Code 201301.

c. YYYY - when the year is known and valid, and the month and day are unknown.

Example: A patient diagnosed with lung cancer with malignant pleural effusion earlier in 2013 has been treated with Picibanil, but the exact date is not known. Record 2013 as the date immunotherapy started.

d. Blank - when no known date applies (no immunotherapy was given or it is unknown if

immunotherapy was given).

3. Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.

4. If immunotherapy was administered do not leave the date blank. If the start date is not known, record the year of diagnosis as the start date and leave the month and day blank. Document in the text field that the start date is unknown.

RX Date-Immunotherapy Flag (NAACCR Item #1241) (FORDS pgs. 276-277)

Description
This flag explains why there is no appropriate value in the corresponding date field.

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

Instructions
1. Leave this item blank if *Date Immunotherapy Started* has a full or partial date recorded.

2. Code 10 if it is unknown whether any immunotherapy was given.

3. Code 11 if no immunotherapy was planned or given.

4. Code 15 if immunotherapy is planned, but not yet started.

Table 7.17 RX Date-Immunotherapy Flag Codes

CODE	DESCRIPTION
10	No information whatsoever can be inferred from this exceptional value (unknown if immunotherapy was given).
11	No proper value is applicable in this context (no immunotherapy given)
15	Information is not available at this time, but it is expected that it will be available later (immunotherapy is planned as part of first course treatment, but had not yet been started at the time of the last follow-up)
(blank)	A valid date is provided in item *Date Immunotherapy Started* (NAACCR Item #1240)

Immunotherapy (NAACCR Item #1410) (FORDS pgs. 278-279; SEER pgs. 138-140)

Description
Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to the tumor cells.

Explanation
This data item allows for the analysis of the administration of immunotherapy agents as part of the first course of therapy.

Immunotherapy is designed to:

1. Make cancer cells more recognizable and therefore more susceptible to destruction by the immune system.

2. Boost the killing power of immune system cells, such as T-cells, NK-cells, and macrophages.

3. Alter growth patterns of cancer cells to promote behavior like that of healthy cells.

4. Block or reverse the process that changes a normal cell or a pre-cancerous cell into a cancerous cell.

5. Enhance the body's ability to repair or replace normal cells damaged or destroyed by other forms of cancer treatment, such as chemotherapy or radiation.

6. Prevent cancer cells from spreading to other parts of the body.

Types of Immunotherapy:

Cancer vaccines: Cancer vaccines are still in the experimental phase and are not coded in this data item. They may be coded in the field Other Therapy. Currently clinical trials use cancer vaccines for brain, breast, colon, kidney, lung, melanoma, ovary, and cervix.

Interferons: Interferons belong to a group of proteins called cytokines. They are produced naturally by the white blood cells in the body. Interferon-alpha is able to slow tumor growth directly as well as activate the immune system. It is used for a number of cancers including multiple myeloma, chronic myelogenous leukemia (CML), hairy cell leukemia, and malignant melanoma.

Interleukins (IL-2): are often used to treat kidney cancer and melanoma.

Monoclonal Antibodies: Monoclonal antibodies are produced in a laboratory, and are used in a variety of ways in systemic therapy. Some artificial antibodies are injected into the patient to seek out and disrupt cancer cell activities and to enhance the immune response against cancer. For example, trastuzumab (Herceptin) may be used for certain breast cancers. When the monoclonal antibody disrupts tumor growth, it is coded as chemotherapy.

Coding Instructions

1. Refer to *SEER*Rx Version 2.0.1* located at: www.seer.cancer.gov/tools/seerrx/ for direction on coding systemic therapy appropriately.

2. Code the type of immunotherapy the patient received as part of the **first course of treatment** at any facility.

3. Code to 00 if immunotherapy was not delivered to the patient and it is known that it is not usually delivered for this type and stage of cancer, or 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.

4. Code to 82, 85, 86, or 87 if it is known that immunotherapy is usually delivered for this type and stage of cancer, but it was not.

5. Code to 87 if the patient refused recommended immunotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.

6. Code to 88 when the only information is that the patient was referred to an oncologist.

Note: Review cases coded 88 periodically for later confirmation of immunotherapy. If follow-up with the oncologist indicates that the patient was never there, change to code to 00.

Note: This table is also available in the Quick Reference, Standard Tables Section.

Table 7.18 Immunotherapy Codes

CODE	DESCRIPTION
00	None, immunotherapy was not part of the first course of therapy.
01	Immunotherapy administered as first course of therapy.
82	Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., 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 treatment. 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 immunotherapy agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

RX Text Immunotherapy (NAACCR Item 2660)

Description
Text information describing all immunotherapy given as part of first course of treatment.

Explanation
Text documentation is an essential component of a complete abstract and used extensively for quality assurance, consolidation of information from multiple sources, and special studies.

Coding Instructions
1. Text information **MUST BE PROVIDED BY ALL FACILITIES.**

2. Document all first course immunotherapy regardless of where it was done.

3. Document if no immunotherapy was given, or if it cannot be determined if intended immunotherapy was given.

Note: See the Text Documentation section of the 2013 TCR CRH for further explanation and examples.

RX Summ– Transplant/Endocrine (NAACCR Item #3250) (FORDS pgs. 281-282; SEER pgs. 141-143)

Description
Systemic therapeutic procedures that include bone marrow transplants, stem cell harvests, surgical and/or radiation endocrine therapy received at any facility as first course of treatment.

Explanation
This treatment involves the alteration of the immune system or changes the patient's response to tumor cells, but does not involve the delivery of antineoplastic agents.

Definitions:

Bone marrow transplant (BMT): Procedure used to restore stem cells that were destroyed by chemotherapy and/or radiation. Replacing the stem cells allows the patient to undergo higher doses of chemotherapy.

BMT Allogeneic: Receives bone marrow or stem cells from a donor.

BMT Autologous: Uses the patient's own bone marrow and/or stem cells. The tumor cells are filtered out and the purified blood and stem cells are returned to the patient.
Conditioning: High dose of chemotherapy with or without radiation administered prior to transplants such as BMT and stem cell to kill cancer cells. This conditioning also destroys normal bone marrow cells so the normal cells need to be replaced (rescue). The high dose chemotherapy is coded in the Chemotherapy field.

Hematopoietic Growth Factors: A group of substances that support hematopoietic (blood cell) colony formation. The group includes erythropoietin, interleukin-3, and colony-stimulating factors (CSFs). The growth-stimulating substances are ancillary drugs and not coded.

Non-Myeloablative Therapy: Uses immunosuppressive drugs pre- and post-transplant to ablate the bone marrow. These are not recorded as therapeutic agents.

Peripheral Blood Stem Cell Transplant (PBSCT): Rescue that replaces stem cells after conditioning.

Stem Cells: Immature cells found in bone marrow, blood stream and umbilical cords. The stem cells mature into blood cells.

Coding Instructions
1. Code the type of hematologic transplant and/or endocrine procedures the patient received as part of the **first course of treatment** at any facility.

2. 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 (bone marrow donated from an identical twin), the item is coded as allogeneic.

3. Stem cell harvests involve the collection of immature blood cells from the patient and the re-

introduction of a transfusion of the harvested cells following chemotherapy or radiation therapy.

4. Endocrine irradiation and/or endocrine surgery are procedures that suppress the naturally occurring hormonal activity of the patient and therefore alter or affect the long-term control of the cancer's growth. 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 qualify as endocrine surgery or endocrine radiation.

Examples:

a. Bilateral orchiectomy for prostate cancer.

b. Bilateral oophorectomy for breast cancer.

c. Bilateral adrenalectomy for microadenoma.

d. Bilateral hypophysectomy for pituitary cancer

e. Bilateral radiation to ovaries for breast cancer, or to testicles for prostate cancer

5. Code to 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 or 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.

6. Code 86 if the treatment plan offered multiple options which included a transplant, and the patient selected treatment that did include a transplant procedure.

7. Code to 82, 85, 86, or 87 if it is known that a transplant or endocrine procedure is usually delivered for this type and stage of cancer, but it was not.

8. Code to 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.

9. Code 88 if the only information is that the patient was referred to a specialist for hematologic transplant or endocrine procedures.

Note: Cases coded 88 should be followed to determine whether they were given a hematologic transplant or endocrine procedure or why not.

Note: This table is also available in the Quick Reference, Standard Tables Section.

Table 7.19 RX Summ– Transplant/Endocrine Codes

CODE	DESCRIPTION
00	No transplant procedure or endocrine therapy was administered as part of first course of therapy.
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.
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 were not recommended/ administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age).
85	Hematologic transplant and/or endocrine surgery/radiation were 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 first course therapy. No reason was stated in patient record.
87	Hematologic transplant and/or endocrine surgery/radiation were 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 were recommended, but it is unknown if it was administered.
99	It is unknown whether hematologic transplant and/or endocrine surgery/radiation were recommended or administered because it is not documented in the medical record. Death certificate only.

RX Summary Systemic /Surgery Sequence (NAACCR Item #1639) (FORDS pgs. 283-284; SEER pgs. 144-145)

Description
Records the sequencing of systemic therapy and surgical procedures given as part of the first course of treatment.

Explanation
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 item can be used to more precisely evaluate the timing of delivery of treatment to the patient.

Coding Instructions
1. 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).

2. If none of the following surgical procedures were performed: *Surgical procedure of primary site* (NAACCR Item #1290), S*cope of Regional Lymph Node Surgery* (NAACCR Item #1292), S*urgical Procedure/Other Site* (NAACCR Item #1294), then this item should be coded 0.

3. If the patient received both systemic therapy and any one or a combination of the following surgical procedures: *Surgical Procedure of Primary Site* (NAACCR Item #1290), S*cope of Regional Lymph Node Surgery* (NAACCR Item #1292), *Surgical Procedure/Other Site* (NAACCR Item #1294), then code this item 2–9, as appropriate.

4. 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.

Example: The sequence chemo, then surgery, then hormone therapy, then surgery is coded 4 for "chemo then surgery then hormone".

Note: This table is also available in the Quick Reference, Standard Tables Section.

Table 7.20 RX Summary Systemic /Surgery Sequence Codes

CODE	LABEL	DESCRIPTION
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. Diagnosed at autopsy. Death certificate only. (***Note:*** *This differs from FORDS instruction.)*
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 after any surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
5	Intraoperative systemic therapy	Intraoperative systemic therapy was given during surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s).
6	Intraoperative systemic therapy with other therapy administered before or after surgery	Intraoperative systemic therapy was given during surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) with other systemic therapy administered before or after surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
7	Surgery both before and after systemic therapy	Systemic therapy was administered between two separate surgical procedures to the primary site; regional lymph nodes, surgery to other regional site(s), distant site(s), or distant lymph node(s)
9	Sequence unknown	Administration of systemic therapy and 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) were performed and the sequence of the treatment is not stated in the patient record. It is unknown if systemic therapy was administered and/or it is unknown if 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) were performed.

Examples:

a. Due to other medical conditions surgery was not performed. The patient received palliative radiation therapy to alleviate pain. Record **code 0** and document the information in the treatment documentation data field.

b. Patient with prostate cancer received hormone therapy prior to a radical prostatectomy. Record **code 2** and document the information in the treatment documentation data field.

c. Patient underwent a colon resection followed by a 5-FU based chemotherapy regimen. Record **code 3** and document the information in the treatment documentation data field.

d. Patient with breast cancer receives pre-operative chemotherapy followed by post-operative Tamoxifen. Record **code 4** and document the information in the treatment documentation data field.

e. Patient with intracranial primary undergoes surgery at which time a glial wafer is implanted into the resected cavity. Record **code 5** and document the information in the treatment documentation data field.

f. Patient with metastatic colon cancer receives intraoperative chemotherapy to the liver followed by 5-FU. Record **code 6** and document the information in the treatment documentation data field.

g. 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. Record **code 9** and document the information in the treatment documentation data field.

Date Other Treatment Started (NAACCR Item #1250) (FORDS pg. 285)

Description
The date other treatment began as first course of therapy.

Explanation
Records the date **other** treatment is delivered that is not included in surgery, radiation therapy, and systemic treatment.

Coding Instructions
1. Record the date the other treatment was delivered.

2. Date format is:

   a. YYYYMMDD - when the complete date is known and valid.

Example: A patient with polycythemia vera was first treated with phlebotomy on February 20, 2013. Record Date of Other Treatment as 20130220.

   b. YYYYMM - when year and month are known and valid, and day is unknown.

Example: A patient with pancreatic cancer is enrolled in a double-blind clinical trial in May 2013, but the day is not known. Record Date of Other Treatment as 201305.

c. YYYY - when year is known and valid, and the month and day are unknown.

Example: A patient diagnosed with essential thrombocythemia in 2013 and has since been treated with aspirin, but the exact date is unknown. Code the date as 2013.

d. Blank - when no known date applies (no other therapy was given or it is unknown if other therapy was given).

3. Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.

4. Do leave blank if other treatment is given. If the date is unknown record the year of diagnosis and leave the month and day blank. Document in the text field that the date is unknown.

RX Date-Other Treatment Flag (NAACCR Item #1251) (FORDS pgs. 286-287)

Description
This flag explains why there is no appropriated value in the corresponding date field, *Date Other Treatment Started,* NAACCR Item #1250.

Explanation
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
1. Leave this item blank if *Date Other Treatment Started* (NAACCR Item #1250) has a full or partial date recorded.

2. Code 10 if it is unknown whether any other treatment was given (*Other Treatment,* NAACCR Item #1420, is 9).

3. Code 11 if no other treatment is planned or given (*Other Treatment* 0, 7 or 8).

Table 7.21 RX Date-Other Flag Codes

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).
(blank)	A valid date value is provided in item *Date Other Treatment Started* (NAACCR Item #1250).

Other Treatment (NAACCR Item #1420) (FORDS pg. 288; SEER pgs. 146-148)

Description
"Other treatment" is designed to modify or control the cancer cells, but is not defined as surgery, radiation, or systemic therapy fields.

Explanation
Used to evaluate treatment practices and for special studies.

Coding Instructions
1. Code the type of "other treatment" the patient received as part of the **first course of treatment** at any facility.

2. 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. 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 "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.

3. **Do not** code ancillary drugs in this field. There is no coding scheme for ancillary drugs such as Leucovorin.

4. Tumor embolization is the intentional blockage of an artery or vein to stop the flow of blood through the desired vessel. Code as Other Therapy when tumor embolization is performed using alcohol as the embolizing agent. Use code 01.

Note: Do not code pre-surgical embolization of hypervascular tumors with particles, coils or alcohol. These pre-surgical embolizations are typically performed to make the resection of the primary tumor easier. Examples where pre-surgical embolization is used include meningiomas, hemangioblastomas, paragangliomas, and renal cell metastases in the brain.

5. Assign code 6 for:

a. Unconventional methods whether they are the only therapy or are given in combination with conventional therapy.

b. Alternative therapy ONLY if the patient receives no other type of treatment.

Note: This table is also available in the Quick Reference, Standard Tables Section.

Table 7.22 Other Treatment Codes

CODE	TYPE	DESCRIPTION
0	None	All cancer treatment was coded in other treatment fields (surgery, radiation, systemic therapy). Patient received no cancer treatment.
1	Other	Cancer treatment that cannot be appropriately assigned to specific treatment data items (surgery, radiation, systemic). Use this code for treatment unique to hematopoietic diseases. *See **Examples**
2	Other-Experimental	This code is not defined. It may be used to record participation in facility-based clinical trials.
3	Other-Double Blind	A patient is involved in a double-blind clinical trial. Code the treatment actually administered when the double-blind trial code is broken.
6	Other-Unproven	Cancer treatments administered by non-medical personnel.
7	Refusal	Other treatment was not administered. It was recommended by the patient's physician, but this treatment (which would have been coded 1, 2, or 3) was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
8	Recommended; unknown if done	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.

Examples:

a. A patient with polycythemia vera is treated with phlebotomies. Use code 1 for polycythemia vera ONLY according to the *2013 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* for cases diagnosed January 2013 and later. Phlebotomy may be called blood removal, bloodletting, or venisection.

b. A patient with pancreatic cancer is enrolled in a double-blind clinical trial. The treatment agents are unknown. Use code 3.

c. A patient was treated for melanoma with PUVA (psoralen and long-wave ultraviolet radiation). Code this treatment as *Other Treatment,* code 1.

Note: Do not collect **blood transfusions** (whole blood, platelets, etc.) as treatment. Blood transfusions are used widely to treat anemia and it is not possible to collect this procedure in a meaningful way. This is a new instruction for cases diagnosed 1/1/2013 and later according to the *2013 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual.*

RX Text Other (NAACCR Item #2670)

Description

Text area for information describing all other treatment given as part of first course of treatment.

Explanation
Text documentation is an essential component of a complete abstract and used extensively for quality assurance, consolidation of information from multiple sources, and special studies.

Coding Instructions
1. Text information **MUST BE PROVIDED BY ALL FACILITES**

2. Document all first course other treatment regardless of where it was done, in date order.

3. Document if no other treatment was given, or if it is unknown if intended other treatment was given.

Note: See the Text Documentation section of the 2013 TCR CRH for further explanation and examples.

RX Summ-Treatment Status (NAACCR Item #1285) (FORDS pg. 208; SEER pg. 112)

Description
This data item summarizes whether the patient received any treatment or the tumor was under active surveillance.

Explanation
This item documents active surveillance (watchful waiting) and eliminates searching each treatment modality to determine whether treatment was given.

Instructions
1. This item may be left blank for cases diagnosed prior to 2010.

2. Treatment given after a period of active surveillance is considered subsequent treatment and it is not coded in this item.

Note: Any type of first course cancer directed treatment, including surgery, is to be coded as "Treatment given".

Table 7.23 RX Summ-Treatment Status Codes

CODE	DESCRIPTION
0	No treatment given
1	Treatment given
2	Active surveillance (watchful waiting)
9	Unknown if treatment was given

Date of Last Contact or Death (NAACCR Item #1750) (FORDS pg. 300; SEER pgs. 150-151)

Description
The date of last contact with the patient or the date the patient expired.

Explanation
This information is used for follow-up and patient outcome studies.

Coding Instructions

1. Record the date the patient was last seen at your facility, date of last contact, or date of death.

2. Date format is YYYYMMDD.

3. Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.

4. If patient is known to be deceased, but date of death is not available, date of last contact should be recorded in this field. In the *Text Remarks-Other Pertinent Information* text area, document that the patient is deceased and the date of death is not available.

Vital Status (NAACCR Item #1760) (FORDS pg. 302; SEER pg. 153)

Description

Records the vital status of the patient as of the *date of last contact or death* known to the reporting facility through all available resources. If the patient has multiple tumors, vital status should be the same for all tumors.

Explanation

This information is used for outcome studies.

Coding Instructions

1. Code the patient's vital status as of the date recorded in the *date of last contact or death* field. Use the most current and accurate information available.

2. If a patient has multiple primaries **simultaneously**, all records should have the same vital status.

Table 7.24 Vital Status Codes

CODE	DESCRIPTION
0	Dead
1	Alive

Place of Death – State (NAACCR Item #1942)

Description

State where the patient died and where certificate of death is filed.

Explanation

When a hospital reports a place of death, the information can help in death certificate matching.

Coding Instructions

See Appendix B of the *SEER Program Code Manual* at seer.cancer.gov/tools/codingmanuals/index.html for numeric and alphabetic lists of places and codes.

Leave blank if patient alive.

Place of Death – Country (NAACCR Item #1944)

Description
Code for the country in which the patient died and where certificate of death is filed.

Explanation
When a hospital reports a place of death that is outside of the registry's country, the information can signal a death for which the death certificate will not be available from another state or through the NDI linkage.

Coding Instructions
Use the International Standards Organization (ISO) 3166-1 Country Three Character Codes, whenever possible, augmented by custom codes.

Table 7.25 Place of Death Sample Codes

CODE	DESCRIPTION
USA	United States
ZZN	North America NOS
ZZC	Central America NOS
ZZX	Non-US NOS
ZZU	Unknown

Date Abstracted (NAACCR Item #2090)

Description:
Record the date the registrar determined the tumor report was complete (all first course therapy administered or treatment plan coded and documented) and the case has passed edits.

Explanation
This field is used for TCR data quality and timeliness evaluation.

Coding Instructions
1. Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.

2. Record the year, month, and day (YYYYMMDD) the form was completed.

Abstractor Initials (NAACCR Item #570) (FORDS pg. 308)

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

Explanation
This data item is used for providing feedback for quality control.

Coding Instruction
1. Record the initials of the person abstracting the case.

8

DOCUMENTATION OF CANCER DIAGNOSIS, EXTENT OF DISEASE, AND TREATMENT

DOCUMENTATION OF CANCER DIAGNOSIS, EXTENT OF DISEASE, AND TREATMENT

(NAACCR Text Item #'s 2220, 2520, 2530, 2540, 2550, 2560, 2570, 2590, 2580, 2600, 2610, 2620, 2640, 2650, 2660, 2670, 2680)

Text information to support cancer diagnosis, stage, and treatment codes **MUST BE PROVIDED BY ALL FACILITIES**. Document all types of the **first course** of definitive treatment administered, regardless of where the treatment was received, in chronological order.

Text documentation is an important element of a complete abstract. It is critical for quality assurance and special studies. Text is used to support coded values and to provide supplemental information not transmitted within coded values. Complete text documentation facilitates consolidation of information from multiple reporting sources. The text field must contain a description that has been entered by the abstractor. Cancer Registry software generating text automatically from coded data cannot be utilized to support coded values. Information documenting the disease and treatment must be entered manually from the medical record. **TNM staging is not an acceptable substitute for stage documentation**.

Text documentation should explain where the cancer started, where it went (lymph nodes, other organs) and how it got there (direct extension, metastasis, implants). Clinical and pathological findings should be documented.

Always use text to document certain basic information:

1. The date of the examination or procedure (Example: 6/15/2013); **keep dates in chronological order.**

2. The name of the examination or procedure (Example: excisional biopsy).

3. The results of the examination or procedure-any pertinent **positive or negative** information (Examples: negative margins, chest X-ray negative, liver biopsy positive for metastasis).

4. The diagnostic impression, final diagnosis, or final conclusion if one is given (Example: Ductal carcinoma of left breast).

5. The planned treatment, whether or not it is known if treatment was given (Example: chemotherapy planned after left modified mastectomy).

6. The date and type of treatment given, even if it was done at another institution (Example: 6/15/2013 5FU administered at ABC hospital).

7. Specific subsite of primary site (Example: upper outer quadrant of left breast).

8. Specific number, chain of lymph nodes examined and results (Example: 3/15+ left axillary lymph nodes).

9. Specific information about metastatic spread of disease to lymph nodes and/or other organs and tissues (Example: metastasis to 15 supraclavicular lymph nodes; brain metastasis).
Documentation is used to verify all coded fields regarding the patient, disease, extent of disease and

spread of disease. Text should be documented in the appropriate text fields.

10. Demographic information such as age at diagnosis, race and sex of the patient should also be recorded in text fields (Example: 76 year old Caucasian male).

Unknown is used when there is insufficient information to determine stage or extent of disease. If the primary site is unknown (C809) then the Summary Stage must be unknown. Document where the cancer was found if the primary site is unidentified.

Documentation is necessary to verify all coded fields regarding types and timing of treatment. Be sure to document in the Treatment Documentation field if the medical record indicates no treatment was planned or given, or if there is no information in the medical record that definitive treatment was given. If it cannot be determined whether therapy was actually performed, record that it was recommended but it is not known if the procedure was administered. For example, "radiation recommended, unknown if given." If a port is placed for chemotherapy, record this information but do not code that chemotherapy was given unless it is known that it was.

Call your Health Service Region for technical assistance if additional direction is needed to determine the appropriate information to document. TCR staff may request copies of the necessary reports with your data submission in order to assist you.

Types of Reports to Review

Medical imaging can provide key information for evaluating clinical extent of disease. For example, a CT of the lung can show the size and location of the tumor within the lung. It can demonstrate the presence of pleural effusion, or extension of the tumor to other tissues such as ribs, chest wall or pleura. Bone scans and MRI or CT of the brain are often used to evaluate for metastatic sites. History and Physical reports sometimes give the results from outside imaging studies. Documentation of all positive and negative findings from imaging exams should be recorded in the Summary Stage Documentation field.

Physical exam or **History and Physical (H&P)** can provide the size for palpable masses and information regarding palpable lymph nodes. For example, during a digital rectal exam (DRE) the prostate is palpated. The physician will note findings such as nodularity, induration, fixation of seminal vesicles, enlargement, firmness, etc. All positive and negative findings pertinent to the patient's cancer are an important aspect of Collaborative Staging and must be noted in the Summary Stage Documentation field to support coding. Patient demographics can also be found in the H&P. Record age, race and sex when available. This information is useful in record consolidation.

Pathology reports provide key information including **cell type**, **grade**, **size** and **location** of tumor, **number of lesions or foci**, **depth of invasion**, **spread of tumor to other organs**, and **lymph node involvement**. Record each of these items in the Summary Stage Documentation. Be sure to record the furthest extension that the pathologist mentions, for example: confined to mucosa; into subserosa; through full thickness of abdomen wall, etc.

Operative reports will often contain the surgeon's observations regarding involvement or lack of involvement of lymph nodes or other organs. The operative report will also contain detailed information of the exact type of surgery performed, tissue or organ(s) excised, and tissue or organ(s) left intact.

Record these findings in the Summary Stage Documentation.

Discharge summaries, clinical notes, or progress reports are good sources for treatment information. Review all available reports and document all planned treatment, as well as the date and modalities of known treatment in the Treatment Documentation. Give specific information when available such as type and number of courses of chemotherapy. If no treatment is planned or the patient refuses recommended treatment, include this information in the text field.

Lab results are used to code many of the Site-Specific Factors. Source documents for many of the Site Specific Factors can be found in Appendix A, Site Specific Factor Coding Instructions.

Specific Instruction on Involvement

Lymph Node Involvement: For solid tumors, the terms "fixed" or "matted" and "mass in the mediastinum, retroperitoneum, and/or mesentery" (with no specific information as to tissue involved) are considered involvement of lymph nodes for the purpose of Collaborative Stage coding. Any other terms, such as "palpable," "enlarged," "visibly swelling," "shotty," or "lymphadenopathy" should be ignored unless there is a statement from the physician of involvement, either clinical or pathological. A metastatic nodule in connective tissue of a lymph drainage area is considered to be evidence of lymph node metastasis.

Exception: Regional lymph nodes of the lung where there is a description of mass*, enlargement, or adenopathy* in the hilum or mediastinum is considered involvement.

Exception: Lymphomas: *Any* mention of lymph nodes is indicative of involvement. In staging lymphomas, bilateral node involvement should be considered 2 chains for the purpose of assigning a stage. For example, bilateral involvement of inguinal lymph nodes would be considered 2 chains.

Note: Regional lymph nodes are not palpable (inaccessible) for sites such as bladder, kidney, prostate, esophagus, stomach, lung, liver, corpus uteri, and ovary. The best description concerning regional lymph node involvement will be the surgeon's evaluation at the time of exploratory surgery or definitive surgery or from radiologic exam.

Venous Invasion: An assessment of blood vessels **within** the primary organ. This does not constitute regional or distant spread of malignancy.

Lymphatic Invasion: A microscopic assessment of involvement of the lymphatic channels **within** the primary organ and at the margins of resection. This is an assessment of the potential, from the primary tumor, to metastasize to lymph nodes, even though the tumor has extended no further than the lymph channels and is still confined to the primary site.

Residual Tumor: Refers to the status of the margins after a surgical procedure of the primary site. It is important to document this information if it is available in the pathology and/or operative report. ***Microscopic residual tumor*** is identified by the pathologist through the microscope but is not grossly visualized. An example would be a positive margin of resection when the surgeon stated that the tumor was completely removed. ***Macroscopic residual tumor*** is identified during the procedure by the surgeon and is a tumor that is grossly visualized. An example of this would be tumor adhering to another structure that the surgeon could not remove.

Note: When there is doubt about assigning the appropriate stage, assign the lesser stage. Do not over stage.

Determination of the cancer stage is both a subjective and objective assessment of how far the cancer has spread. The following list of terms may be used to determine involvement for **Collaborative Staging only.**

Note: Do not use these lists for case finding or to determine multiple primaries or histology.

Consider as Involvement

adherent	induration
apparent(ly)	infringe/infringing
appears to	into*
comparable with	intrude
compatible with	invasion to, into, onto, out onto
consistent with	most likely
contiguous/continuous with	onto*
encroaching upon*	overstep
extension to, into, onto, out onto	presumed
features of	probable
fixation to another structure**	protruding into (unless encapsulated)
fixed**	suspected
impending perforation of	suspicious
impinging upon	to*
impose/imposing on	up to
incipient invasion	

***interpreted as involvement whether the description is clinical or operative/pathological**

****interpreted as involvement of other organ or tissue**

Do Not Consider as Involvement

abuts	extension to without invasion/involvement of
approaching	kiss/kissing
approximate	matted (except for lymph nodes)
attached	possible
cannot be excluded/ruled out	questionable
efface/effacing/effacement	reaching
encased/encasing	rule out
encompass(ed)	suggests
entrapped	very close to
equivocal	worrisome

The following table lists suggestions for the type of text to include for each text field.

Table 8.1 Text Field Examples

NAACCR TEXT FIELD AND DATA ITEM#	TEXT SUGGESTIONS	DATA ITEM(S) VERIFIED WITH TEXT
Other Pertinent Information #2680	• Age, sex and race of patient • Spanish/Hispanic Origin • Place of birth • Country of Birth • Insurance/primary payer information • Name of Follow Up Physician • Unknown demographic information (unknown SS#, unknown address at diagnosis) • Overflow or problematic coding issues	Date of Birth **#240** Country of Birth #**254** Sex #**220** Race 1-5 **#160-164** Spanish/Hispanic Origin **#190** Place of Birth **#250** Physician Follow Up **#2470** Primary Payer at Dx **#630**
Other Primary Tumors #2220	• Site of *Other Primary* • Morphology of *Other Primary* • DX Date of *Other Primary*	Sequence Number **#560**
Summary Stage Documentation #2600	• Date(s) of procedure(s) including biopsies and clinical procedures that provide staging information such as x-rays • Organs involved by direct extension • Size of tumor • Status of margins • Number and sites of positive lymph nodes • Metastatic sites • Physician's specialty (Surgeon, Oncologist, etc.) • Physician's comments	Date of Initial Diagnosis **#390** Diagnostic Confirmation **#490** Primary site **#400** Morphology/Behavior **# 522, 523** Collaborative Stage variables **#2800-2930** Regional Nodes Positive **#820** Regional Nodes Examined **#830** Laterality **#410**
Summary Stage Documentation –PE #2520	• Date of diagnosis • History relating to cancer diagnosis • Impression pertaining to cancer diagnosis • Positive and negative clinical findings • Palpable lymph nodes • Treatment plan	Date of First Contact **#580** Date of Diagnosis **#390** Race 1-5 **#160-164** Span/Hispanic Origin **#190** Sex **#220** Primary Site **#400** Laterality **#410** Histology ICD-O-3 **#522** Sequence # Hospital **#560** Collaborative Stage variables **#2800-2930** SEER Summary Stage 2000 **#759**

NAACCR TEXT FIELD AND DATA ITEM#	TEXT SUGGESTIONS	DATA ITEM(S) VERIFIED WITH TEXT
Summary Stage Documentation-Xray/Scan #2530	• Date and type of X-ray or Scan • Primary site • Histology (if given) • Tumor location • Tumor size • Lymph nodes • Record positive and negative findings • Distant disease or mets	Date of Diagnosis **#390** Primary Site **#400** Laterality **#410** Histology ICD-O-2 **#420** Histology ICD-O-3 **#522** Collaborative Stage variables **#2800-2930** SEER Summary Stage 2000 **#759**
Summary Stage Documentation-Scopes #2540	• Dates of endoscopic exams • Primary site • Histology • Tumor location • Tumor size • Site and type of endoscopic biopsy • Positive and negative clinical findings	Date of Diagnosis **#390** Diagnostic Confirmation **#490** Primary Site **#400** Laterality **#410** Histology ICD-O-2 **#420** Histology ICD-O-3 **#522** Collaborative Stage variables **#2800-2930** SEER Summary Stage 2000 **#759** RX Date-Surgery **#1300**
Summary Stage Documentation-Lab Tests #2550	• Type of lab test/tissue specimen • Both positive and negative findings • Tumor markers, special studies etc. Including : Estrogen Receptor Assay (ERA), Progesterone Receptor Assay (PRA), Her2/neu, Human Chorionic Gonadotropin (hCG) • Date of lab tests	Primary Site **#400** Grade **#440** Diagnostic Confirmation **#490** Collaborative Stage variables **#2800-2930** Date of Diagnosis **#390**
Summary Stage Documentation-Op #2560	• 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	Date of Diagnosis **#390** Diagnostic Confirmation **#490** Primary Site **#400** Collaborative Stage variables **#2800-2930** SEER Summary Stage 2000 **#759** Reason for No Surgery **#1340**
Summary Stage Documentation Path #2570	• Dates of procedures • Anatomic source of specimen • Type of tissue specimen	Date of Diagnosis **#390** Primary Site **#400** Laterality **#410**

NAACCR TEXT FIELD AND DATA ITEM#	TEXT SUGGESTIONS	DATA ITEM(S) VERIFIED WITH TEXT
	• Tumor type and grade (include all modifying adjectives: predominantly, with features of etc.) • Gross tumor size • Extent of tumor spread • Involvement of resection margin • Number of lymph nodes involved and examined • Both positive and negative findings • Record any additional comments from the pathologist, including differential diagnosis considered and any ruled out or favored	Histologic Type ICD-O-3 **#522** Grade **#440** Collaborative Stage variables **#2800-2930** Diagnostic Confirmation **#490** RX Summ-Surg Prim Site **#670** RX Sum-Scope Reg LN Sur **#1392** RX Summ-Surg Oth Reg/Dis **# 1394** SEER Summary Stage 2000 **#759** Regional Nodes Positive **#820** Regional Nodes Examined **#830** RX Date-Surgery **#1300** Reason for No Surgery **#1340** RX Summ-Surg/Rad Seq **#1380** RX Summ-Systemic/Sur Seq **#1639**
Final Diagnosis (Primary, Laterality) #2580	• Location of primary site of tumor • Information on laterality of tumor	Primary site **#400** Laterality **#410**
Final Diagnosis (Morphology, Behavior, Grade) #2590	• Morphology/Behavior • Grade of tumor	Morphology/Behavior **#522, #523** Grade **#440**
Rx Text Surgery #2610	• Date of each surgical procedure • Type(s) of surgical procedure(s), including surgery to other and distant sites • Lymph nodes removed • Regional tissues removed • Facility and date for each procedure • Reason for no surgery	DX confirmation **#490** RX Date Surgery **#1300** Surgery Rx Code **#1390** RX Summ Scope of Reg LN Surgery **#1392** RX Summ-Surg Other/Dist RX Code **#1394** Reason for No Surgery **#1340**
Rx Text-Radiation #2620	• Date radiation treatment began and ended • Type(s) of radiation • Planned doses • Other treatment information (discontinued after 2 treatments; unknown if radiation was given)	Date Radiation Started **#1310** Rad-Regional RX Modality Code **#1570** RX Summ-Surg/Rad Sequence **#1380**
Rx Text-Chemo #2640	• Date when chemotherapy began and ended • Where chemotherapy was given	Chemotherapy Code **#1390** RX Date-Systemic **#3230** Systemic/Surgery Sequence

NAACCR TEXT FIELD AND DATA ITEM#	TEXT SUGGESTIONS	DATA ITEM(S) VERIFIED WITH TEXT
	• Type of chemotherapy (name of agent(s) and doses planned/received • Other treatment information (treatment cycle incomplete, unknown if chemotherapy was given.)	**#1639**
Rx Text-Hormone #2650	• Planned hormone treatment • Date treatment was started • Where treatment was given • Type of hormone or antihormone	Hormone Code **#1400** RX Date-Systemic **#3230** Systemic/Surgery Sequence **#1639**
Rx Text – Immunotherapy #2660	• Planned immunotherapy treatment • Type of immunotherapy given	Immunotherapy Code #**1340**
Rx Text-Other #2670	• Date treatment was started • Where treatment was given • Type of other treatment • Other treatment information (not given, incomplete)	Date of Initial Treatment **#1360** RX Summ-Other **#1420** RX Date-Other **#1350**

The pertinent information in the following examples has been documented in **bold lettering** for easier identification of required text.

Documentation Examples

Case #1 Lung

Imaging Reports

2/18/13 VA Clinic: **CT Chest**: Findings: **Supraclavicular, axillary, and mediastinal structures unremarkable. No mediastinal or hilar adenopathy**. There is a **2.8 x 2.4 x 4.8cm mass in the right lower lobe.** The margins are well defined with minimal peripheral ground-glass opacity, **probably some degree of obstructive pneumonitis**. The **remainder of the lungs is clear.**

IMPRESSION
1. Lobulated soft tissue **mass in the right lower lobe consistent with neoplasm. No evidence of adenopathy, mediastinal or hilar spread.**

2/28/13 CT Brain Your Hospital: Impression: **No evident disease process.**

Pathology Reports

2/28/13 Your Hospital: Final Diagnosis: **Fine Needle Aspirate, right lower lobe lung: positive for malignant cells**

3/1/13 Your Hospital: Final Diagnosis: Superior segment **right lower lobe, resection: moderately differentiated squamous cell carcinoma**, maximum tumor diameter **5.0cm**, **2nd nodule in right lower lobe measures 0.5cm,** resection **margin free** of tumor, **peribronchial lymph node negative** for tumor, right lower **paratracheal lymph node negative for tumor**, right **pretracheal lymph node negative** for tumor.

Clinic Reports

3/15/13: **Oncologist recommended 4 cycles of adjuvant taxol and carboplatin. The patient would rather receive treatment closer to home and has been referred to an oncologist in that area.**

Summary Stage Documentation (2520, 2530, 2540, 2550, 2560, 2570, 2600)

2/18/13 CT Chest: 4.8cm mass in RLL c/w neoplasm, supraclavicular, axillary, and mediastinal structures unremarkable, no mediastinal or hilar lymphadenopathy, probably some obstructive pneumonitis, remainder of lungs clear

2/28/13 Fine Needle Aspirate RLL lung: positive for malignant cells

2/28/13 Ct Brain: No evident dz process

3/1/13 RLL Resection: MD Squamous cell car, 2 nodules 5cm and 0.5cm, margin free, 0/3 peribronchial, paratracheal and pretracheal lns

Treatment Documentation (2610, 2620, 2640, 2650, 2660, 2670)

3/1/13 RLL lobectomy with mediastinal ln dissection

3/15/13 Oncologist recommends 4 cycles adjuvant taxol and carboplatin. PT wants treatment closer to home, referred to oncologist in his area, unknown if chemo done.

Case #2 Lung

Imaging Reports

6/25/13 River Ranch Radiology **CT Chest**: I see **no pneumothorax or pleural effusion**. There is an **11.7 x 8.5cm soft tissue mass in the right apex.** There is associated **marked mediastinal lymphadenopathy** with enlarged **nodes in** the **anterior mediastinum, enlarged nodes lying lateral to** the **main pulmonary artery,** and **enlarged nodes in** the **pretracheal and precarinal region.** There are **enlarged nodes around the right hilum.** The **left lung appears normal.**

Conclusion: Right upper lobe mass with associated marked mediastinal lymphadenopathy. The findings are **highly suspicious for a primary carcinoma of the lung.**

7/1/13 Oncology Associates **Bone scan**: Non-specific increased uptake at L3 and L5, **no obvious metastasis.**

7/1/13 Oncology Associates **MRI brain: Diffuse cerebral atrophy**

Bronchoscopy Report

6/26/13 Bronchoscopy: The **vocal cords** were visualized and **appeared to move normally.** The bronchoscope was passed to the trachea, which was widely patent. **No endobronchial lesions were noted.** There was a small amount of bleeding from the right upper orifice. **No lesions were noted at the right lower lobe or right middle lobe**. Endobronchial biopsy was performed times six at the right upper lobe. Bleeding was minimal.

Pathology Report

6/26/13 Right upper lobe mass biopsy Final Diagnosis: **non-small cell carcinoma**

Clinical Reports

7/5/13 Oncology Clinic Consultation: This patient has at least Stage 3b disease. This **condition can best be treated with a combination of chemotherapy and radiation therapy concurrently**. We want to start treatment as soon as possible

7/15/13 Discharge Summary: The **patient has been treated with VP-16 times three days along with daily radiation therapy** for a diagnosis of non-small cell carcinoma. He was hospitalized because of shortness of breath and iron deficiency anemia. At this time his condition has stabilized.

Summary Stage Documentation ((2520, 2530, 2540, 2550, 2560, 2570, 2600)

6/25/13 CT chest: no pneumothorax or pleural effusion, 11.7cm mass in rt apex, highly suspicious for lung carcinoma, marked mediastinal lymphadenopathy, enlarged nodes in anterior mediastinum, enlarged nodes lateral to main pulmonary artery, in pretracheal and precarinal region and in rt hilum, lft lung appears normal

6/26/13 Bronchoscopy: vocal cords appear to move normally, no endobronchial, rll or rml lesions

6/26/13 RUL mass bx: Non-small cell carcinoma

7/1/13 Bone Scan: no mets

7/1/13 MRI brain: diffuse cerebral atrophy

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

7/5/13 concurrent chemo/radiation therapy recommended

7/15/13 Discharge Summary: PT has been treated with VP-16 x 3 days along with daily radiation therapy

Case #3 Breast

Imaging Reports

1/2/13 Mammogram: Left breast: No dominant masses, or suspicious calcifications, or architectural disturbances are present. **In the right breast** there is a **3.5 x 4.6cm irregular spiculated mass in the lower-outer quadrant.**

Impression: Large mass in the lower-outer quadrant of the right breast, biopsy is recommended.

1/13/13 CT Chest: COPD with mild parenchymal scarring. No evidence of cardiomegaly. There is **bone destruction of posterior ribs/spine. CT Abdomen and Pelvis no abnormal findings.**
Impression: Bone destruction of posterior ribs/spine, probably mets from known breast cancer.

Pathology Reports

1/10/13 Core biopsy right breast lower outer quadrant: Final Diagnosis: Infiltrating ductal carcinoma, poorly differentiated, ER and PR positive, HER2 ICH 0, negative.

Clinical Reports

1/15/13 Surgery consult: Patient noted a mass in the lower-outer quadrant of her **right breast**. There is **marked lymphadenopathy in the right axilla**. The **left breast is within normal limits**.
HEENT: Clear conjunctivae, pupils equal, round and reactive to light. Nasal passages clear without drainage.
Neck: Supple, full range of motion. No thyromegaly, trachea is midline.
Lungs: No wheezing or crackles. There are no bronchial breath sounds or pleural rub.
Abdomen: Soft, non-tender, non-distended without hepatosplenomegaly or masses. Normal bowel sounds.

Patient will be referred to Radiation Oncology for consideration of radiation therapy to known bony mets.

2/1/13 Oncology Note: Patient has decided to try alternative therapy and has declined radiation therapy and chemotherapy.

Summary Stage Documentation (2520, 2530, 2540, 2550, 2560, 2570, 2600)

1/2/13 Mammogram: Lt breast no masses, Rt breast 4.6cm mass in LOQ, biopsy recommended.

1/10/13 Bx rt breast LOQ Infil ductal car, PD, ER and PR positive, HER2 IHC 0-Negative

1/13/13 CT Chest: Bone destruction posterior ribs/spine, probably mets from breast ca, CT Abdomen/Pelvis: no abnormal findings

1/15/13 Surg consult: marked lymphadenopathy in rt axilla

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

1/15/13 Surg Consult: Patient referred to radiation oncology for consideration of radiation therapy to bony mets.

2/1/13 Oncology note: Pt has decided to try alternative therapy, declined radiation therapy and chemotherapy.

Case #4 Breast

Imaging Reports

6/1/13 Mammogram: In the **right breast** there is a **1.2 x 1.5cm mass in the upper-outer quadrant**. There is **no evidence of axillary lymphadenopathy**. The **left breast appears normal.**

6/14/13 Chest Xray: Within normal limits

6/14/13 Bone Scan: Impression**: No evidence of skeletal disease. Thoracic and lumbar spine negative for metastases.**

Pathology Reports

6/8/13 Right breast fine needle aspiration cytology: Adenocarcinoma

6/15/13 Right breast modified radical mastectomy: Final Diagnosis: **Infiltrating ductal carcinoma, tubular type, 1.4cm, margins clear, Bloom Richardson score 3, no dermal or lymphatic invasion, no evidence of tumor in 32 regional lymph nodes, Estrogen and Progesterone Receptors negative, HER2 IHC 3+, positive.**

Clinical Reports

6/1/13 History and Physical: Family physician noted **2cm mass in right breast on physical exam**. No pain or tenderness; **no nipple discharge; no skin changes**. Slight nipple retraction. Freely movable mass. **Left breast: no masses palpated. No enlarged lymph nodes.**

10/13/13 Oncology Clinic Follow-up Note: Patient started **3 cycles of adjuvant Adriamycin and Cytoxan on 7/20/13**, recently completed and now **has begun Tamoxifen.**

Summary Stage Documentation (2520, 2530, 2540, 2550, 2560, 2570, 2600)

6/1/13 Mammogram: 1.5cm mass rt breast UOQ, no lymphadenopathy, lt breast appears normal

6/1/13 H&P 2cm mass in right breast, no masses palpated in lt breast, no enlarged lymph nodes

6/14/13 CXR: WNL; Bone Scan: no evident mets

6/8/13 Rt Breast fine needle aspiration = adenoca

6/15/13 Rt breast mastectomy: infiltrating duct carcinoma, tubular type, 1.4cm, margin clear, Bloom Richardson score 3, 0/32 LNS positive, ER/PR negative, HER2 IHC 3+ positive.

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

6/15/13 Rt breast modified radical mastectomy

10/13/13 Oncology note: pt had 3 cycles Adriamycin and Cytoxan begun on 7/20/13, recently

completed and has begun Tamoxifen.

Case #5 Colon/Rectum

IMAGING REPORTS:

4/20/2013 CT ABDOMEN AND PELVIS

CONCLUSION:
1. Two areas of circumferential colonic wall thickening affecting the distal sigmoid colon and a loop of colon in the right lower quadrant/right pelvic region with multiple low-density lesions being noted in the liver. Although these could represent incidental benign hepatic cysts, metastatic liver disease cannot be excluded at this time as colonic carcinoma is one of the causes of cystic liver metastasis. It should be noted **although there are shotty lymph nodes present, there is no definite lymphadenopathy** demonstrated.

2. **History of uterine cancer in 2003** with evidence of prior hysterectomy. This is not usually a cause of cystic liver metastasis.

3. **Otherwise, unremarkable CT scan of the abdomen and pelvis** with other incidental findings as noted above.

4/25/13 WHOLE BODY PET SCAN

CONCLUSION:
1. Radionuclide uptake in the left abdomen, representing a nonspecific finding.
No focal areas of increased uptake are seen in the liver to suggest hepatic metastasis.

PATHOLOGY REPORTS:

4/15/2013 Final Diagnosis: **Colon biopsy at 135cm moderately differentiated adenocarcinoma, mucin producing signet ring cell, high grade**

5/1/2013 Final Diagnosis **right hemicolectomy**

A. **High-grade mucin-producing signet ring cell carcinoma, 4 cm in size and located in colon near ileocolic junction, tumor invades pericolonic adipose tissue, (PT3)**
B. **No evidence of lymph node metastasis among seven lymph nodes. (PNO)**
C. **Excision margin is negative.**
D. **Microsatellite Instability-Stable**
E. **KRAS mutated**
F. **Normal heterozygous state (Normal LOH)**

OPERATIVE REPORT:

Date of Procedure: 5/1/13

PREOPERATIVE DIAGNOSIS: Right colon cancer
POSTOPERATIVE DIAGNOSIS: Right colon cancer, with adhesive bowel disease.
PROCEDURES PERFORMED: Exploratory laparotomy, lysis of adhesions, **right hemicolectomy.**

Findings: On exploration of the abdomen, the liver was palpated found to be unremarkable. **There were no lesions in the colon other than in the right colon.** In the small bowel, there were adhesions, especially in the terminal ileum, adherent to the cecum

Oncology Consult 5/15/13

HISTORY OF PRESENT ILLNESS: Patient is a 56-year old female who had a diagnosis of endometrial cancer, status post surgery followed by radiation therapy fifteen years ago. A few weeks ago the patient had a routine colonoscopic examination and the patient was found to have lesions in the right side of the colon. The patient underwent surgery on May 1, 2013.

ASSESSMENT: The patient has a **new diagnosis** of **high-grade mucin producing signet ring cell adenocarcinoma of colon.** This is about **4 cm in size** with **pericolonic tissue invasion**. Based on these reports and findings, **the patient may benefit from adjuvant chemotherapy**.

Summary Stage Documentation (2520, 2530, 2540, 2550, 2560, 2570, 2600)

4/15/13 Colon biopsy at 135cm: Moderately differentiated adenoca, mucin producing signet ring cell, high grade.

4/20/13 Ct Abdomen and Pelvis: 2 areas circumferential colonic wall thickening affecting the distal sigmoid colon and a loop of colon in the rt lower quadrant/rt pelvic region. Multiple liver lesions could represent benign hepatic cysts, mets liver dz cannot be excluded; shotty lymph nodes present, no definitive lymphadenopathy, otherwise unremarkable CT abdomen and pelvis; pt has a history of uterine cancer in 2003 with evidence of hysterectomy

4/25/13 Whole body PET scan: no focal areas of increased uptake in liver to suggest hepatic mets

5/1/13 Operative report: Liver palpated, found to be unremarkable, no lesion in colon other than rt colon

5/1/13 Right hemicolectomy: High-grade mucin producing signet ring cell carcinoma, 4cm, located near ileocolic junction, invades pericolonic adipose tissue, 0/7LNS positive, excision margin is negative; MSI-stable, KRAS mutated, normal LOH

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

5/1/13 Right Hemicolectomy

5/15/13 Oncology consult: The patient may benefit from adjuvant chemotherapy; unknown if chemotherapy given.

Case #6 Melanoma

IMAGING REPORTS

5/10/13 CT Chest: Impression: **Probably malignant involvement of left axillary lymph nodes**. Several lymph nodes seen in supraclavicular region too small to characterize. **The remainder of the exam is normal.**

PATHOLOGY REPORTS

5/3/13 Final Diagnosis: **Shave biopsy skin of left forearm, Malignant melanoma**

5/11/13 Final Diagnosis: **Wide excision of skin of left forearm**, **Malignant melanoma, nodular type, Clark's Level III, Breslow's depth 1.0mm, papillary dermis invaded, no ulceration present no mitosis present. Margins of resection free, but within less than 2mm**. **LDH Less than 1.5 x upper limit of normal for lactate dehydrogenase (LDH) assay**

ONCOLOGY REPORT

6/15/13 The patient was **started on an interferon regimen today**.

Summary Stage Documentation (2520, 2530, 2540, 2550, 2560, 2570, 2600)

5/3/13 Shave bx skin of lt forearm: Malignant melanoma

5/10/13 CT chest: Probably malignant involvement of lt axillary lymph nodes, remainder of exam normal

5/11/13 Wide exc skin of lt forearm: Malignant melanoma, nodular type, Clark's Level 3, Breslow's depth 1.0mm, papillary dermis invaded, no ulceration, no mitosis, margin free but within less than 2mm, LDH Range 1: Less than 1.5 x upper limit of normal for lactate dehydrogenase (LDH) assay

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

5/11/13 Wide excision of skin of lt forearm

6/15/13 started interferon regimen

Case #7 Melanoma

IMAGING REPORTS

11/18/013 Chest Xray: Within normal limits

11/24/13 CT Chest, Abdomen and Pelvis: Impression: Nonspecific soft tissue nodule in the right upper lobe. This is nonspecific but would be consistent with benign parenchymal scar or granuloma. The remainder of the lungs is clear.
There is no evidence of metastatic disease in the chest, abdomen or pelvis.

PATHOLOGY REPORTS

Outside Facility:
11/13/13 Final Diagnosis: **Excision of lesion** on **right side of neck**, 1.5 x .0.8 x 0.5 cm specimens contains a pigmented, **0.4 x 0.3cm area consistent with malignant melanoma in situ, extending to margins of excision.**

Your Facility:
11/25/13 Final Diagnosis: **Wide re-excision skin of right neck**, Inflammation and organizing granulation tissue, **negative for any residual melanoma, margins of resection negative.**

Summary Stage Documentation (2520, 2530, 2540, 2550, 2560, 2570, 2600)

11/18/13 CXR: Within normal limits

11/24/13 CT Chest/abdomen/pelvis: No evidence of mets in chest, abdomen or pelvis

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

11/13/013 Exc of lesion rt side of neck: 0.4x0.3cm malignant melanoma in situ, Ext to margin

11/25/13 Wide re-excision of skin rt neck, negative for residual melanoma, margins negative

Case #8 Lymphoma

Imaging Reports

2/2/13 CT Chest Impression: Extensive **right and left hilar lymphadenopathy**, **enlarged lymph nodes in the mediastinum.**

2/2/13 CT Abdomen Impression: **Splenomegaly, otherwise within normal limits**.

2/4/13 PET scan: Intense **focus of tracer uptake seen in peri-portal region consistent with lymphoma**.

Pathology Reports

2/3/13 Biopsy of **left axillary lymph nodes, Follicular Lymphoma, Gr 1**

H&P

2/2/13 Patient presents with **bilateral cervical and axillary lymphadenopathy**, **night sweats, and fevers for last couple of months.**

Oncology Consult

2/13/13 The patient was started on **combination chemotherapy including Rituxan on February 5** and has done well with the exception of nausea. We will start him on a trial of antiemetics.

Summary Stage Documentation (2520, 2530, 2540, 2550, 2560, 2570, 2600)

2/2/13 H&P Pt has bilateral cervical and axillary lymphadenopathy, hx of night sweats, fevers

2/2/13 CT Chest: rt and lt hilar lymphadenopathy, enlarged lymph nodes in the mediastinum

2/2/13 CT Abdomen: Splenomegaly, otherwise within normal limits

2/3/13 Biopsy lt axillary lns: Follicular Lymphoma, Gr 1

2/4/13 PET scan: focus of tracer uptake in peri-portal region consistent with lymphoma

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

2/5/13 Combination chemotherapy including Rituxan, other types of chemo not mentioned

Case #9 Prostate

Imaging Reports

4/14/13 CT Abdomen/Pelvis Impression: 1. Tiny cyst in the liver.
2. **No lymphadenopathy in abdomen or pelvis**.

4/14/13 Bone scan Impression: Evidence of previous fracture in right 13th rib, otherwise **negative bone scan.**

Pathology Reports

4/1/13 Final Diagnosis: Prostate **core needle biopsy, adenocarcinoma present in 8 of 13 cores, Gleason Score 3+3=6**

Clinical Reports

3/27/13 Surgical consult: Patient is seen in consultation because **PSA elevated at 6**. **DRE shows slightly enlarged prostate with no nodularity or induration**. The **abdomen and pelvis** are examined and **show no palpable abnormalities.**

7/1/13 Patient was counseled regarding various treatment options including radiation therapy, surgery and hormonal treatment. He decided to proceed with **external beam radiation therapy** and this was **completed on 6/15/13.**

Summary Stage Documentation (2520, 2530, 2540, 2550, 2560, 2570, 2600)

3/27/13 PE: DRE shows slightly enlarged prostate with no nodularity or induration, abdomen and pelvis with no palpable abnormalities, PSA 6

4/1/13 Prostate core needle biopsy: adenocarcinoma in 8/13 cores, Gleason Score 3+3=6

4/14/13 CT Abdomen/Pelvis: no lymphadenopathy in abdomen or pelvis

4/14/13 Bone scan: negative

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

External beam radiation therapy completed on 6/15/13, start date not given; estimate start date 5/2013

A

APPENDIX A

GENERAL CODING INFORMATION

Appendix A

Appendix A consists of Collaborative Staging Coding Guidelines and Instructions for recording information such as lab tests, tumor markers, and other reports in Site-Specific Factors only. The information comes from Collaborative Stage Work Group of the American Joint Committee on Cancer. Collaborative Stage Data Collection System User Documentation and Coding Instructions, version 02.04.40. published by American Joint Committee on Cancer (Chicago, IL). This version should be used for all cases diagnosed **January 1, 2004** and **forward**.

Site Specific Factors collected by the TCR:
http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589981967

The site specific surgery codes are from The American College of Surgeons Commission on Cancer's Standards of the Commission on Cancer Volume II: Facility Oncology Registry Data Standards (FORDS).

The Site-specific Surgery Codes can be found in Appendix B of the FORDS Manual on page 357:
http://www.facs.org/cancer/coc/fords/fords-manual-2013.pdf

Recording Information: Lab Tests, Tumor Markers, and Other Reports in Site-Specific Factors

Important Notes

The following information is intended as a guide to help the registrar locate the test in the medical record and to identify which lab test results should be coded in the Collaborative Stage Data Collection System site-specific factors (SSF).

1. The results of many tumor markers and other laboratory tests vary according to the laboratory conducting the test. The normal reference range is included in the tumor marker comments as background information *only*. Some site-specific factors ask for a lab value, others ask for the "interpretation" of the lab test (normal, elevated, and so forth).

When the site-specific factor asks for the interpretation of a lab test, code the clinician's/pathologist's interpretation, if available, as first priority. This would include statements of "abnormal", "elevated", "normal", "equivocal", "present", "absent", and so forth. In addition, the physician's statement of a T, N, or M value or stage group for the case could be an implied interpretation of a lab value used to determine the TNM classification, taking all information into consideration.

Example 1: Physician summarizes breast cancer workup by saying "HER2 IHC was positive at 3+. Registrar would code interpretation as 010 (positive).

Example 2: Physician statement: "He was found to have a PSA of 4.5." The medical record indicates that the biopsy results were positive and the physician stages the case as T1c (tumor identified by needle biopsy, e.g., because of elevated PSA). Registrar may code PSA Interpretation as 010 elevated because it resulted in the needle biopsies that were staged as T1c.

Note: If the pathologist uses the term "indeterminate," code as 030 (borderline; undetermined if positive or negative) if that code exists in the site-specific factor. If code 030 does not exist, code as 999.

a. In the absence of a physician's interpretation of the test, if the reference range for the lab is listed on the test report, the registrar may use that information to assign the appropriate code.

Example 3: Medical record laboratory report shows ovarian cancer patient's CA-125 as 235 (normal range < 35 U/ml). Registrar may infer that CA-125 is elevated (code 010).

b. When there is no clinician/pathologist interpretation of the lab test and no description of the reference range in the medical record the registrar should code 999 (not documented, unknown) to code the SSF. Do not code the lab value interpretation based on background information provided in this manual for the SSF. TCR does not collect SSFs for Ovary.

Example 4: Physician reports that Alpha Fetoprotein (AFP) collected in the office for a patient suspected to have primary liver cancer was 750 but does not interpret this value. Background information in CS User Documentation indicates a high normal would be > 500 but hepatocellular carcinoma values are > 1000. Registrar should code AFP interpretation as 999, unknown or no information.

Note: There will be some cases where an interpretation may be inferred from the background information in the CS User Documentation because the lab result is extremely abnormal. In such cases,

common sense would dictate that the case should be coded as 010 (elevated) rather than 999. TCR does not collect SSFs for Liver.

Example 5: Physician reports a CEA of 450 for a colon cancer without interpreting it. Background information in the CS User Documentation indicates a high normal would be 5 ng/ml. Registrar may code CEA as 010 Elevated. TCR does not collect SSF 1 and 3 for Colon.

2. In the site-specific notes in this document, only the codes pertaining to coding the test are listed. Refer to the specific CS schema tables for additional code choices when the test results are not in the medical record.

3. What does SI mean? SI is the French abbreviation for International System (*Systeme Internationale)*, standard units of measure (meter, kilogram, second). Most SI values are based on the kilogram and the liter. A nanogram (ng) is one-thousandth of a microgram (µg). A milliliter (ml) is one-thousandth of a liter. So a lab value expressed in µg/L is equivalent to the same value expressed in ng/ml. Some lab values, such as hormone levels, are recorded in International Units per Liter (IU/L). This is equivalent to mIU/mL. The equivalence of mIU to ng varies according to what is measured. This is one measurement conversion website http://www.amamanualofstyle.com/oso/public/jama/si_conversion_table.html. There are many others available. Note that instructions for entering many lab values state that the registrars should not convert the values.

SI Conversion: 1 µg/L = 1 ng/ml. For example, 1 ng of AFP is approximately equal to 1 mIU.
Note: Micrograms (µg) per liter may be printed as ug/L.

4. Prefixes and abbreviations: Units of measure can be described and written in various ways in the medical record. In some circumstances, the unit of measure may be dependent on the printer used for the report. For example, the prefix “micron” (one millionth of a unit) is represented in scientific notation by the Greek letter *mu* (µ), but not all printers have the capability to print Greek symbols.

As a result, micro- may be printed as a lower case *u* or as the abbreviation mc. Do not confuse the abbreviation for micro- (u) with the abbreviation for Unit (an international system measurement, U).

Tables A.1 below show abbreviations for units of measurement and the abbreviations for fractions or multiples of those units.

Table A.1 Measurement Prefixes

NUMBER	PREFIX	WRITTEN
1,000,000	Mega-	M
1,000	Kilo-	K
1 (baseline)	Deka-	Da
1/10	Deci-	d
1/100	Centi-	c
1/1000	Milli-	m
One millionth	Micro-	µ
One billionth	Nano-	n
One trillionth	Pico-	p
One quadrillionth	Femto	f

Table A.2 Unit Abbreviations

UNIT	ABBREVIATION
Liter	l
Unit	U
Meter	m
Unit of substance	mole, mol
Gram	g, gr
milli Equivalent	mEq, meq

5. Histologic examination: Histologic examination is the assessment of a tissue specimen. Aspiration of fluid (cells) is a cytologic examination. Some site-specific factors require analysis of tissue, whereas others can be performed on any specimen (tissue or fluid). Pathologic examination can refer to either histologic or cytologic examination.

Table A.3. Common Codes in Site-Specific Factors

CODE	DESCRIPTION
000	0 ng/ml
001	0.1 or less ng/ml
002-979	0.2-97.9 ng/ml
980	98.0 or greater ng/ml
988	Not applicable. Information not collected for this case. May include cases converted from code 888 used in CSv1 for "Not Applicable" or when the item was not collected. If this item is required to derive T, N, M, or any stage, use of code 988 may result in an error.
997	Test ordered, results not in chart
998	Test not done (test was not ordered and was not performed)
999	Unknown or no information Not documented in patient record

Code 000: In a numeric site-specific factor, such as a lab value for CEA, Chromogranin, CA-125, code 000 means a zero value on the test itself.

Rounding: Rounding instructions for most numeric site-specific factors: for numbers or percentages less than 1 (such as 0.3 or 0.4%), round up to 001. Do not round down to 000, as this means a zero value. For numbers above 1, round .1 to .4 down, and round .5 to .9 up to the next whole unit.

Examples
10.4% therapy response: Code as 010.
25% tumor necrosis: Code as 025
Size of metastasis in lymph node: 0.4 mm: Code as 001
95% chemotherapy effect: Code as 095

Upper Range of Lab Test Values: The upper range of values is usually 97.9 or 979 (depending on the type of test), with code 980 indicating that the actual test result was 98.0/980 or higher.

Code 988 – Not Applicable: Information Not Collected For This Case: In most site-specific factors, code 988 appears as 'Not applicable: Information not collected for this case.' The intended meaning for code 988 is that the registry does not routinely collect the information for cases coded using this schema. Code 988 is not intended to mean that the information is not collected for a case because the information is deemed not applicable for the particular case circumstances. This code may be used if the data field is not required by the registry's standards setters. However, code 988 cannot be used by a registry where the field is required for collection. *Example* Colon Site-Specific Factor 9, KRAS, is required for collection by COC-Accredited facilities in all areas and all registries in SEER regions. Canadian registries and registries not participating in the COC Accreditation program in National Program of Cancer Registries (NPCR) states may use code 988 if the registry makes the decision not to collect information about KRAS. COC-Accredited and SEER registries must select a code other than 988 to

complete this field.

Note: In CS version 1, the 'not applicable code' was 888, which limited the code range for lab test values. In CS version 2, code 888 was converted to 988.

Code 997 – Test Ordered, Results Not In Chart: If it is known that the test was ordered but there is no report in the record, select the code that indicates that the test was ordered but results are not available (code description varies depending on site-specific factor and primary site). This code is useful as a quality control flag to indicate cases where information may be available at a later date.

Code 998 – Test Not Done: If there is a statement that the test was not performed, select the code that documents that the test was not done (code description varies depending on site-specific factor and primary site). Do not assume that the test was not done if the report is not available in the medical record; use code 999 instead (except as noted in the next paragraph).

Test Never Done by Facility: This code may also be used by a registry in a facility that does not perform the test. In other words, code 998 can also be used if the registry staff has discussed tests with the laboratory medicine department of the facility and the lab has indicated that it never does the test and never sends it to a reference lab. Decisions on these tests should be documented in the registry's procedure manual or coding manual and reviewed annually, as tests and procedures may be added or dropped by the facility. If the facility does offer the test (in-house or sent out), code 998 should not be used unless there is a statement in the record that the test was not done for the case.

Other Meanings: Code 998 may have other meanings in some site-specific factors, generally related to a procedure not being performed or a specimen not available. Read the definitions carefully.

Examples:
Prostate SSF7: No core biopsy/TURP performed
CorpusCarcinoma SSF2: No pathologic specimen available
MelanomaSkin SSF7: No histologic examination of primary site.
Rectum SSF5: No preoperative treatment or no resection of primarysite after preoperative treatment

Code 999: If there is no information in the medical record about the lab value, use code 999.

Note: Source documents are suggested for some site-specific factors as the most likely sources of information. If no source document is suggested, use any information provided in the medical record. If a pathology report is suggested, that document includes any addenda or revisions to the report, as well as synoptic report, CAP protocol, or cancer checklist information provided by the pathologist.

Note: The symbols C, S, N, and c indicate that the field is required to be collected by the standards setter.

C - Commission on Cancer-accredited facilities (ACoS-CoC)
S - Participants in SEER Program areas
N - National Program of Cancer Registries areas (NPCR)
c - Canadian Council of Cancer Registries (CCCR)

Note: CCCR uses the term "essential" rather than required. Items marked include fields collected in CS

version 1. Other data items may be collected if information is available in the pathology report or readily available in the clinical chart.

Note: Not all codes are discussed for each site-specific factor. In particular, guidelines for using code 988 are provided only when none or all of the standards setters require the field. When a site-specific factor is required by one to three standards setters, refer to their instructions for docmenting the field.

Site-Specific Factors Common to Several Schemas

The following site-specific factors are common to several site or histology-specific schemas.
The items in this section are in alphabetical order by the name of the test.

LACTATE DEHYDROGENASE: LDH, LDH VALUE, LDH UPPER LIMIT OR NORMAL
Appears in schemas: Melanoma skin (TCR collects SSF 4), LymphomaOcularAdnexa (TCR does not collect LDH information), Testis (TCR collects SSF 16 for 2013 cases).

Source documents: clinical laboratory report; may be included in a liver or hepatic panel/profile, a cardiac panel, or a general metabolic panel of tests.

Other names: LD, Lactate dehydrogenase, lactase dehydrogenase, lactic acid dehydrogenase.

Normal Reference Range: varies widely by laboratory, patient age, and the units of measurement. Examples of reference range lab values:

Lab A Total LDH 7 1 – 207 U/L
Lab B Total LDH 3 0 0 – 600 U/L
Lab C Total LDH 45 – 90 U/L
Lab D Total LDH 150 – 250 U/L

When cells (normal or tumor) are damaged or destroyed, an enzyme called lactate dehydrogenase (LDH) is released into the bloodstream. LDH is an indirect indication of possible tumor burden or damage to an organ, which may be caused by metastatic involvement of liver or lung, or a myocardial infarction. The total LDH should be the test value that is coded, but there are five fractions of LDH that measure tissue specific cellular damage: LD1 and LD2: heart, red blood cells and kidneys; LD3: lung; LD4 and LD5: liver, skin and skeletal muscles. LDH is elevated in 60% of patients with non-seminomatous germ cell tumors of the testis. LDH is not a screening test, nor is it diagnostic of melanoma, ocular adnexal lymphoma, or testicular cancer.

Serum Lactate Dehydrogenase (LDH) (MelanomaSkin) C S N**; LDH Interpretation (LymphomaOcularAdnexa)** C S**; Preorchiectomy Lactate Dehydrogenase (LDH) Range (Testis)** C S N**; Post-Orchiectomy Lactate Dehydrogenase (LDH) Range (Testis)** C S N c
Record the code describing the range of the highest LDH value prior to treatment, based on the reference range used by the lab. The codes vary slightly for each schema, but the concepts are the same. For MelanomaSkin, read the codes and definitions carefully, as several were made obsolete and the data were converted or the code was re-used in version 0203. In the table below, ‘orch’ is short for orchiectomy.

Note: Use only the codes for the primary site being abstracted.

Table A.4 Serum Lactate Dehydrogenase Codes

MELANOMA	TESTIS		OCULAR ADNEXAL LYMPHOMA	DESCRIPTION
	PRE-ORCH	POST-ORCH		
000	000	000	000	Within normal limits
010	010	010	010	Range 1: less than 1.5 times the upper limit of normal for that lab; *for melanoma only:* Stated as elevated, NOS
			020	*For ocular adnexal lymphoma only:* 1.5 to 5 times upper limit of normal
			025	*For ocular adnexal lymphoma only:* 5.1 to 10 times upper limit of normal
020	020	020		Range 2: 1.5 to 10 times the upper limit of normal for that lab
030	030	030	030	Range 3: more than 10 times the upper limit of normal for that lab
		990		Post-orchiectomy LDH unknown, but pre-orch LDH normal
	991	991		LDH (pre/post-orch) stated to be elevated
	992	992		LDH (pre/post-orch) unknown, but concurrent tumor markers stated to be normal
	993	993		LDH (pre/post-orch) unknown, but concurrent tumor markers stated to be elevated; *Post-orch only:* Stated as Stage IS
	995			Pretreated case, initial LDH range recorded as post-orch [rare]
	996			No orch; initial LDH recorded as post-orch [rare]
997	997	997	997	Test ordered, but results not in chart
998	998	998	998	Test not done; test not ordered and not performed
999	999	999	999	Unknown; no information; not documented in medical record

To calculate whether the lab result is in a particular range, multiply the lab's upper limit of normal (usually stated on the report) times the stated multiplier. For example, if the test is done for a melanoma and the result is within normal limits, code as 002. If the test result is elevated, determine whether it is less than 1.5 times the upper limit of normal (code 004), between 1.5 and 10 times the upper limit of normal (code 005) or more than 10 times the upper limit of normal (code 006).

Example:
Test result is 155.Normal range
Lab A: 105 to 333 IU/L
Lab B: Female: 46-100 IU/L, Male: 46-232 IU/L,
Lab C:45 - 90 IU/L
For Labs A and B, that result is within the normal range (code 000).

For Lab C, the test result is elevated (upper limit of normal for Lab C is 90). Calculate 1.5 times the upper limit of normal for Lab C (1.5 x 90 = 135). For Lab C, this test result would be coded as 020 for testis, between 1.5 and 10 times the upper limit of normal.

For melanoma, an abnormal value (SSF4 codes 010-030) must be documented by at least two separate tests obtained more than 24 hours apart, according to the *AJCC Cancer Staging Manual*.
Note: LDH may not be done for early stage melanomas. If so, code as 999.

Serum Lactate Dehydrogenase (LDH) Lab Value (MelanomaSkin) C S N.

Record the actual value of the LDH prior to treatment or within 6 weeks of diagnosis. The first test has priority. Code the actual value if between 001 and 800. Above 800, code the appropriate range.

Read the range choices carefully as they differ as the values increase. A value over 10,000 is coded as 932.

a. Use code 995 if the test is stated to be within normal limits but the LDH value is not stated.

b. Use code 996 if the test is stated to be elevated but the LDH value is not stated.

c. Use code 997 if the test was ordered but the results are not in the medical record.

d. Use code 998 if there is a statement that the test was not performed or was not ordered.

e. Use code 999 if there is no information in the medical record about an LDH test.

LDH Upper Limits of Normal (MelanomaSkin) C S

This site-specific factor corresponds to LDH Value and can be used to calculate the range in the LDH [Interpretation] field. Code the upper limit of normal as stated on the same clinical laboratory report from which the LDH value is taken.

a. Use a code in the range 001-979 for the stated upper limit of normal.

b. Use code 997 when the upper limit of normal is not stated in the clinical laboratory report or medical record.

c. Use code 998 when there is a statement in the record that the test was not done or was not ordered.

d. Use code 999 when there is no information in the record about the LDH test.

MICROSATELLITE INSTABILITY (MSI)
Appears in schemas: SmallIntestine, Colon, Rectum, Appendix [carcinoma]. The TCR does not collect this information.

Source documents: pathology report, reference lab report, supplemental report, admitting note or consultation reporting a test done elsewhere Microsatellite instability (MSI) is a molecular marker (genetic test using polymerase chain reaction) performed on tumor tissue to identify differences in length of sections of nonfunctioning DNA. The differences in length may be caused by problems with the genes that normally repair DNA. A highly positive MSI (MSI-H) test may be related to the development of cancer in a condition called hereditary nonpolyposis colorectal cancer (HNPCC or Lynch Syndrome). HNPCC is a hereditary autosomal dominant condition characterized by rapid progression from adenomas to malignant lesions. Low positive (MSI-L) or stable (MSS) MSI result means it is unlikely that the cancer results from a hereditary genetic condition.

MSI may also be a predictive marker of a patient's response to chemotherapy as well as an indicator of the patient's prognosis. Indications for MSI testing include colorectal cancer in a patient less than 50 years old, the presence of other HNPCC-associated tumors, or family history of colorectal cancer.

a. Code the statement in the report whether the microsatellite instability test is stable (code 020), unstable low (code 040), unstable high (code 050), or unstable, not stated as low or high (code 060).

b. Code 988 may be used by any registry, since this field is not required by the standards setters.

c. If there is no mention of an MSI test in the record, code as 999.

Mitotic Count

Appears in schemas: GISTEsophagus C S N c; GISTStomach C S N c; GISTSmallIntestine C S N c; GISTColon C S N c; GISTAppendix C S N c; GISTRectum C S N c; MelanomaSkin C S N c; GISTPeritoneum C S N c; TCR collects Mitotic Count for all these sites.

Source documents: pathology report

Other names: mitotic rate, mitotic index (a ratio-do not record this measurement), mitotic activity
Mitotic count is a way of describing the potential aggressiveness of a tumor. For GIST tumors, the count is translated into a mitotic rate that is used with T, N, and M to stage group a case.

Record the number of cells actively dividing as determined by the pathologist. The count will vary according to the type of tumor. Follow the instructions in the SSF notes for the primary cancer being

coded.

a. GIST (appendix, colon, esophagus, peritoneum, rectum, small intestine, stomach): count per 50 HPF* or 5 square millimeters

b. Melanoma of skin: count per square millimeter

* The usual high power is 40 x magnifications.

This site-specific factor is a three-digit field with an implied decimal point between the second and third digits. For example, if the mitotic count is reported as 0.5 mitoses per 10 HPF for a neuroendocrine tumor, record as 005. If the mitotic rate is reported as 12 mitoses per 50 HPF for a gastrointestinal stromal tumor, record as 120.

a. Use code 000 if there are no mitoses present in the high power field area designated for the primary cancer (10, 40, 50 HPF).

b. Codes in the range 001 to 008 are used when the number of mitoses is reported as a decimal number (part of a whole mitotic figure).

c. Use code 009 when the pathologist states that the mitotic rate is less than 1 mitosis per HPF area.

d. Codes in the 010 to 100 range are used when there are between 1 and 10 mitoses per HPF area.

e. Codes 990 – 992 can be used for general statements that the mitotic rate is up to the cut point for low mitotic rate for the primary site being coded or more than the cut point for a high mitotic rate.

   Note: For MelanomaSkin, this may be stated as “nonmitogenic” (code 990) or “mitogenic” (code 991).

f. Use code 996 when the unit of measurement is not consistent with the primary site specification.

   Note: For example, the pathologist states that a neuroendocrine tumor of the colon has a mitotic rate of 6 per 40 HPF (the denominator for NET tumors is per 10 HPF).

g. Use code 998 when there has been no specimen from the primary site.

h. Use code 999 if there is no mention of a mitotic rate in the pathology report.

SITE-SPECIFIC NOTES

Note: Not all code choices are listed in the following discussions of site-specific factors. ALWAYS refer to the complete listing of codes in the Part II table when coding the site-specific factor.

<u>Head and Neck Sites</u>

Site-Specific Factor 1 – Size of Lymph Nodes C S N c

Site-Specific Factor (SSF) 1 is used to code the size of involved lymph nodes. This information is needed to derive the N value for both sixth and seventh edition TNM staging. SSF1 uses the standard CS version 2 size measurement scale, 001 to 979 measured in millimeters. To convert centimeters to millimeters, multiply by 10.

Example: Largest cervical lymph node measures 2.3 centimeters on CT scan. *Code as 023 (mm).*

Code the largest diameter of any involved regional lymph node (listed in CS Lymph Nodes). The measurement can be pathologic, if available, or clinical.

a. Use code 000 when no regional lymph nodes are involved.

b. Use code 980 for any lymph node larger than 979 millimeters.

c. Code 988 should not be used by any registry in the US or Canada, as all standards setters require these fields.

d. Use special codes 990-997 for non-specific sizes if an exact size is not stated in the medical record.

e. Use code 999 when there is no information about the size of involved regional lymph nodes.

Site-Specific Factor 25 – Schema Discriminator: Nasopharynx/PharyngealTonsil C S N c (Nasopharynx, PharyngealTonsil)
Source documents: pathology report, imaging report, endoscopy report

ICD-O topography code C11.1, posterior wall of nasopharynx, includes both the mucosal surface of the posterior wall and the adenoid or pharyngeal tonsil. Two CS version 2 schemas use C11.1, but the schemas map to different seventh edition TNM chapters. The posterior wall of nasopharynx (mucosal surface) is staged with nasopharynx, and the lymphoid tissues of the pharyngeal tonsil are staged with the oropharynx. In order to determine which schema should be presented to the abstractor for topography code C11.1, a schema discriminator has been included as Site-Specific Factor 25 for both Nasopharynx and PharyngealTonsil. This schema discriminator applies only to C11.1. For other nasopharyngeal sites (C11.0, C11.2, C11.3, C11.8, C11.9), use code 981. Code the description of the true primary site as stated in the medical record.

a. Use code 010 when the primary site is stated as posterior wall of nasopharynx (NOS); this will present the Nasopharynx schema for coding and mapping to TNM.

b. Use code 020 when the primary site is stated as adenoid, pharyngeal tonsil or nasopharyngeal tonsil; this will present the PharyngealTonsil schema for coding and mapping to TNM.

c. See schema table for additional code choices.

Upper Gastrointestinal (UGI) Tract - Esophagus, Stomach, Small Intestine
(See also section on gastrointestinal stromal tumors (GISTs)

Site-Specific Factor 25 – Schema Discriminator: Involvement of Cardia and Distance from Esophagogastric Junction (EGJ) (Esophagus-GE Junction, Stomach) C S N c

The esophagus chapter of the AJCC Cancer Staging Manual seventh edition includes the esophagogastric junction (also called the cardia or gastroesophageal junction) and the proximal 5 cm of the stomach. The cardia is defined as the opening or junction between the esophagus and the stomach, and it is between 0.1 and 0.4 cm in length. In CS version 2, there is a separate schema for Esophagus-GE Junction, which includes all of the cardia (C16.0) and is mapped to the seventh edition esophagus staging. Two additional stomach topography codes are included in the proximal 5 cm of the stomach, the fundus (C16.1) and body (C16.2) (Figure I-2-3). This 5 cm boundary measurement is based on the Siewert classification of gastroesophageal cancers, which defines an area 5 cm above and 5 cm below the cardia or esophagogastric junction. To determine whether a cancer in the fundus or body of the stomach should be coded according to the esophagus schema or the stomach schema, it is necessary to identify the midpoint or epicenter of the tumor. If the midpoint is at or above the cardia, the tumor is definitely esophageal. If the midpoint of the tumor is within 5 cm distal to the gastroesophageal junction (GEJ) and the lesion extends to or across the GEJ, the case should be coded with the Esophagus-GE Junction schema. If the midpoint of the tumor is within 5 cm distal to the GEJ and the lesion does not extend to the GEJ, the case should be coded with the stomach schema. Any tumor with a midpoint more distal than 5 cm from the GEJ is coded with the stomach schema. In order to determine which schema should be used for gastric tumors within 5 cm of the GE junction, a schema discriminator has been included as Site-Specific Factor 25. Select the code that best describes the location and extent of the tumor, and the computer algorithm will bring the correct schema to the screen. If the tumor midpoint is anywhere in the stomach other than cardia, fundus or body, use code 981. If the tumor midpoint is in the cardia itself, use code 982.

Clinical Assessment of Regional Lymph Nodes
Site-Specific Factor 1 (Esophagus, EsophagusGEJunction, Stomach) C S N c
Site-Specific Factor 2 (Small Intestine, Colon, Appendix [carcinoma], Rectum) C S N c

Source documents: imaging report, possibly physical exam; *does not include* surgical observation or lymph node biopsies.

The purpose of this field is to document a diagnostic work-up to assess regional lymph nodes before surgery or neoadjuvant therapy. This data field handles correct mapping to the clinical N category when multiple involved regional lymph nodes are identified on imaging of the chest, abdomen or pelvis.

Diagnostic procedures include CT, MRI, plain radiographs and endorectal ultrasound (EUS). It is possible, but unlikely, that a physical exam would show involved regional nodes for the gastrointestinal tract. Endoscopic procedures without ultrasound are excluded; they can only view the inside of the gastrointestinal tract and cannot assess regional lymph nodes.

a. Use code 000 when there is imaging or ultrasound and lymph nodes are not mentioned or stated to be uninvolved. A statement of “no adenopathy” of regional lymph nodes (meaning no regional lymph nodes are enlarged or abnormal) is sufficient to code 000.

b. Use a code in the 100 – 399 range (varies by site) when imaging or ultrasound was done and there is a statement of a clinical N (N1, N2, N3 according to primary site) or a specific number of involved nodes in lieu of a statement of clinical N.

c. Use code 400 when imaging or ultrasound mentions clinically positive nodes but does not indicate how many or give a clinical N value.

d. Code 988 should not be used by any registry in the US or Canada, as all standards setters require these fields.

e. Gastrointestinal tract sites are included in the "inaccessible nodes rule," but only in unusual cases are gastrointestinal tract sites staged clinically. Do not apply the "inaccessible nodes rule" to code this field. There must be an attempt to assess regional lymph nodes clinically prior to the start of treatment in order to code 000.

f. Use code 999 when there is no diagnostic work-up to assess regional lymph nodes there is no imaging or ultrasound reported it is unknown whether imaging or ultrasound was done a scan or ultrasound states adenopathy is present without making a definite statement that the nodes are clinically positive (such as fixed, matted, or metastatic terminology). The terms *adenopathy*, *enlargement,* and *suspicious* are not sufficient to code as involvement when they are included without a definite statement. For example, statements of "adenopathy" or "suspicious lymph nodes" should be coded as 999, but a statement of "lymph nodes suspicious for malignancy" should be coded as 400.

Colon, Appendix, Rectum, Anus

Site-Specific Factor 2 – Clinical Assessment of Regional Lymph Nodes (Colon, Appendix, Rectum) C S c
See Clinical Assessment of Regional Lymph Nodes in UPPER GI section.

Site-Specific Factor 11 – Histopathologic Grading (Appendix) C S N c
Source document: pathology report

The histopathologic grading of mucinous adenocarcinomas (morphology codes 8480, 8481 and 8490) appears to have prognostic value for appendiceal carcinomas. Mucinous adenocarcinomas have a better prognosis and are graded differently from intestinal-type adenocarcinomas-a two-grade system, low or high. Adenocarcinomas of the appendix use a standard four-grade system. Grade is used in deriving AJCC stage groups IVA (low grade mucinous adenocarcinoma or well-differentiated adenocarcinoma with intraperitoneal metastasis) and IVB (high grade mucinous adenocarcinoma or moderately and poorly differentiated adenocarcinoma with non-peritoneal metastasis).

a. Code histopathologic grade for all appendix carcinomas as described in the pathology report.

b. Mucinous adenocarcinoma: Use code 011 for low grade. Use code 021 for high grade.

c. Non-mucinous adenocarcinomas (codes other than 8480, 8481, and 8490):
   - Use code 010 for Grade 1 or well differentiated.
   - Use code 020 for Grade 2 or moderately differentiated.

- Use code 030 for Grade 3 or poorly differentiated.
- Use code 040 for Grade 4 or undifferentiated.

d. Code 988 should not be used by any registry in the US or Canada, as all standards setters require this field.

e. Use code 998 if there was no histologic confirmation or the patient did not have surgery.

f. Use code 999 if there is no information in the record about histopathologic grade.

Gastrointestinal Stromal Tumors (GIST)
(Esophagus, Stomach, Small intestine, Appendix, Colon, Rectum, and Peritoneum-omentum and mesentery)

Gastrointestinal stromal tumors (GISTs) are a rare type of soft tissue sarcoma (mesenchymal tumor). They are different from carcinomas of the gastrointestinal tract because they develop in the muscle layer and grow outward. These tumors were first described as a distinct entity in 1998 and codes were added to ICD-O-3 in 2000. GIST is an umbrella term covering most mesenchymal tumors of the stomach and intestine. Most tumors diagnosed as leiomyosarcomas a decade ago are now referred to as GISTs.

GISTs are believed to develop from the interstitial cells of Cajal that regulate peristalsis. Because the staging of GISTs is based on the size of the primary tumor and the mitotic count, a new chapter was added to the seventh edition of the AJCC Cancer Staging Manual, and new schemas were added to CS version 2. There are separate GIST schemas for esophagus, stomach, small intestine, appendix, colon, rectum and peritoneum (omentum and mesentery).

About 55% of GISTs occur in the stomach, followed by 30% in the small intestine. Other sites are much less frequent. Even in the stomach, GISTs are only 1-3% of all gastric malignancies. In the small intestine, GISTS are about 20% of all malignancies. About 35-50% of gastrointestinal stromal tumors are malignant. Both the GIST chapter of the AJCC Cancer Staging Manual and the schemas in CS version 2 can be used to code benign, borderline, and malignant GISTs, but only malignant GISTs should be reported to population-based cancer registries. Benign and borderline GISTS may be reportable-by-agreement in facility-based registries.

All GISTS use the same five site-specific factors, but to maintain site-specific factor formatting similar to carcinomas of the gastrointestinal sites, the numbering of the site-specific factors differs among the upper GI, lower GI, and peritoneum sites, as shown in Table I-2-8. Because carcinoembryonic antigen (CEA) is not pertinent to GIST, when new schemas were created for GIST of stomach, small intestine, colon, appendix and rectum, the site-specific factor for CEA was made obsolete. The same holds true for clinical assessment of regional lymph nodes for stomach, appendix, colon and rectum, because lymph node involvement by GIST is rare.

In the discussions below, the site-specific factors will be described by name rather than SSF number.

Mitotic Count C S N c
See Mitotic Count in *Lab Tests and Tumor Markers* on page 226.

Mitotic count is a site-specific factor for a number of primary sites. For GIST, the standard measurement

is the total number of mitoses per 50 high power fields (HPF at 40 times magnification) or per 5 square millimeters.

Note: Code 988 should not be used by any registry in the US or Canada, as all standards setters require these fields.

For esophagus, stomach, and small intestine, mitotic count is collected in SSF 6.

For appendix, colon, and rectum, mitotic count is collected in SSF 11.

For peritoneum mitotic count is collected in SSF 5.

Neuroendocrine Tumors (NET)
(Stomach, Colon, Rectum)

Neuroendocrine tumors (NET) originate in the diffuse neuroendocrine system from cells that produce small amounts of hormones in response to signals from the nervous system. There are neuroendocrine cells in many body systems, including respiratory tract, lung, skin (Merkel cell carcinoma), gastrointestinal tract, and endocrine glands. Neuroendocrine cells regulate neighboring cells. NETs are also called carcinoids, but the preferred terminology is well-differentiated neuroendocrine tumor. In the gastrointestinal system, abnormal production of hormones can cause unusual symptoms, such as flushing, fatty diarrhea (steatorrhea), and dumping syndrome.

Neuroendocrine tumors in general are rare, so they are not well understood and there may be difficulty in diagnosing them. Gastrointestinal NETs can grow slowly for many years before producing symptoms leading to diagnosis. Malignant NETs tend to be more aggressive than carcinomas and metastasize earlier. When they metastasize, the most common site is liver, but NETs will also metastasize to lymph nodes and bone. Small NETs less than 1 cm in size are unlikely to spread, but a tumor larger than 2 cm has a 95% chance of developing metastases. The principle criteria for staging NETs are size of tumor and depth of invasion, which are part of CS Tumor Size and CS Extension, respectively.

Well-differentiated or low grade neuroendocrine carcinoma (ICD-O-3 morphology code 8240; also called carcinoid, NOS) is most common in the appendix and rectum, and uncommon in the colon. Enterochromaffin (EC) cell carcinoid (8241) is most common in the appendix. Entero-Chromaffin-Like (ECL) cell tumor (8242) is most common in the gastric fundus or body. Neuroendocrine tumor (8246) is a broad term covering carcinoids and some adenocarcinomas. Atypical carcinoid (8249) is also included among the codes that are mapped to the TNM system, but is uncommon in the gastrointestinal tract. The NET schemas for stomach, small intestine, appendix, colon, rectum, and ampulla of Vater include malignant gastrinomas, which are found in the duodenum and ileum as well as the stomach. These morphology codes were not staged in the sixth edition of the *AJCC Cancer Staging Manual*. The CS version 2 computer algorithm will not derive sixth edition T, N, M, or stage group.

Clinical Assessment of Regional Lymph Nodes
Site-Specific Factor 1 (NETStomach) C S N c
Site-Specific Factor 2 (NETColon, NETRectum) C S N c

Source documents: imaging report, possibly physical exam; *does not include* surgical observation or lymph node biopsies

The purpose of this field is to document a diagnostic work-up to assess regional lymph nodes before surgery or neoadjuvant therapy. This data field handles correct mapping to the clinical N category when multiple involved regional lymph nodes are identified on imaging of the chest, abdomen or pelvis.

Diagnostic procedures include CT, MRI, plain radiographs and endorectal ultrasound (EUS). It is possible, but unlikely, that a physical exam would show involved regional nodes for the gastrointestinal tract. Endoscopic visualization procedures are excluded; they can only view the inside of the gastrointestinal tract and cannot assess regional lymph nodes.

a. Use code 000 when there is imaging or ultrasound and lymph nodes are not mentioned or stated to be uninvolved. A statement of "no adenopathy" of *regional* lymph nodes (meaning no regional lymph nodes are enlarged or abnormal) is sufficient to code 000.

b. Use a code in the 100 – 399 range (varies by site) when imaging or ultrasound was done and there is a statement of a clinical N (N1, N2, N3 according to primary site) or a specific number of involved nodes in lieu of a statement of clinical N..

c. Use code 400 when imaging or ultrasound mentions clinically positive nodes but does not indicate how many or give a clinical N value.

d. Code 988 should not be used by any registry in the US or Canada, as all standards setters require these fields.

Note: Gastrointestinal tract sites are included in the "inaccessible nodes rule," but only in unusual cases are gastrointestinal tract sites staged clinically. Do not apply the "inaccessible nodes rule" to code this field. There must be an attempt to assess regional lymph nodes clinically prior to the start of treatment in order to code 000.

e. Use code 999 when:
   - there is no diagnostic work-up to assess regional lymph nodes
   - there is no imaging or ultrasound reported
   - it is unknown whether imaging or ultrasound was done
   - a scan or ultrasound states adenopathy is present without a definitive statement that the nodes are clinically positive (such as fixed, matted, or metastatic terminology).

The terms *adenopathy*, *enlargement, suspicious*, and so forth, by themselves are not sufficient to code as involvement. For example, statements of "adenopathy" or "suspicious lymph nodes" should be coded as 999, but a statement of "lymph nodes suspicious for malignancy" should be coded as 400.

Biliary Organs
(Intrahepatic Bile Ducts, Perihilar Bile Ducts, Cystic Duct, Distal Bile Duct)

A number of changes in CS version 2 schemas resulted from revisions to chapters in the seventh edition of the *AJCC Cancer Staging Manual*, particularly in the liver and biliary sites. Intrahepatic bile ducts

(C22.1) were separated from liver (C22.0). These schemas are now histology-specific.

Primary liver cancers include morphology codes 8170-8175, hepatocellular carcinoma and its subtypes. Intrahepatic bile duct histologies include 8160, cholangiocarcinoma, 8161, bile duct cystadenocarcinoma, and 8180, combined hepatocellular and cholangiocarcinoma. Only these cell types will derive T, N, M and Stage Group for seventh edition mapping. The extrahepatic bile ducts were split into three chapters in TNM seventh edition: perihilar bile ducts (proximal to the origin of the cystic duct), the cystic duct, and distal bile duct (between the junction of the cystic duct and the ampulla of Vater). Perihilar bile ducts include the right, left, and common hepatic duct. Distal bile duct is essentially the common bile duct below the point where the cystic duct and common hepatic duct join. The separate stagings for the extrahepatic bile ducts caused an issue in CS version 2 because all of the extrahepatic bile ducts are coded to C24.0 in ICD-O-3. Without extra information about the precise location of the tumor, the computer does not know which schema to present to the abstractor. Consequently, a "schema discriminator" is required to determine which CS schema is to be used for a case.

Schema Discriminator (Site-Specific Factor 25 for Perihilar Bile Ducts, Cystic Duct, and Distal Bile Duct) C S N c

Code the location of the tumor, such as hepatic duct or Klatskin tumor. The computer algorithm will then bring up the schema based on the code entered in the schema discriminator. Code 030 will display the cystic duct schema; codes 040 and 070 will display the distal bile duct schema. All other codes will display the perihilar bile ducts schema because 70-80% of all extrahepatic bile duct malignancies arise in the perihilar ducts (right, left, and common hepatic ducts).

Table A.5 Schema Discriminator Codes

CODE	DESCRIPTION
010	Perihilar bile duct(s); Proximal extrahepatic bile duct(s); Hepatic duct(s)
020	Stated as Klatskin tumor (tumor at junction of right, left and common hepatic ducts)
030	Cystic bile duct; cystic duct (duct between gallbladder and common bile duct)
040	Common bile duct, including common duct, NOS (also called choledochal duct)
050	Diffuse involvement; More than one subsite involved, subsite of origin not stated
060	Subsite of extrahepatic bile ducts not stated OR subsite stated as middle extrahepatic bile duct AND treated with combined hepatic and hilar resection
070	Subsite of extrahepatic bile ducts not stated OR subsite stated as middle extrahepatic bile duct AND treated with pancreaticoduodenectomy
100	C24.0 - originally coded in CS version 1 (this code should not be used for 2010 diagnoses and forward)
999	Subsite of extrahepatic bile ducts not stated and not classifiable in codes 050-070

Site-Specific Factor 10 – Tumor Growth Pattern (Intrahepatic Bile Ducts) C S N
Source document: pathology report

Record whether a periductal tumor growth pattern is absent or present.

a. Use code 000 when:

- the tumor is described as mass forming type
- the pathologist indicates absence of periductal component
- the pathologist indicates no periductal component of growth pattern
- there is no mention of a tumor growth pattern

b. Use code 010 when the pathologist indicates the presence of a periductal or mixed growth pattern.

c. Code 988 should not be used by any registry for the BileDuctsPerihilar schema for cases coded in CS version 0203 and higher. This field is required by standards setters since it is used in determining the T value for AJCC 7 staging.

d. Use code 999 when there is no information about tumor growth pattern in the medical record or when there is no pathology report.

Lung and Pleura

Major changes occurred in the staging of lung cancers in the seventh edition of the AJCC Cancer Staging Manual. For example, pleural effusion was moved from T4 to M1, and separate tumor nodules in the same lobe of the lung were moved from T4 to T3 while separate tumor nodules in a different lobe of the same lung were moved from M1 to T4. Two site-specific factors were added in CS version 2.

For pleura, four additional site-specific factors were added to pleural effusion, which was a factor in CS version 1.

Site-Specific Factor 1 – Separate Tumor Nodules in Ipsilateral Lung (Lung) C S N c
Source documents: imaging reports and pathology reports

Beginning with cases diagnosed on or after January 1, 2010, separate tumor nodules in the same lung are recorded separately from CS Extension codes. This site-specific factor is used in “extra tables” along with Tumor Size, Extension, and Mets at DX to determine the output values for T and M in seventh edition.

Record the presence or absence of separate tumor nodules in the lobes of the same lung (ipsilateral) as the primary site. Do not code separate tumor nodules in the opposite (contralateral) lung in this field; code them in CS Mets at DX. Information about separate tumor nodules can be obtained from imaging (clinical) or pathology reports (pathologic).

a. Use code 000 when no separate tumor nodules are noted or when separate tumor nodules are not mentioned.

b. Use code 010 when there are separate tumor nodules in the same lobe as the primary tumor (ipsilateral lung, same lobe).

c. Use code 020 when there are separate tumor nodules in a different lobe of the same lung.

d. Use code 030 when there are separate tumor nodules in both the same lobe and a different lobe of the same lung.

e. Use code 040 when there are separate tumor nodules but it is not known whether they are in the same lobe or a different lobe of the same lung.

f. Code 988 should not be used by any registry because this field is required by all standards setters.

g. Use code 999 if it is unknown whether there are separate tumor nodules or when there is no documentation in the patient record

Site-Specific Factor 1 – Pleural Effusion (Pleura) C S N c

Source documents: imaging, pathology and cytology reports
Other terms: pleural fluid, thoracentesis Pleural effusion is the accumulation of fluid between the two layers of pleura: visceral (covering the lungs) and parietal (lining the chest wall and covering the diaphragm). Pleural effusion is a symptom of mesothelioma that increases the summary stage from local or regional direct extension to distant involvement.

Record the absence or presence of pleural effusion. If pleural effusion is present and examined microscopically, record whether the pleural effusion is non-malignant, malignant, or not specified.

a. Use code 000 when there is no evidence of pleural effusion

b. Use code 010 when:
   - pleural effusion is found microscopically to be non-malignant
   - pleural effusion is stated to be negative for malignant cells
   - pleural effusion is seen on imaging but pleural fluid cytology is negative for malignant cells

c. Use code 020 when:
   - pleural effusion is found microscopically to be malignant
   - pleural effusion is stated to be positive for malignant cells
   - pleural fluid cytology described as suspicious or suspicious for mesothelioma

d. Use code 030 when:
   - pleural effusion is reported on imaging but there is no cytology [pleural effusion, NOS]
   - pleural fluid cytology is described as atypical or atypical mesothelial cells but not specifically to be non-malignant or malignant)

e. Code 988 should not be used by any registry because this field is required by all standards setters.

f. Use code 999 when:
   - it is unknown whether pleural effusion is present
   - pleural effusion is not documented in the patient record

Skin

Skin, MelanomaSkin, MerkelCell (Scrotum, Vulva), MycosisFungoides
Site-Specific Factor 1 – Measured Thickness (Depth) (Skin, Scrotum) C S
Site-Specific Factor 1 – Measured Thickness (Depth), Breslow's Measurement (MelanomaSkin) C S N c

Source document: pathology report

Other names: maximum tumor thickness, Breslow depth of invasion, Breslow thickness, Breslow measurement, Breslow's microstaging

This site-specific factor measures tumor thickness or tumor depth (vertical dimension), not the size (lateral dimension). The depth of invasion of the primary tumor is recognized as an important predictor for risk of nodal metastases in some tumors. The depth of invasion or tumor thickness measurement for skin, scrotum, and melanoma of skin is collected in hundredths of millimeters as stated in the pathology report for the resected specimen. The measurement of tumor thickness (Breslow depth) is precisely defined in the melanoma protocol of the College of American Pathologists (CAP checklist) as a vertical measurement from the granular layer of the epidermis (or base of ulceration) to the deepest point of invasion, as measured on a calibrated ocular micrometer.

Code a measurement specifically labeled as "thickness" or "depth" or "Breslow depth of invasion" in the pathology report. In the absence of this label, a measurement described as taken from the cut surface of the specimen may be coded. And in the absence of either of these labels, the third dimension in a statement of tumor size can be used to code this field.

If the tumor is excised post-neoadjuvant treatment, tumor measurements cannot be compared before and after treatment to determine which would indicate the greater involvement. The same code (998) is used for cases with no surgical procedure of the primary site and cases with surgical procedure of the primary site after neoadjuvant treatment.

Because the thickness table is similar to many other tables that collect a measurement, it is important to identify the correct unit of measurement. The value collected for skin, scrotum and melanoma of skin is measured in *hundredths* of millimeters. This site-specific factor actually has two names:

Measured Thickness (Depth), Breslow Measurement for melanoma of the skin and Measured Thickness (Depth) for skin and scrotum. For MelanomaSkin, several codes from CS version 1 have been made obsolete and the data have been converted to a new code in CS version 2.

In the range 001 to 979, code the actual tumor thickness, tumor depth, or Breslow measurement in hundredths of millimeters as stated in the pathology report. This is a three-digit field with an implied decimal point between the first and second digits.

Examples:
Tumor described as 0.15 mm in depth: Code as 015

Lesion 1 mm thick: Code as 100

Breslow 2.5 mm: Code as 250

Thickness of 10 mm (1 cm): Code as 980 (9.80 millimeters or larger)

The 900 codes are used to document specific case situations.

a. Use code 990 *for skin and scrotum only* when:
   - there is a statement of microinvasion but no depth is given
   - there is a description of a microscopic focus or foci but no depth is given

b. For MelanomaSkin, code 988 should not be used by any registry in the US or Canada, as all standards setters require these fields.

c. Use code 998 *for skin and scrotum only* when there is no histologic examination of the primary site.

d. Use code 999 when:

- tumor depth or thickness information is unknown, including cases in which the primary tumor is removed but the measurement of thickness cannot be determined from the pathology report
- tumor thickness or depth is not documented in the medical record
- *for melanoma of skin only:* there is a statement of microinvasion but no depth is given
- *for melanoma of skin only:* there is a description of a microscopic focus or foci but no depth is given

Site-Specific Factor 2 – Ulceration (MelanomaSkin) C S N c
Source documents: pathology report, physical exam, consultant notes, other statement in medical record

Ulceration of the epidermis over a cutaneous melanoma is an important adverse prognostic factor. The presence of ulceration upstages the melanoma to the next higher category, for example from T1a to T1b. Ulcerated melanomas typically show invasion through the epidermis, whereas nonulcerated melanomas tend to lift the overlying epidermis. The determination of ulceration is based on several pathologic criteria and must be microscopically confirmed.

Code whether ulceration of the melanoma is present, based on information in the pathology report. If there is no mention of ulceration in the pathology report, assume ulceration is not present and code 000.

a. Use code 000 when:
   - there is a statement in the pathology report that no ulceration is present
   - no mention of ulceration in the pathology report

b. Use code 010 when the pathologist states that ulceration is present.

c. Code 988 should not be used by any registry in the US or Canada, as all standards setters require

these fields.

d. Use code 999 when:
   - it is unknown whether there was a pathology report
   - the pathology report is not documented in patient record

Site-Specific Factor 3 – Clinical Status of Lymph Node Mets (MelanomaSkin, MerkelCell {Skin, Penis, Scrotum, Vulva}) C S N c
Source documents: physical exam, consultant notes, other statement in record
Other names: micrometastasis, macrometastasis, occult nodal metastases
The tumor burden (microscopic versus macroscopic metastases) in regional lymph nodes is an important prognostic factor for cutaneous melanoma. According to the AJCC Melanoma Task Force, the majority of Stage III patients have clinically occult rather than clinically apparent nodal metastases. Involvement of regional lymph nodes is based on both physical examination (palpation) and imaging, as well as microscopic confirmation resulting from diagnostic sentinel lymph node biopsy. Site-Specific Factor 3 for both melanoma and Merkel cell schemas records whether lymph node metastases are determined clinically and/or pathologically, and for melanoma the number of nodes involved clinically.

a. Use code 005 when:
   - there is no regional involvement clinically and no pathologic examination is performed, or it is unknown if a pathologic examination is performed
   - there is no regional involvement clinically and nodes are negative on pathologic examination

b. Use code 010 when:
   - there are microscopic lymph node metastases or “micrometastases”
   - lymph nodes are negative on palpation or imaging but contain metastases on pathologic examination
   - lymph nodes are negative on palpation or imaging but positive for isolated tumor cells (ITCs) on pathologic examination
   - lymph node metastases are confirmed microscopically but there is no statement of the clinical status in the medical record

c. Use code 020 for Merkel Cell when:
   - lymph node metastases are clinically apparent and they are confirmed microscopically, macrometastases”
   - lymph node metastases are clinically apparent and there is no pathology

d. Use codes 043-050 for Melanoma when:
   - Lymph node metastases are clinically apparent and they are confirmed microscopically, “macrometastases”

- Lymph node metastases are clinically apparent and there is no pathology

- The number of clinically involved nodes is stated (1=code 043, 2-3=code 045, 4 or more=code 048), or the number of clinically involved nodes is not stated (code 050)

e. Use code 100 when:
   - There are clinically apparent in transit metastases only with no nodal involvement

f. Use code 150 when:
   - There are clinically apparent in transit metastases and clinically apparent nodal metastases (at least one node)

g. Code 988 should not be used by any registry in the US or Canada, as all standards setters require these fields.

h. Use code 999 when:
   - there is no clinical information about regional lymph nodes in the patient record

   - the status of regional lymph nodes is not documented in the patient record

Site-Specific Factor 4 – Serum Lactate Dehydrogenase (LDH) (MelanomaSkin) C S c

See LDH *in Lab Tests and Tumor Markers*

LDH is a site-specific factor for several primary sites.

Site-Specific Factor 7 - Primary Tumor Mitotic Count/Rate (MelanomaSkin) C S c

See Mitotic Count in *Lab Tests and Tumor Markers*

Mitotic count or mitotic rate is a site-specific factor for a number of primary sites. For cutaneous melanoma, the standard measurement is the total number of mitoses per 1 square millimeter. For melanoma of skin, a mitotic rate of 1 or more mitotic figure per square millimeter is a powerful adverse prognostic factor, according to the College of American Pathologists.

Site-Specific Factor 12 – High Risk Features (Skin, Scrotum) C S N c

Source documents: pathology report, consultation report, other statements in the medical record
Other names: high risk histologic features, high risk tumor features

In addition to the tumor size (diameter, not depth), the presence of certain specific high risk features is of prognostic significance for non-melanoma skin cancers other than Merkel cell. The presence of two or more of the high risk features listed below upstages a lesion 2 cm or less in greatest dimension from T1 to T2.

This site-specific factor is to be calculated and coded by the registrar. Information can be taken from any part of the medical record. Disregard any unknown or negative features; count only those that meet the criteria below (each positive feature equals one risk factor). Tally the number of high risk features present, and assign the code representing that number.

a. *Histologic grade or differentiation:* Poorly differentiated/Undifferentiated (grade 3 or 4)-review pathology report and 6th digit of ICD-O morphology code elsewhere on the cancer registry abstract.

b. *Depth of tumor*: greater than 2 mm in depth-review pathology report and site-specific factor 1, Depth of invasion (tumor thickness).

c. *Clark level* IV or V-review pathology report and site-specific factor 10, Clark level

d. *Perineural invasion*-review pathology report and site-specific factor 11, Perineural invasion.

e. *Primary site*: skin of external ear (C44.2) OR skin of lip (hair-bearing, also called non-glabrous lip) (C44.0)-review physical exam, pathology report and other parts of the medical record, as well as ICD-O-3 primary site code elsewhere on the cancer registry abstract.

Note: *Lymph-vascular invasion* was included as a high risk feature in CS versions 0201 and 0202 but was removed from the final list by AJCC. Cases with lymph-vascular invasion should be reviewed and recoded in CS version 0203.

f. Use code 000 when the medical record indicates no high risk features are present.

g. Use a code in the range 001 to 005 for the exact number of high risk features either stated by the clinician or calculated by the registrar.

h. Code 988 should not be used by any registry in the US or Canada, as all standards setters require these fields.

i. Use a code in the 991 to 993 range when the medical record indicates high risk features are present but there is no information about which ones or how many.

j. Use code 999 when:

- it is unknown whether any high risk features present

- there is no documentation of high risk features in the medical record

Site-Specific Factor 16 – Size of Lymph Nodes (Skin, Scrotum) C S c

Source documents: pathology report, imaging report, physical exam, other statement in medical record

The size and number of involved lymph nodes are prognostic factors for non-melanoma skin cancer other than Merkel cell. This site-specific factor supplements the information in CS Lymph Nodes to enable mapping to the N category. The code structure and definitions are the same as for site-specific factor 1 in the head and neck sites. This site-specific factor captures information about the size of the entire involved lymph node, not just the size of the metastasis within the lymph node.

Code the largest dimension (diameter) in millimeters of the involved regional lymph node(s) in the range 001 to 979. The measurement may be clinical or pathologic (pathologic takes priority if there has been no neoadjuvant therapy). Do not code information about distant lymph nodes in this field.

a. Use code 000 in this field if there are no regional lymph nodes involved (CS Lymph Nodes is coded 000).

b. Use code 990 if the tumor in the lymph node(s) is described as a microscopic focus or foci and no size is given.

c. Use the appropriate code in the 991 to 997 range if the largest size of an involved regional node is described imprecisely (for example ‘less than 2 cm’ or ‘greater than 4 cm’.

d. If the only information given is a statement of N value by the clinician, code the corresponding size description in the 992 to 997 range.

e. Use code 999 when:
   - there is no information about the size of involved regional nodes
   - when it is unknown whether regional lymph nodes are involved
   - the size of involved lymph nodes is not documented in the medical record

Merkel Cell Carcinoma

Site-Specific Factor 3 – Clinical Status of Lymph Node Mets (MerkelCell Vulva) C S N c

See *Clinical Status of Lymph Node Mets* above.

Note: Code 988 should not be used by any registry in the US or Canada, as all standards setters require these fields.

Site-Specific Factor 11 – Regional Lymph Node – Laterality (MerkelCellVulva) C S N c

Source documents: pathology report, imaging, physical exam, other statement in record

The MerkelCellVulva schema is a combination of Merkel cell carcinoma and the standard schema for vulva as a gynecologic cancer. This site-specific factor is included in the MerkelCellVulva schema to retain compatibility with AJCC sixth edition for mapping of the N category.

Code the appropriate description of involved regional lymph nodes.

a. Use code 000 when all regional lymph nodes are negative.

b. Use code 010 when:
   - all positive regional nodes are ipsilateral
   - involved lymph nodes are described as unilateral

c. Use code 020 when:
   - at least one regional lymph node is involved on both sides of the pelvis
   - involvement is described as bilateral or contralateral

d. Use code 030 when regional lymph node(s) are described as positive but the laterality of the involved nodes is unknown.

e. Code 988 should not be used by any registry in the US or Canada, as all standards setters require these fields.

f. Use code 998 when:
   - lymph nodes were not examined
   - lymph nodes were not assessed

g. Use code 999 when:
   - there is no information in the medical record about regional lymph node involvement
   - the status of regional lymph nodes is unknown

Mycosis Fungoides

Site-Specific Factor 1 – Peripheral Blood Involvement (MycosisFungoides) C S N c

Source documents: pathology report, clinical laboratory reports of blood analysis (tissue and blood samples)

Other names: Peripheral blood involvement: circulating Sezary cells
T-cell clonality: T-cell receptor (TCR) gene rearrangement
Monoclonal: clone +, clone positive
Polyclonal: clone –, clone negative

Mycosis fungoides is the most common type of primary cutaneous T-cell lymphoma. Sezary syndrome

is a more aggressive type of primary cutaneous T-cell lymphoma in which a specific type of malignant T lymphocytes (Sezary cells) is present in the circulating blood. Staging of mycosis fungoides includes analysis of the circulating blood for Sezary cells. This analysis can be done by microscopy or flow cytometry. Results of microscopy are reported as counts of Sezary cells per cubic millimeter or the percentage of Sezary cells as a proportion of total lymphocytes. Flow cytometry looks for specific cell surface markers such as CD26.

Information about peripheral blood involvement and T-cell clonality identified by polymerase chain reaction (PCR) or Southern blot analysis is combined in a “B” category unique to mycosis Fungoides staging in the TNM system. The basic categories are B0 (no significant blood involvement); B1 (low blood tumor burden); and B2 (high blood tumor burden). Any mention of B2 puts the case into Stage IV. B0 and B1 are subcategorized by clonality. In the sixth edition of TNM and CS version 1, mycosis fungoides site-specific factor 1 described only the presence or absence of Sezary cells in circulating blood. In the seventh edition and CS version 2, the structure of SSF1 is more complex. Codes 001 to 003 have been made obsolete and new codes and definitions have been created to account for peripheral blood involvement and clonality. The lack of monoclonality (clone negative) generally indicates a better prognosis.

Table A.6 Mycosis Fungoides Site-Specific Factor 1 Codes

CODE	DESCRIPTION	B MAP
010	Absence of significant blood involvement: 5% or less of peripheral blood lymphocytes are atypical (Sezary) cells Clone negative Stated as B0a	B0a
020	Absence of significant blood involvement: 5% or less of peripheral blood lymphocytes are atypical (Sezary) cells. Clone positive; Stated as B0b	B0b
030	Absence of significant blood involvement: 5% or less of peripheral blood lymphocytes are atypical (Sezary) cells. Clone unknown; Stated as B0 [NOS]	B0NOS
040	Low blood tumor burden: More than 5% of peripheral blood lymphocytes are atypical (Sezary) cells but does not meet the criteria of B2. Clone negative Stated as B1a	B1a
050	Low blood tumor burden: More than 5% of peripheral blood lymphocytes are atypical (Sezary) cells but does not meet the criteria of B2. Clone positive; Stated as B1b	B1b
060	Low blood tumor burden: More than 5% of peripheral blood lymphocytes are typical (Sezary) cells but does meet the criteria of B2. Clone unknown; Stated as B1 [NOS]	B1NOS
070	High blood tumor burden: 1000/uL Sezary cells or more with positive clone; Stated as B2	B2
080	Percent of atypical peripheral blood lymphocytes not stated and B rating not stated	BX
090	Sezary cell counts, blood flow cytometry, and/or clonality results in chart, B rating not stated	BX
988	This code should not be used by any registry in the US or Canada, as all standards setters require these fields.	BX
997	Sezary cell counts, blood flow cytometry, and/or clonality tests ordered, test results not in chart, B rating not known	BX
999	Unknown or no information; not documented in patient record	BX

Code a statement of peripheral blood involvement and clonality (if given) as reported by the clinician from tissue and/or blood samples. If the physician does not provide a B rating but counts or percentages of neoplastic cells, flow cytometry test results, and/or clonality test results are performed, use the appropriate code for the amount of blood involvement with “clone unknown”.

Codes 010 – 030: Absence of significant blood involvement (no peripheral blood involvement)

Site-Specific Factor 1 Codes

Codes 040 – 060: Low blood tumor burden: more than 5% of peripheral blood lymphocytes are atypical (Sezary) cells but does not meet the criteria of B2.

Site-Specific Factor 1 Codes

Soft Tissue

Soft Tissue, HeartMediastinum, Retroperitoneum, Peritoneum (PeritoneumFemaleGen is discussed with GYN sites.)

The histologies for the soft tissue schema include a wide range of sarcomas and mixed tumors (noncarcinoma and non-hematopoietic) in the ICD-O-3 morphology code range 8800 to 9582, except 9140 Kaposi sarcoma, which has its own schema. The primary sites included in the soft tissue schema include the peripheral nerves and autonomic nervous system (C47._) and the connective, subcutaneous, and other soft tissues throughout the body (C49._). The peritoneum schema includes omentum and mesentery primary sites (C48.1-C48.2, C48.8) and all sarcomas in the range 8800 to 9852 except gastrointestinal and endometrial stromal sarcomas (8935-8936) and Kaposi sarcoma (9140). The retroperitoneum schema (C48.0) includes the same histologies as peritoneum.

Site-Specific Factor 1 – Grade for Sarcomas (SoftTissue, HeartMediastinum, Retroperitoneum, Peritoneum) C S N c

Source documents: pathology report

Other names: FNCLCC grade, NCI grade

For soft tissue sarcomas, the grade of the tumor is the predominant prognostic indicator, and grade has been included as a category in TNM stage grouping for sarcomas since the first edition of the TNM system in 1978. Through the sixth edition, a four-grade system was used. There are a number of grading systems for adolescent and adult soft tissue tumors, the most widely used of which are the National Cancer Institute (NCI) system and the system of the French Federation of Cancer Centers Sarcoma Group (FNCLCC). Both are three-grade systems using criteria for mitotic activity, extent of necrosis, and differentiation, and both are highly correlated with prognosis. The NCI system also quantifies cellularity and pleomorphism for certain types of sarcomas, making it somewhat more difficult to use. The seventh edition of the *AJCC Cancer Staging Manual* adopted the FNCLCC grading system as the preferred grading system. This site-specific factor allows any three grade system for sarcomas to be coded. It should be noted that stage grouping uses essentially a two tier system, where grade 1 is categorized as low grade and grades 2 and 3 are categorized as high grade. Grading should be attempted for all sarcomas, although a fine/core needle biopsy may not yield enough tissue to assign a grade in a three-grade system.

Code the grade stated in the pathology report. Do not code “well differentiated” or “poorly differentiated” or similar terminology in this field. If the only information available is “low grade” or “high grade”, use code 100 or 200 as appropriate. Codes 010-030 take priority over codes 100 and 200, and can also be coded in Grade Path Value and Grade Path System. If there is no biopsy/resection or there is no microscopic examination of tissue from the primary site, use code 998.

a. Use code 010 when the pathology report specifies the grade as Grade 1 [of 3].

b. Use code 020 when the pathology report specifies the grade as Grade 2 [of 3].

c. Use code 030 when the pathology report specifies the grade as Grade 3 [of 3].

d. Use code 100 when the grade is stated as "low grade" [NOS] with no mention of numeric grade.

e. Use code 200 when the grade is stated as "high grade" [NOS] with no mention of numeric grade.

f. Code 988 should not be used by any registry in the US or Canada, as all standards setters require this field.

g. Use code 998 when there is:
   - no histologic examination of the primary site
   - no biopsy or resection

h. Use code 999 when:
   - the sarcoma is ungraded
   - the grade cannot be determined
   - the grade for the sarcoma is unknown
   - there is no information in the medical record about tumor grade
   - the tumor is not a sarcoma

Site-Specific Factor 25 – Schema Discriminator (Peritoneum) C S N c

Source documents: face sheet, other statement of patient gender in medical record

Both sarcomas and carcinomas of the peritoneum can be staged. For peritoneum, a schema discriminator is necessary to identify the gender of the patient so that the correct schema can be presented to the abstractor. Carcinomas in the morphology code range 8000-8576, specialized gonadal neoplasms, and mixed complex and stromal neoplasms (except gastrointestinal stromal tumors) are coded with the same staging criteria for female patients as ovarian cancer in the PeritoneumFemaleGen schema.

Code 002, Female, presents the PeritoneumFemaleGen schema to the abstractor. All other categories of gender (codes 001, 003, 004, 009 and 100) present the Peritoneum schema to the abstractor. For males, a carcinoma of the peritoneum will output T NA N NA M NA Stage NA. Code 981 is new in CS version 0203 and includes non-carcinoma, non-GIST histologies formerly coded as "blank" in CS versions 0200 through 0202.

Breast

Coding Regional Lymph Nodes

For breast, regional lymph node information is coded in several fields (Table I-2-12). These SSFs will be discussed as a group.

Table A.7 Regional Lymph Nodes Data Fields

FIELD	DESCRIPTION
CS Lymph Nodes	Regional lymph nodes: number, laterality
CS Reg Nodes Eval	Clinical or pathologic evaluation
CS LN Pos	Number of lymph nodes microscopically positive
CS LN Exam	Number of lymph nodes microscopically examined
CS SSF3	Number of positive ipsilateral Level I-II Axillary Lymph Nodes
CS SSF4	Immunohistochemistry of Regional Lymph Nodes
CS SSF5	Molecular Markers of Regional Lymph Nodes
CS SSF19	Assessment of Ipsilateral Axillary Lymph Nodes

Coding regional lymph node involvement for breast cancers is more complex than for many other sites, especially when dealing with isolated tumor cells (ITCs) and micrometastases. The following definitions may help clarify the code choices in CS Lymph Nodes and Site-Specific Factors 3 – 5. For a more detailed explanation, see the section in the breast chapter of the *AJCC Cancer Staging Manual*, seventh edition, called "Specific Considerations for Evidence-Based Changes to the *AJCC Cancer Staging Manual, seventh edition,*" beginning on page 362.

Isolated Tumor Cells (ITCs): Pathologists can detect isolated tumor cells (ITCs) spread from a breast cancer into regional lymph nodes. These are very small deposits of tumor cells, no larger than 0.2 mm or no more than 200 cells-so small that they are *not* considered significant for assigning stage. They usually do not show evidence of malignant activity in the nodes, such as proliferation or stromal reaction. To be identified as ITCs, they must be single tumor cells or small clusters not more than 0.2 mm. As more data are collected about these ITCs, their prognostic significance may be better understood. In both the sixth and seventh editions, nodes containing only ITCs are *not* considered positive nodes and are classified as pN0 in TNM. ITCs are most often found using immunohistochemistry tests on sentinel lymph node specimens. The ITCs may sometimes also be seen on routine H&E stained sections.

Hematoxylin and Eosin (H & E): (from "Hematoxylin & Eosin: (The Routine Stain)"), by H. Skip Brown, BA, HT(ASCP), from: http://www.sigmaaldrich.com/img/assets/7361/Primer-H&Emay04.pdf.

In histology, the standard or routine stain is the hematoxylin and eosin stain, better known as the "H&E" stain. With rare exceptions, every specimen being examined will first receive an H&E stain to give the laboratorian a visible look at the nucleus of the cells and their present state of activity. With most disease states there is abnormal growth and/or division in the nucleus of the cells. The hematoxylin and eosin stain uses two separate dyes, one staining the nucleus and the other staining the cytoplasm and connective tissue. Hematoxylin is a dark purplish dye that will stain the chromatin (nuclear material) within the nucleus, leaving it a deep purplish-blue color. Eosin is an orangish-pink to red dye that stains

the cytoplasmic material including connective tissue and collagen, and leaves an orange-pink counterstain. This counterstain acts as a sharp contrast to the purplish-blue nuclear stain of the nucleus, and helps identify other entities in the tissues such as cell membrane (border), red blood cells, and fluid.

Micrometastasis: When the tumor deposits in the lymph nodes are larger than 0.2 mm but not larger than 2.0 mm, they are defined as micrometastasis. Nodes with micrometastasis *are* defined as positive for staging.

In coding CS Lymph Nodes and Site-Specific Factors 3-5, the important things to abstract are the size of the tumor detected in the lymph nodes and the methods of detection. Table I-2-13 below may help in coding this information. Note that the table includes codes for levels I and II axillary nodes only (including intramammary nodes), not internal mammary nodes, supraclavicular, or level III axillary nodes. The table is followed by examples to illustrate likely coding situations.

To use the table, identify the group (numbered I-VI) of applicable rows based on the information in column 2 that best represents the information in the case. Within that group, find the row or rows that represent the information in the case, and read right to the last four columns to find the codes to use. The group numbers are for convenience in using this chart only, and do not correlate with any anatomic groups of nodes.

Table A.8 Example of Lymph Node, IHC and Mol Coding Scenarios

CASE INFORMATION CATEGORIES WITH EXAMPLES	IHC AND/OR MOL STUDIES DONE METHOD OF DETECTION, VERIFICATION	CS LYMPH NODES	SSF3 (NUMBER POS AXILLARY NODEBOUTS)	SSF4 (IHC)	SSF5 (MOL)
I. Clinical information only; no pathological information used to code CS Lymph Nodes; no nodes examined pathologically, nodes clinically NEGATIVE.					
1. Nodes clinically negative, patient refused further workup.	None; does not apply	000	098	000	000
II. Clinical information; no pathological information used to code CS Lymph Nodes; no nodes examined pathologically, nodes clinically POSITIVE					
2A. Fixed and matted ipsilateral axillary nodes clinically, patient had pre-op chemotherapy. Subsequent modified radial mastectomy showed negative axillary nodes. (CS Reg Nodes Eval = 5 in this case.)	None; does not apply	510	098	987	987
2B. Axillary Nodes clinically positive, patient refused further workup.	None; does not apply	600	098	987	987
III. Nodes examined pathologically, nodes negative; no isolated Tumor Cells (ITCs) **Note**: SSF4 and SSF5 are coded independently of each other.					
3A. Modified radial mastectomy, path report with 12 lymph nodes neg for tumor, no special stains, cytokeratin, IHC, or molecular studies performed on lymph nodes.	Immunohistochemistry (IHC) (cytokeratin staining) not done, OR unknown if done	000	000	000	000

3B. Sentinel nodes neg on H&E. Unknown if IHC done. RT-PCR done, negative for ITCs.		000	000	000	001
4. Sentinel nodes neg on H&E. IHC (cytokeratin stain) performed, negative for ITCs. Molecular studies not done.	IHC done, neg for tumor	000	000	001	000
5A. Sentinel nodes neg on H&E. IHC (cytokeratin stain) performed, negative for ITCs. Molecular studies not done. 5B. Modified radical mastectomy, path report with 12 lymph nodes neg for tumor, no special stains, cytokeratin, IHC, or molecular studies performed on lymph nodes	Molecular studies not done, OR unknown if done	000 000	000 000	001 000	000 000
6. Sentinel nodes on H&E. Unknown if IHC done. RT-PCR done, negative for ITCs	Molecular studies done, neg for tumor	000	000	000	001

Site-Specific Factor 3–Number of Positive Ipsilateral Level I-II Axillary Lymph Nodes C S N c

Source documents: pathology report

In CS version 1, this field was called Number of Positive Ipsilateral Axillary Lymph Nodes. In CS version 2, the content has been modified slightly to limit the count of axillary lymph nodes to levels I and II on the same side of the body as the primary site. These nodes are the low axillary (level I and intramammary) and mid-axillary (level II, also called interpectoral or Rotter's nodes). Thus the count of axillary lymph nodes now *excludes* level III (high axillary, also called apical or infraclavicular; N3a), internal mammary (N3b) and supraclavicular (N3c) lymph nodes. (Do not confuse intramammary nodes, which are within breast tissue and included in level I, with internal mammary nodes, which are along the sternum and map to N3b.) The number of positive Ipsilateral Level I-II axillary lymph nodes determines the N category and the pathologic stage group.

The structure of this 3-digit field is similar to the 2-digit field Regional Nodes Positive, and the same coding rules apply to both fields. This field is based on pathologic examination of ipsilateral (same side as the primary cancer) level I and II axillary lymph nodes, so pathologic information is included even if the patient had neoadjuvant therapy prior to lymph node removal.

a. Do not include lymph nodes containing only isolated tumor cells (ITCs-metastases less than 0.2 mm in size) in the count of positive nodes.

b. Use code 000 when all level I and II axillary lymph nodes are negative on pathologic examination.

c. Use a code in the range 001 to 089 for the exact count of level I and II axillary lymph nodes, or 090 if more than 89 level I and II axillary lymph nodes are positive.

d. Use code 095 if there was only a positive aspiration of level I or II axillary lymph node(s).

e. Use code 097 if level I and II axillary lymph nodes were positive but the number is not specified.

f. Use code 098 when:
   - no axillary nodes were examined
   - an axillary dissection was performed but no axillary lymph nodes were found
   - there is a clinical diagnosis (no axillary lymph nodes were removed)

g. Use code 099 when it is unknown whether axillary lymph nodes are positive.

h. Code 988 should not be used by any registry in the US or Canada, as all standards setters require these fields.

Site-Specific Factor 4 – Immunohistochemistry (IHC) of Regional Lymph Nodes C S N c

Source documents: pathology report

Other names: cytokeratin (HC) staining, pankeratin (IHC) staining, immunocytochemistry, Immunochemistry Immunohistochemistry (IHC) tests use antibodies to stain for proteins of interest in tissue specimens. The IHC test for metastatic breast cancer in lymph nodes uses antibodies to cytokeratin. Specific stains include AE1, AE3, AE1/3, MNF116 and CAM5.2 Other IHC tests are used on the primary breast tumor, rather than the lymph nodes, to assess estrogen and progesterone receptors and HER2 neu (human epidermal growth factor receptor). Immunohistochemistry is an additional test performed by the pathologist on lymph nodes that are pathologically negative on standard H&E stains. If IHC is done, it will be noted as an addendum to the pathology report of the specimen or reported on a separate form. If there is no mention of IHC in the medical record, code breast Site-Specific Factor 4 as 000 Not Done.

Site-Specific Factor 4 codes IHC results for isolated tumor cells (ITCs-see above) in lymph nodes only, as shown in Table I-2-14 below. Use a code in the range 000 to 009 when CS Lymph Nodes is coded 000 (no regional lymph nodes involved). If regional lymph nodes are positive, code Site-Specific Factor 4 as 987.

Table A.9 H&E and IHC Combinations for SSF4

CODE	ROUTINE H&E STAINS	IMMUNOHISTOCHEMISTRY (SPECIAL STAINS)
000	Negative	Not done or unknown if done
000	Negative, ITC status not mentioned	
000	Nodes clinically negative (not examined pathologically)	
000	Negative	Not mentioned
001	Negative	Done, ITCs not present (negative)
002	Negative	Done, ITCs present (positive)
009	Negative	Done, positive for tumor but size of ITC clusters or mets not stated
009	Negative	Stated as N0 (i+), no further information
987	Not applicable: CS Lymph Nodes not coded 000	

Code 988 should not be used by any registry in the US or Canada, as all standards setters require these fields.

Site-Specific Factor 5 – Molecular (MOL) Studies of Regional Lymph Nodes C S N c
Source documents: pathology report

Reverse transcriptase polymerase chain reaction (RT-PCR), a molecular test looking for expression of

the genes of interest, is an even more sensitive test used to detect ITCs in lymph nodes. This test is rarely done, so this field will almost always be coded 000 if CS Lymph Nodes is coded 000 (negative).

Code the results of molecular studies in Site-Specific Factor 5 as shown in Table I-2-15. Use a code in the range 000 to 002 when CS Lymph Nodes is coded 000 (no regional lymph nodes involved). If regional lymph nodes are positive, code Site-Specific Factor 5 as 987.

Table A.9 H&E and Molecular Studies Combinations for SSF5 Codes

CODE	ROUTINE H&E STAINS	MOLECULAR STUDIES (RT-PCR)
000	Negative	Not done or unknown if done
000	Negative, ITC status not mentioned	
000	Nodes clinically negative (not examined pathologically)	
000	Negative	Not mentioned
001	Negative	Done, ITCs not present (negative)
002	Negative	Done, ITCs present (positive)
987	Not applicable: CS Lymph Nodes not coded 000	

Code 988 should not be used by any registry in the US or Canada, as all standards setters require these fields.

Site-Specific Factor 1 – Estrogen Receptor (ER) Assay C S N c
Other names: ER, **ERA,** Estrogen Receptor Assay, Estrogen Receptor Status, Estradiol Receptor, Estrogen Binding Protein, hormone receptor status (with PRA).

In CS version 0203, code 000 was made obsolete and the data were converted to 998 Test not done. In CS version 0203, code 080 was made obsolete and the data were converted to 997 Test ordered, results not in chart.

Code 988 should not be used by any registry in the US or Canada, as all standards setters require these fields.

Site-Specific Factor 2 – Progesterone Receptor (PR) Assay C S N c

Other names: PR, PgR, Progesterone Receptor Assay, Progesterone Receptor Status, hormone receptor status (with ERA).

In CS version 0203, code 000 was made obsolete and the data were converted to 998 Test not done. In CS version 0203, code 080 was made obsolete and the data were converted to 997 Test ordered, results not in chart.

Code 988 should not be used by any registry in the US or Canada, as all standards setters require these fields.

The following information applies to both Estrogen Receptor and Progesterone Receptor Assays.
Source documents: pathology report (usually as an addendum), separate clinical laboratory report
Estrogen receptor (ER) positivity and progesterone receptor (PR) positivity are favorable prognostic factors in breast cancer, as well as endometrial carcinoma and meningioma. Positive results indicate a favorable response to endocrine (hormonal) therapy. Combined ER and progesterone receptor (PR) positivity is associated with increased response to antiestrogen therapies.

There are a variety of ways to report information on ER and PR results, but there is almost always a summary statement that the result is positive or negative.

Table A.10 Estrogen Receptor and Progesterone Receptor Assays Examples

TEST NAME ASSAY TYPE	STAINING INTENSITY AVERAGE	PERCENT POSITIVE (%)	RESULT
ER	3+	72	Positive
PR	3+	57	Positive

Example: The neoplastic cells show mild (1+/4+) cytoplasmic staining with the estrogen receptor marker. The neoplastic cells exhibit abundant (3+/4+) nuclear staining with progesterone receptor marker.

Example: ER positive (72%); PR positive (68%)

Record the pathologist's interpretation of the assay value from the tumor specimen. Results from the ER or PR assay done prior to neoadjuvant therapy take priority. If assays are performed on more than one specimen and any result is interpreted as positive, code as 010 Positive/elevated. If there are no results prior to neoadjuvant treatment, code the results from a post-treatment specimen. Do not report the results of an ER or PR done as part of a multigene test such as OncotypeDX or MammaPrint.

a. Use code 010 when the ER or PR is reported as positive or elevated.

b. Use code 020 when the ER or PR is reported as negative or normal.

c. Use code 030 when the ER or PR is reported as borderline; undetermined whether positive or negative.

Note: New guidelines for interpreting test results do not provide for a borderline result. Therefore, the code for borderline will rarely, if ever, be used for diagnoses 2010 forward. The new guidelines state that any test which results in 1% of the cells staining positive is a positive test. If <1% of cells stain, the test is considered negative.

d. Code 988 should not be used by any registry in the US or Canada, as all standards setters require these fields.

e. Use code 996 when the ER or PR test was ordered but the results are not interpretable.

f. Use code 997 when the ER or PR test was ordered but the results are not in the medical record.

g. Use code 998 when there is a statement in the medical record that the test was not done, not ordered and/or not performed, for example, if the tumor tissue is completely in situ.

h. Use code 999 when:
   - there is no information in the medical record about the ER or PR test
   - it is unknown whether the ER or PR test was performed
   - the patient has only a clinical diagnosis of breast cancer

The two most common ways to report ER and PR results are the proportion score (PS) (Table I-2-16) and the intensity score (IS) (Table I-2-17). Both the PS and IS are based on immunohistochemical staining of tumor cells. The PS reports the percentage of tumor cells with positive nuclear staining. The IS is the degree of nuclear positivity; in other words, the average intensity of all positive tumor cells on a scale from pale to dark. In some reports, these two scores are combined for a total score (TS, the sum of the PS and the IS). The Allred score, "H" score, or Quick score may be reported. Each of these is a total score for proportion and intensity. For each of these, results of 0 (None + None) or 2 (<1% + 1 Weak) are considered negative and any sum from 3 to 8 is considered positive.

Table A.11 Proportion Score (PS) Codes

CODE	DESCRIPTION
0	None
1	> 0 to < 1 %
2	1% to 10%
3	10% to 33%
4	33% to 66%
5	>66%

Table A.12 Intensity Score (IS) Codes

CODE	DESCRIPTION
0	None
1	Weak
2	Intermediate
3	Strong

Older ER and PR reports may have different cut-offs for negative and positive results.

Table A.13 Immunoperoxidase (immunohistochemical) staining of tumor cell nuclei Codes

CODE	DESCRIPTION
< 5%	negative
5 – 19%	borderline; also expressed as 1+ or +
> 20%	positive; 20 – 80%; also expressed as 2+ or ++
> 80%	also expressed as 3+ or +++

Another less frequently used assay is the amount of cytosol protein in the tumor sample. This is reported in femtomoles per milligram.

Table A.14 Femtomoles (fmol/mg) of cytosol protein per milligram Codes

CODE	DESCRIPTION
< 6	negative
6-10	borderline
> 10	positive
> 100	highly positive

For further information on estrogen and progesterone receptor quantification, refer to the invasive breast cancer protocol published by the College of American Pathologists for AJCC seventh edition, published October 2009 available at:
www.cap.org/apps/docs/committees/cancer/cancer_protocols/2009/InvasiveBreast_09protocol.pdf.

Recording HER2 Information
Nine of the 24 site-specific factors for breast collect information about HER2.

Site-Specific Factor 8 – HER2: Immunohistochemistry (IHC) Test Lab Value C S N c
Site-Specific Factor 9 – HER2: Immunohistochemistry (IHC) Test Interpretation C S N c
Site-Specific Factor 10 – HER2: Fluorescence In Situ Hybridization (FISH) Test Lab Value C S N c
Site-Specific Factor 11 – HER2: Fluorescence In Situ Hybridization (FISH) Test Interpretation C S N c
Site-Specific Factor 12 – HER2: Chromogenic In Situ Hybridization (CISH) Test Lab Value C S N c
Site-Specific Factor 13 – HER2: Chromogenic In Situ Hybridization (CISH) Test Interpretation C S N c
Site-Specific Factor 14 – HER2: Result of Other or Unknown Test C S N c
Site-Specific Factor 15 – HER2: Summary Result of Testing C S N c
Site-Specific Factor 16 – Combinations of ER, PR, and HER2 Results N c

Source documents: pathology report (usually in an addendum to the report), specialized lab tests, reference laboratory report

Other names: HER2, HER2 neu, c-erbB2, c-neu

HER2 is Human Epidermal growth factor Receptor 2, a protein on the surface of cancer cells that accepts growth signals. There are actually four HER categories; only HER2 is of interest for breast cancer. The presence of too many HER2 receptors ("overexpression") indicates that the tumor may grow more aggressively. About 20-30% of breast cancers overexpress HER2. Overexpression is both a prognostic and predictive factor for breast cancer. A lack of overexpression indicates patient may not respond to certain therapies such as Herceptin (trastuzumab), which is designed to "turn off" or deregulate the overexpression of HER2. There are several ways to measure HER2: immunohistochemistry (IHC), Fluorescence In Situ Hybridization (FISH), and Chromogenic In Situ Hybridization (CISH, pronounced 'kish'). The information obtained from these tests plays a critical role in treatment planning, because HER2-positive patients tend to respond favorably to the expensive drug Herceptin (trastuzumab) or Tykerb (lapatinib), which work by blocking these receptors and preventing growth signals from getting through to the cancer cell. HER2-positive patients also may have a greater benefit from anthracycline based adjuvant therapy, such as idarubicin. Usually only one test is performed, but if result of that single test is equivocal, American Society of Clinical Oncology (ASCO) guidelines recommend that a second test be performed.

When there is more than one HER2 NEU value available, record the highest value. If there are positive and negative values, record the positive. This same rule applies to ER and PR.

HER2 NEU results are to be recorded from IHC, FISH, CISH or another pathologic test only. Do not use results from Multigene Signatures tests (i.e. Oncotype). If you have results from Oncotype tests, record this information in a text field. This same rule applies to ER and PR.

Common Codes and Definitions for Site-Specific Factors 8 – 14

988 Not applicable: information not collected for this case

Note: Code 988 should not be used by any registry in the US or Canada, as these fields are required by all standards setters.

997 Test ordered, results not in chart

Note: For paired lab value and interpretation tables, code 997 in the lab value table may be used where the value is unknown but the result interpreted; code 997 in the interpretation table may be used where the value is known but the result is not interpreted.

998 Test not done (test not ordered and not performed)

Note: There must be a statement in the medical record that the test was not done or that there were other circumstances that prevented the test from being done, such as a clinical diagnosis only (no histologic specimen). The registry may also have a documented policy that the lab test is never performed by the facility and a specimen is never sent out to a reference laboratory for performance of the test.

999 Unknown; No information; Not documented in patient record.

Common Codes and Definitions for Site-Specific Factors 9, 11, 13, 14
010 Test reported as positive or elevated
020 Test reported as negative or normal or within normal limits
030 Test reported as borderline, equivocal, indeterminate, undetermined whether positive or negative

Important note for HER2 field pairs SSFs 8-9, SSFs 10-11, and SSFs 12-13
Code the lab value and interpretation from the same test (same specimen). Do not mix lab values and interpretations from different facilities in the pairs of tests. However, results can be coded from different facilities for different tests (IHC from Hospital 1 and FISH from Hospital 2).

Example:
Facility A (breast biopsy): HER-2/neu (ACIS score): 1.7 (reflexed to FISH testing). Reference states "1.5 to 3.4 - Score 2+". Facility B (resection): HER-2/neu (HercepTest): neg for overexpression. *Using Facility A information, code SSF8 as 020 (2+) and SSF9 as 999 (interpretation not documented). Code SSF10 as 170 and SSF11 as 999 (interpretation not documented. Alternatively, using Facility B information, code SSF8 as 997 (test ordered, results not in record), SSF9 as 020 (negative), SSF10 and SSF11 as 999 (not documented).*
Do not combine the negative test result from Facility B with the lab result from Facility A.

Site-Specific Factors 8 – 9 Immunohistochemistry (IHC) Lab Value and Interpretation
Site-specific factor 8 codes the IHC score in a range of 000 to 030, with additional codes for test not done and other explanations for missing information. Site-specific factor 9 codes the interpretation of the IHC score. Read the code definitions carefully. In CS version 0203, codes 001, 002, and 003 were made obsolete and the data were converted to codes 010, 020, and 030, respectively.

Immunohistochemistry or IHC is the most commonly used test for HER2 and is usually the initial HER2 test done. IHC is a special staining process performed on fresh or frozen breast cancer tissue removed during biopsy. The stains used carry various names, such as CB11 (anti HER2 mouse monoclonal antibody), 4B5 (anti HER2 rabbit monoclonal antibody), SP1, SP2, and SP3 (rabbit monoclonal antibodies), HercepTest®, Pathway®, and others. IHC is used to show whether or not the cancer cells have HER2 receptors and/or hormone receptors on their surface. The IHC test gives a score of 0 (no expression) to 3+ (strong complete tumor cell membrane expression) that indicates the amount of HER2 receptor protein on the cells in a sample of breast cancer tissue. If the tissue scores 0 to 1+, it is called “HER2 negative,” and Herceptin is not considered effective for tumors with IHC scores of 0 or 1+. When the result is 2+, the HER2 status of the tumor is not clear. This often leads to testing the tumor with FISH (see below). If the tissue score is 3+, it is called “HER2 positive,” and the patient is likely to receive Herceptin as part of first course therapy. (The symbols 1+, 2+, and so forth should be read as “1 plus” or “2 plus” rather than “1 positive” or “2 positive.”) It is important to note that results of the IHC test may vary from lab to lab and that some labs are more experienced with testing for HER2 than others. The IHC test results are most reliable for fresh or frozen tissue samples. IHC tends to be an unreliable way to test tissue that's preserved in wax or other chemicals.

Definitions of “positive” and “negative” interpretations for the test vary from one lab to another. Each may have a different range for normal values. Look for the interpretation of the test by patient’s clinician or the facility pathologist as first priority. In the absence of the local doctor’s interpretation, look on the actual lab report for that particular lab’s reference values and use that information to assign the appropriate interpretation code. The codes for interpretation are similar to other site-specific factors that are evaluated as positive/elevated, negative/normal, borderline, and so forth. If neither a physician

interpretation nor a lab reference range can be found, do not attempt to interpret the results; code as 999 unknown.

Site-Specific Factors 10 – 11 Fluorescence In Situ Hybridization (FISH) Lab Value and Interpretation

FISH results are reported in SSFs 10 (ratio) and 11 (interpretation). The FISH test is another method of testing for overexpression of the HER2 gene that uses fluorescent pieces of DNA that attach only to the HER2 gene copies in cells, which can then be counted under a special microscope. FISH tests include PathVysion®, HER2 FISH pharmDx™, and INFORM®. The FISH technique is more expensive than IHC and takes longer to get the results, but it is also thought to be more accurate. The result is expressed as a ratio of the number of copies of the HER2 receptors to the control rather than as a score. The result is reported as a number with the remainder of the ratio expression implied. For example, the report may indicate a ratio of 2.2 [: 1].

In SSF10, code the exact ratio to two decimal places in the range 100 (1.00) to 979 (9.79), as stated in the report. Code a ratio over 9.79 to 980. For example, a FISH result of 5.5 would be reported as 550; a result of 11.85 would be reported as 980 (ratio of 9.79 or greater). If the result in the report is less than 1, use code 991.

In SSF11, code the local doctor's interpretation of the FISH test, if available; otherwise, look at the results on the lab report. For FISH, the definition of positive, negative or borderline varies from lab to lab. The code structure for this field is similar to other lab tests requiring an interpretation. If a FISH test was performed and the results are interpreted in the chart, record as positive, negative or borderline. If the test results are in the chart but there is no interpretation and no laboratory guideline given, code SSF11 as 999.

Site-Specific Factors 12 – 13 Chromogenic In Situ Hybridization (CISH) Lab Value and Interpretation

CISH results are reported in SSFs 12 (mean number) and 13 (interpretation). CISH is the most recent technique for determining HER2 status, and may be called SPOT-Light® on the report. It has only been approved in the United States since July of 2008. CISH works in a manner similar to FISH, by using small DNA probes to count the number of HER2 genes in breast cancer cells. But this test looks for color changes (not fluorescence) and doesn't require a special microscope, which makes it less expensive. In addition, unlike other tests, it can be used on tissue samples that have been stored in the lab. CISH is in widespread use in Canada, and because of its advantages, CISH may replace FISH testing in the US.

CISH results are expressed as the mean (average) number of HER-2/neu gene copies per cell. In other words, CISH is the ratio of the number of gene copies detected, divided by the number of tumor cell nuclei counted; for example, 253 gene copies divided by 60 nuclei counted = 4.22. In SSF12, record the exact mean to two decimal places in the range 100 (1.00) to 979 (9.79), as stated in the report. For example, a CISH result of 3.2 would be reported as 320; a result of 10.05 would be reported as 980 (ratio of 9.79 or greater).

Record the interpretation of the CISH test in SSF13, which has a similar code structure to the HER2 IHC and HER2 FISH interpretation fields. For CISH, the definition of positive, negative or borderline

varies from lab to lab. If a CISH test was performed and the results are interpreted in the chart, code as positive, negative or borderline. Usually, the results will be either positive or negative, because if the result of counting the mean number of gene copies per cell from 30 cells is between 4.0 and 6.0, another 30 cells are counted and the mean from those 60 cells is interpreted according to the following scoring guideline:

Non-amplification: 1–5 signals/nucleus in tumor cells. Result: negative.

Amplification: > 5 signals/nucleus, or cluster of amplified signals/nucleus in >50% of tumor cells. Result: positive.

Site-Specific Factor 14 - Result of Other or Unknown Test

Site-specific factor 14 documents other types of HER2 testing, in other words, not IHC, FISH, or CISH. The most likely scenario will be a statement in the CAP Protocol or elsewhere in the chart that the patient is HER2 positive or HER2 negative, with no indication of how this information was determined and no test results in the chart. This may be particularly true for cases diagnosed or treated outside the reporting facility or cases being reported by freestanding radiation therapy or ambulatory surgery centers. Other possibilities are SISH (silver in-situ hybridization) test and RISH (rapid in situ hybridization against mRNA), which are still experimental. The code structure is the same as the IHC, FISH and CISH test interpretation fields. Code a statement of HER2 status (positive, negative, borderline) by the clinician/pathologist in this field when there is no information about the specific HER2 test in the chart.

Site-Specific Factor 15 - Summary Result of Testing

Site-specific factor 15 can be derived from SS Factors 9, 11, 13, and 14. When there is only one test done (IHC, FISH, or CISH), repeat the result of that test in this field. When more than one HER2 test is done, code the final result in this field. If the results of one test are available and a second test is known to have been performed but the results are not available, use code 997. To determine which result to code in this field, use the following guidelines:

a. Gene-amplification tests (in situ hybridization) are considered to be a more reliable test of the over-expression of the HER2 gene. Thus, if both an IHC and a gene-amplification test (FISH, CISH, etc.) were done, code the result of the gene-amplification test in site-specific factor 15, except as noted below.

b. If the gene-amplification test was given first and the result was borderline/equivocal and an IHC was done to clarify these equivocal results, code the result of the IHC.

c. Code 988 should not be used by any registry in the US or Canada, as this field is required by all standards setters.

Site-Specific Factor 16 – Combinations of ER, PR, and HER2 Results

This is another summary field that allows researchers to rapidly identify those women who are “triple negative”-ER negative, PR negative and HER2 negative-a group comprising approximately 15% of all breast cancer cases. Younger women, African American women, and Hispanic women are more likely to be triple negative than older women and Caucasians, meaning that they are less likely to respond to

hormone therapy or Herceptin as part of their breast cancer treatment.

SSF16 uses information from Site-Specific Factors 1, 2, and 15. The first digit reflects the result of ER testing, the second of PR testing, and the third HER2 testing as shown in Table I-2-19. The values in each digit are simply 0 for a negative test result and 1 for a positive test result. Thus "triple negative" patients are coded 000 in this field. In contrast, code 111 identifies women who are "triple positive." If the result of any of the three tests is borderline/equivocal, unknown, or not performed, code as 999.

Table A.15 Layout of SSF16

1ST DIGIT	2ND DIGIT	3RD DIGIT	FOR EACH DIGIT
			0 Negative
ER	PR	HER2	1 Positive

Female Genital Organs
Vulva, CorpusCarcinoma, CorpusAdenosarcoma, CorpusSarcoma, Placenta, PeritoneumFemaleGen

This section covers 10 schemas of the gynecologic organs. The new PeritoneumFemaleGen schema includes a schema discriminator to separate soft tissue sarcomas of the peritoneum from carcinomas of the female peritoneum, which are staged in the TNM system with the ovary schema. In the seventh edition of TNM and therefore in CS version 2, corpus uteri has three histology-specific staging systems: endometrium and carcinosarcomas (CorpusCarcinoma), ICD-O morphology codes 8000-8790, 8980-8981, 9700-9701 leiomyosarcomas and endometrial stromal sarcomas (ESS) (CorpusSarcoma), 8890-8898, 8930-8931 adenosarcomas (CorpusAdenosarcoma), 8933 only.

Many of the site-specific factors are the same for multiple primary sites, but the numbering of the site-specific factors differs, as shown in Table I-2-22. These site-specific factors will be discussed generically (without reference to SSF numbers) below.

Table A.16 Site-specific Factor Locations for Gynecologic Organ Prognostic Factors

	Vulva	Corpus Carcinoma	Corpus Adenosarcoma	Corpus Sarcoma	Placenta	Peritoneum Femalegen
Peritoneal Cytology		2	2	2		
Regional LN Laterality	11					
Prognostic Scoring Index					1	
Schema discriminator						25

Site-Specific Factor 11 – Regional Lymph Node Laterality (Vulva) C S N c
Source documents: pathology report, imaging, physical exam, other statement in record

This site-specific factor is included in the CS version 2 vulva schema to retain compatibility with AJCC sixth edition for mapping of the N category.

Code the appropriate description of involved regional lymph nodes.

a. Use code 000 when all regional lymph nodes are negative.

b. Use code 010 when:
   - all positive regional nodes are ipsilateral
   - involved lymph nodes are described as unilateral

c. Use code 020 when:
   - at least one regional lymph node is involved on each side of the pelvis
   - involvement is described as bilateral or contralateral

d. Use code 030 when regional lymph node(s) are described as positive but the laterality of the involved nodes is unknown.

e. Code 988 should not be used by any registry in the US or Canada, as this field is required by all standards setters.

f. Use code 998 when:
   - lymph nodes were not examined
   - lymph nodes were not assessed

g. Use code 999 when:
   - there is no information in the medical record about regional lymph node involvement
   - the status of regional lymph nodes is unknown

Site-Specific Factor 2 – Peritoneal Cytology (Corpus – Carcinoma, Adenosarcoma, Sarcoma) C S N c

Source documents: cytology reports (look for multiple reports), pathology report

Other names: peritoneal washings, peritoneal lavage, possibly paracentesis (if no surgery)

Peritoneal cytology looks for malignant cells in the fluid in the pelvic and peritoneal cavities. Excess natural fluid accumulation is called ascites. If at laparotomy an analyzable amount of ascites is not present, the surgeon may flood the pelvis and abdomen with saline solution then suction it out and send the fluid for cytology. Prior to the seventh edition of TNM, positive peritoneal cytology was coded in CS extension. In CS version 2 peritoneal cytology is reported separately but does not change the FIGO or seventh edition TNM stage.

1. Use code 000 when the peritoneal cytology is reported as positive.

2. Use code 010 when the peritoneal cytology is reported as negative or normal.

3. Use code 020 when the peritoneal cytology test was done and the results were reported as suspicious undetermined if negative or positive

4. Code 988 should not be used by any US or Canadian registry, as this field is required by all standards setters.

5. Use code 997 when the peritoneal cytology test was ordered but the results are not in the medical record.

6. Use code 998 when:
   - there is a statement in the medical record that the test was not done, not ordered and/or not performed
   - no pathologic specimen is available

7. Use code 999 when:
   - there is no information in the medical record about the peritoneal cytology
   - it is unknown whether the peritoneal cytology was performed

Site-Specific Factor 1 – Prognostic Scoring Index (Placenta) C S c

The Prognostic Index is a non-anatomic risk factor scoring system that adds a fourth dimension to the stage grouping of gestational trophoblastic tumors (GTT) of the placenta. The score subcategorizes GTTs into low risk or high risk based on a point system.

Code the clinician's statement of the total point value for the Prognostic Index in priority over the clinician's statement of risk.

1. Use code 000 if the clinician states no risk factors.

2. Use code 010 if the point value is between 1 and 6.

3. Use code 110 if the point value is 7 or more.

4. If there is no statement of point value, look for a statement of low risk (code 010) or high risk (code 110), or a statement of Substage A (code 050) or Substage B (code 150).

5. Use code 200 if the clinician indicates that risk factors are present but does not state whether they are low or high risk.

6. If none of these clinician statements is available, the registrar may attempt to determine the point value and risk. If any one of the factors is unknown, stop trying to assign score, unless the risk

category-low or high-has already been determined with the known factors.

7. Use code 999 if risk factors are not assessed or are not documented in the medical record

Schema Discriminator (PeritoneumFemaleGen, Site-Specific Factor 25) C S N c

Source documents: face sheet, other statement of patient gender in medical record

Both sarcomas and carcinomas of the peritoneum can be staged. For Peritoneum and PeritoneumFemaleGen, a schema discriminator is necessary to identify the gender of the patient so that the correct schema can be presented to the abstractor. Carcinomas in the morphology code range 8000-8576, specialized gonadal neoplasms, and mixed complex and stromal neoplasms (except gastrointestinal stromal tumors) are coded with the same staging criteria for female patients as ovarian cancer in the PeritoneumFemaleGen schema.

In this field, code 002, Female, presents the PeritoneumFemaleGen schema to the abstractor. All other categories of gender (codes 001, 003, 004, 009 and 100) present the Peritoneum schema to the abstractor. For males, a carcinoma of the peritoneum will output T NA N NA M NA Stage NA. Code 981 is new in CS version 0203 and includes non-carcinoma, non-GIST histologies formerly coded as "blank" in CS versions 0200 through 0202.

Male Genital Organs
Prostate, Testis, Penis, Scrotum

The schemas for the male genital system have no site-specific factors in common. These sites will be discussed in order of their frequency of occurrence: prostate first, then testis, penis and scrotum.

Prostate
CS Extension– Clinical Extension

The prostate Extension field is unique among CS schemas because it includes only clinical information. The Prostate CS Extension – Clinical Extension field includes many notes that should be read prior to coding clinical extent of tumor. Pathologic information is recorded in Site-Specific Factor 3, CS Extension-Pathologic (see below).

The assessment of tumor extension in the TNM system is subcategorized by whether the tumor is clinically inapparent (T1) or clinically apparent (T2 – 4). A clinically inapparent tumor cannot be palpated nor seen on imaging, although it may be an incidental microscopic finding in one or both lobes. For example, adenocarcinoma of the prostate may be discovered in the specimen from a transurethral resection of the prostate (TURP) in a patient treated for benign prostatic hyperplasia. Alternatively, the patient may have had an elevated Prostate Specific Antigen (PSA), for which needle biopsies were done and showed adenocarcinoma. In either case, the cancer was not clinically apparent at the time the prostate tissue was examined.

The determination of the clinically inapparent T1 category in the TNM system is based on information obtained from digital rectal examination (DRE) and imaging *only*. Information obtained from core needle biopsies of the prostate is specifically excluded from clinical T but is coded in Site-Specific Factors 12 through 15 in CS version 2. The physician may not use the words "clinically inapparent" but

a statement of cT1 implies this. This information is captured in the CS Extension – Clinical Extension code range of 100-150. Codes 130 and 140 may be used for surgical procedures other than TURP that do not meet the criteria for pathologic staging (total prostatectomy), such as a partial prostatectomy for benign prostatic hyperplasia. Even though needle biopsies that confirm the diagnosis may indicate tumor in both lobes, this microscopic information should not be used to code the case in the 200 and higher range.

The determination of clinically apparent T2 and higher categories in the TNM system is based on information from physical examination, such as a statement of "mass", "tumor", or "nodule", or physician staging of cT2_. The physical examination may be supplemented by information from imaging, but not from microscopic examination of biopsy specimens. This information about clinically apparent tumor is coded in the range 200 – 240.

It is important to note that the registrar is not to infer clinically inapparent or apparent tumor based on any other terminology in the physical exam (digital rectal exam) or imaging reports. (The registrar may infer clinically apparent tumor from the terms *mass*, *tumor*, or *nodule*.) Use code 300 when the medical record does not provide a clear statement of inapparent or apparent tumor.

Note: Biopsies of extraprostatic sites that document T3 and T4 extent of disease may be included in CS Extension – Clinical Extension, but needle or core biopsies of the prostate itself are not part of the CS Extension – Clinical Extension information.

Site-Specific Factor 1 – Prostate Specific Antigen (PSA) Lab Value C S N c
PSA Value

Source documents: clinical laboratory report (blood or serum test), history, clinician note, pathology report

Other names: Prostate specific antigen, serum PSA, total PSA

*Normal reference range***:** varies by age and race of patient. The reference range should be shown on the clinical laboratory report. In general, normal findings are 0 – 4.0 nanograms per milliliter (ng/ml).

Optimal normal range is 0 – 2.6 ng/ml. Nanograms per milliliter may be reported as micrograms per liter (µg/L or ug/L). The number to be recorded in SSF1 is the same for both measurements.

Serum PSA is the most sensitive tumor marker for monitoring individuals with prostate cancer, including progression of disease and response to therapy. Although originally not intended to be a screening test, this relatively simple blood test has become a very common method of detecting new prostate cancer in its earliest stages. PSA can be totally negative when prostate cancer is found on digital rectal exam. In such cases, PSA will not be helpful in monitoring for recurrence. Serum PSA is not the same as free PSA or precursor PSA-do not record values from either of these tests in this field.

a. Record the highest PSA value prior to, and closest to, diagnostic biopsy of prostate and initiation of treatment in the range 001 to 979. This site-specific factor is a 3 digit field with an implied decimal point between the second and third digits. If the PSA result is between 0 and 0.1 ng/ml, round up and code as 001. Results for SSF1 and SSF2 should be from the same test.

Examples:

12.4 code as 124

4.2 code as 042

94 code as 940

Note: If there are PSA tests prior to diagnosis and other PSA tests after diagnosis but before treatment, use the PSA before diagnosis. If there are multiple PSA tests within three months prior to diagnosis and treatment, record the highest value. If all PSA tests are greater than 3 months, prior to diagnosis and treatment, record the most recent one.

Example 1: PSA on January 5, 2010 is 5.8. PSA on January 29 2010 is 5.2. Biopsy February 22, 2010 is positive for adenocarcinoma. *Code the highest PSA (from January 5) as 058*.

Example 2: PSA on December 19, 2010 is 44.3. PSA on March 11, 2011 is 42.8. DRE on May 1, 2011 indicated palpable nodularity in both lobes of the prostate consistent with cancer so treatment with Casodex initiated without performing a needle core biopsy. *Code the highest PSA (from March 11) as 428.*

b. A clinician may document an adjusted PSA value due to the patient taking medication for benign prostatic hypertrophy (BPH). Record the adjusted PSA value ONLY if documented by the clinician in the medical record. The registrar does not adjust the PSA value due to BPH medication use.

c. Use code 980 if the actual value of the test exceeds 98.0.

d. For site-specific factor 1 PSA Lab Value, code 988 should not be used by any registry in the US or Canada, as this field is required by all standards setters.

e. Use code 997 if the PSA was ordered but the results are not in the medical record.

f. Use code 998 if there is a statement in the medical record that the PSA was not done or was not ordered.

g. Use code 999 when there is no information in the medical record about whether a PSA was done.

Site-Specific Factor 3 – CS Extension – Pathologic Extension C S N c

Source documents: pathology report

This site-specific factor records information about primary tumor extension based on the prostatectomy or autopsy specimen *only*. Information from core needle biopsies is coded in site-specific factor 14. Codes used in CS version 1 in the range 020 to 099 have been converted to three digits in the range 200 to 750 in CS version 2 to be more comparable with CS Extension-Clinical.

The definitions for the same code may not be the same between CS Extension-Clinical and SSF3 CS Extension-Pathologic. New codes have been added as a result of revisions in AJCC seventh edition. In CS version 0203, code 410 has been made obsolete and the data have been reviewed and recoded into 415 and 483. There are also codes and descriptions in SSF3 that can only be determined microscopically from the prostate specimen. Read the code definitions carefully. Do not rely on memory from CS version 1 or codes from CS Extension-Pathologic to code SSF3.

Note: The seventh edition of TNM is not as specific about the type of prostatectomy as previous editions, which required a total prostatoseminalvesiculectomy. Procedures less than radical prostatectomy may be used to code Site-Specific Factor 3 if tumor is confined to the prostate and the margins are negative. However, newer techniques such as "Greenlight" Photoselective Vaporization (PVP) and laser prostatectomy are intended to treat benign prostatic hyperplasia rather than cancer. These procedures vaporize prostate tissue to open the urethra but generally do not reach to the areas of the prostate where cancer is most commonly found.

The following special codes may apply to the timing of the prostatectomy:

960 Unknown if prostatectomy done

970 No prostatectomy performed as part of first course of treatment

980 A prostatectomy was performed but was not considered first course of treatment

Example:
Patient initially treated with "watchful waiting." When obstructive symptoms progressed, patient underwent prostatectomy. *"Watchful waiting" was the first course of treatment. Use code 980 for SSF3 in this situation.*

985 Patient underwent autopsy, but extent of disease unknown

Note: Do not use this code unless autopsy occurred within the timeframe for initial diagnosis and staging.

990 A prostatectomy was performed, but:

- the extent of disease was not stated
- the primary tumor cannot be assessed

- the pathologic findings from the procedure are not documented in the medical record

Site-Specific Factor 8 – Gleason's Score on Needle Core Biopsy/Transurethral Resection of Prostate (TURP) C S N c

Source documents: pathology reports from needle biopsies or transurethral resection of prostate

The Gleason system for grading prostate cancer is the one recommended by the AJCC and College of American Pathologists. Site-specific factors 7 and 8 code information on Gleason pattern and score from core needle biopsy or transurethral resection of the prostate (TURP) *only*. This information is used for clinical stage grouping in AJCC seventh edition and in predictive nomograms, such as the Kattan nomograms and the Partin tables, which guide individual treatment decisions. (Information on Gleason pattern and score from prostatectomy or autopsy is collected in SSFs 9 and 10-see below.) The pathologist determines the Gleason patterns and score by looking at prostate tissue under the microscope. He assigns a grade to the most predominant pattern (largest surface area of involvement-more than 50% of the tissue) and a grade for the secondary pattern (second most predominant) based on published Gleason criteria. Gleason grades range from 1 (small, uniform glands) to 5 (lack of glands, sheets of cells). The cancer protocol for prostate published by the College of American Pathologists (CAP checklist or synoptic report) provides specific instructions to the pathologist for describing patterns and score from diagnostic procedures and prostatectomy specimens.

The notes above the tables in Site-Specific Factors 8 and 10 are extensive and describe how to handle situations where information about Gleason Patterns and Score may not be complete.

Gleason Score

The Gleason score is the sum of the values for the primary and secondary patterns. The score ranges from 2 (1 + 1) to 10 (5 + 5). The SSF8 code is three digits, with the Gleason score in the right-most digit(s) and leading zeros (Table I-2-27).

Examples:
Gleason 3 + 3 code SSF8 as 006

Gl 4 + 3 code SSF8 as 007

Gleason 7 code SSF8 as 007

Gleason 10/10 code SSF8 as 010

No needle biopsy or TURP performed: code as 998.

Gleason 4 code SSF8 as 004 (assume a number in the range 2 to 5 is a primary pattern and that it is the score)

No Gleason information on needle biopsy or TURP: code as 999.

Note: Code 988 should not be used by any registry in the US or Canada, as this field is required by all standards setters.

Table A.17 Format for SSFs 8 and 10

1ST DIGIT	2ND AND 3RD DIGITS
0	Gleason Score 02-10

Site-Specific Factor 10 – Gleason's Score on Prostatectomy/Autopsy C S N c

Source documents: pathology report from prostatectomy or autopsy report

Other names: Gleason sum, combined Gleason grade

This site-specific factor codes information on Gleason pattern score from prostatectomy or autopsy *only*. This information is used for pathologic stage grouping in AJCC seventh edition. Information on Gleason score from core needle biopsy or TURP is collected in SSF 8-see above. The pathologist's process for determining the Gleason score and examples of the codes are described in SSF 8. The same format is used for prostatectomy or autopsy information.

Note: If a tertiary pattern is documented in the prostatectomy pathology report, do not add it to SSF10.

Example:
No prostatectomy performed *Code as 998 in SSF 10.*

Diagnosed at autopsy but no Gleason information *Code as 999 in SSF 10.*

Note: Code 988 should not be used by any registry in the US or Canada, as this field is required by all standards setters.

Testis

In CS version 1, testis used five site-specific factors. Of these, three have been made obsolete and replaced by other site-specific factors in CS version 2.0. The data in the original site-specific factors 1 through 3 will be retained in the CS data record, but these SSFs are not to be used in CS version 2. The reason for the revised SSFs is that AJCC clarified that the tumor marker values should be captured prior to orchiectomy. This was not clear in CS version 1, so the data in SSFs 1 to 3 are a mix of pre- and postorchiectomy information. In addition to revising the tumor markers into separate data fields for the lab value and the clinician's interpretation of that lab value, an additional element has been added-persistence of elevated tumor markers-that documents the post-orchiectomy status of the markers for assigning the stage group IS.

The data elements and codes have been modified in CS version 2 to calculate the S value correctly. Any analysis of testis staging over time relying on the tumor marker data collected in CS version 1 might require review of medical records to verify the appropriate preoperative tumor marker values and the presence of persistent tumor markers post-orchiectomy.

Site-Specific Factor 4 – Radical Orchiectomy Performed C S N c

Source documents: operative report, pathology report

Other names: transinguinal orchiectomy

This site-specific factor documents whether radical orchiectomy was performed (code 010), not performed (code 000) or unknown (code 999). The information is used to map the T value in AJCC sixth edition.

A radical orchiectomy is defined as complete removal of the testicle, epididymis, and spermatic cord to the level of the internal inguinal ring, either as a diagnostic procedure or as treatment. The spermatic cord is usually excised with the testicle, although the cord may not be mentioned in the pathology report. Unless the operative report says that the cord was not removed, assume that the procedure was a radical orchiectomy.

Note: Code 988 should not be used by any registry in the US or Canada, as this field is required by all standards setters.

Site-Specific Factor 5 – Size of Metastasis in Lymph Nodes C S N c

Source documents: pathology report

In CS version 2, site-specific factor 5 codes incorporate not only size ranges for the metastasis in a regional lymph node mass, but also the absence or presence of extranodal extension and clinician statements of the N category. CS version 1 codes 001 to 003 have been made obsolete and the data converted to codes in the 010 to 030 range. The AJCC definitions for the N category describe "metastasis with a lymph node mass" of a stated size, rather than the size of the metastasis in the lymph node. Extranodal extension is defined as metastatic tumor growing from within the lymph node outward through the lymph node capsule and into surrounding connective tissues. If extranodal extension is not mentioned, assume that it is not present and code as 010.

a. Use code 000 when there are no lymph node metastases (CS Lymph Nodes is 000).

b. Use code 010 when:
   - the lymph node mass containing metastasis is up to 2 cm in size and there is no pathologic evidence of extranodal extension
   - the clinician stages the case as N1 without any further information about lymph nodes

c. Use code 020 when:
   - the lymph node mass containing metastasis is between 2 and 5 cm in size
   - there is a statement of extranodal extension regardless of the size of the lymph node mass
   - the clinician stages the case as N2 without any further information about lymph nodes

d. Use code 030 when:
   - the lymph node mass containing metastasis is more than 5 cm in size
   - the clinician stages the case as N3 without any further information about lymph nodes

e. Code 988 should not be used by any registry in the US or Canada, as this field is required by all standards setters.

f. Use code 999 when:
   - regional lymph nodes are involved but the size of the mass is not stated
   - it is unknown whether regional lymph nodes are involved
   - the status of regional lymph nodes or metastases within regional lymph nodes is not documented in the medical record

Serum Tumor Markers for Testis

Tumor markers for testicular cancer serve several purposes. Pre-orchiectomy, they help determine the histologic cell type. Post-orchiectomy, they assist in treatment management for patients with germ cell tumors, and provide an extra prognostic dimension (S) to AJCC stage grouping. For the pathologist, elevated levels of the markers alpha fetoprotein (AFP) or beta subunit of human chorionic gonadotropin (beta-hCG) may indicate the need for additional microscopic analysis of resected tissue. The serum lactate dehydrogenase (LDH) helps the clinician assess the patient's metastatic tumor burden. AFP, hCG, and LDH information is combined into the S (serum tumor marker) category in the TNM system, although each may be given an individual S value. The value used for stage group IS is calculated on the serum marker values measured post-orchiectomy (this is a change in AJCC seventh edition). To determine the S category for other stage groups, lab values for the three markers must be within the ranges below. In CS version 2, the computer algorithm compares the values coded in SSFs 7, 9 and 10 to derive an S value.

- S0 All three markers are within normal limits
- S1 All three markers are done and all three are no more than minimally elevated
- AFP <1000 ng/ml **AND** hCG <5,000 mIU/ml **AND** LDH <1.5 times N* or unknown
- S2 **ANY** marker is moderately elevated (not all three have to be done)
- AFP 1000-10,000 ng/ml **OR** hCG 5,000-50,000 mIU/ml **OR** LDH 1.5-10 times N* S3 **ANY** marker is highly elevated (not all three have to be done)
- AFP > 10,000 ng/ml **OR** hCG >50,000 mIU/ml **OR** LDH >10 times N*
- N = upper limit of normal

Note: According to AJCC, the S category can be determined for both AJCC sixth and seventh editions even if the LDH value is unknown when either the AFP or hCG is moderately or highly elevated.

For CS Version 0204 Summary of Changes go to: http://www.cancerstaging.org/cstage/news/release-notes.pdf

Penis

Site-Specific Factor 17 – Extranodal Extension of Regional Lymph Nodes C S c
See *Extranodal Extension of Regional Lymph Nodes* under *Bladder* below.

Scrotum

Site-Specific Factor 12 – High Risk Features C S c
See High Risk Features in the SKIN section.

Site-Specific Factor 16 – Size of Lymph Nodes C S c
See Size of Lymph Nodes in the SKIN section.

Urinary Tract
Bladder

Site-Specific Factor 2 – Size of Metastasis in Lymph Nodes C S N c
Source documents: pathology report, imaging (in that order)
In AJCC sixth and seventh editions, the N category describes the number and location of involved lymph nodes. This site-specific factor adds prognostic information by coding the size of the metastasis within the lymph node.

Code the size in whole millimeters of the largest metastasis in regional lymph nodes as stated in the pathology report in the range 001 to 979. To convert metastasis sizes reported in centimeters to millimeters, multiply by 10. Round up to 1 (code 001) a metastasis reported as less than 1 mm in size. If the size of the metastasis is not stated, code the size of the entire lymph node using pathologic then clinical information in that order. Do not code information about distant lymph nodes in this field.

Examples:
Tumor nest 0.20 mm in size: *Code as 001 (round up to 1 mm).*

1 mm solitary metastasis: *Code as 001.*

Macrometastasis 0.5 cm (5 mm): *Code as 005.*

Metastasis 2.3 cm in node: *Code as 023.*

Lymph node metastasis < 2 cm: *Code as 992.*

Positive inguinal lymph node: *Code as 990.*

a. Use code 000 when there is no regional lymph node involvement.

b. Use code 980 when the size of the metastasis is 980 millimeters or larger (98 cm).

c. Code 988 should not be used by any registry in the US or Canada, as this field is required by all standards setters.

d. Use code 990 when the size of the metastasis is stated as a microscopic focus or foci only and an exact size is not stated.

e. Use a code in the range 991 to 997 when the size of the metastasis is given in non-specific terms, such as “less than 10 millimeters.

f. Use code 999 when:
   - regional lymph node(s) are involved but the size of the metastasis is not stated
   - it is unknown whether regional lymph nodes are involved
   - there is no information about the size of the metastasis in the lymph node in the medical record
   - there is no information about the size of the lymph node in the medical record

Central Nervous System
Brain, CNSOther, IntracranialGland

Central nervous system sites include all parts of the brain, meninges, spinal cord, and the pituitary and pineal glands and craniopharyngeal duct. There is no TNM staging for any of these primary sites, but there is a chapter for brain and spinal cord in the seventh edition of the *AJCC Cancer Staging Manual*.

Site-Specific Factor 1 – World Health Organization (WHO) Grade Classification (Brain, CNSOther, IntracranialGland) C S N c
Source documents: pathology report
The World Health Organization (WHO) has promoted a histologic grading classification for central nervous system tumors since 1979. The most recent version was published in 2007 as part of the WHO classification of central nervous system tumors. Tumor grade is the most important prognostic indicator for response to therapy and outcomes for brain and spinal cord tumors. According to WHO, the classification is more of a “malignancy scale” than a strict histologic grading system. Therefore, the WHO grade is different from the ICD-O grade/differentiation value that is stored with the morphology code. Do not use WHO grade to code the sixth digit of the ICD-O morphology code. WHO grade ranges from I (low proliferative potential and possibly surgically curable-essentially benign behavior) through IV (cytologically malignant, mitotically active neoplasms that are rapidly fatal). Most CNS tumors are assigned a WHO grade, so there is usually a one-for-one correspondence between the ICD-O morphology code and the WHO grade.

Code the WHO grade as documented in the pathology report: Grade I – code 010; Grade II – code 020; Grade III – code 030; Grade IV – code 040. Do not convert terminology such as well-, moderately-, or poorly differentiated to code this field.

a. Code 988 should not be used by any registry in the US or Canada, as this field is required by all standards setters.

b. Use code 998 if there was no histologic examination of the primary site (clinical diagnosis).

c. Use code 999 if the WHO grade is unknown, not stated, or not documented in the medical record.

Note: Do not use WHO grade information to code the fields Grade Path Value and Grade Path System.

Lymphoma

Site-Specific Factor 2 – Systemic Symptoms at Diagnosis (Lymphoma) C S N c
Source documents: patient history, progress notes, consultant notes, other statements in medical record

Other names: B symptoms; Fever: Pel-Ebstein fever, hyperpyrexia, febrile response; sleep hyperhydrosis, nocturnal hyperhydrosis

The stages of malignant lymphoma can be subclassified as A or B by whether certain specific constitutional symptoms are present at the time of diagnosis. The stage group suffix for a patient without these systemic symptoms is "A," meaning absence of symptoms or asymptomatic; for example Stage IIA. The stage group suffix for a patient with any of the symptoms listed below is "B," such as Stage IIIB.

The symptoms are carefully defined:

Fevers: persistent, cyclic, unexplained; with a temperature over 38 degrees centigrade or 101.5 degrees Fahrenheit. Cyclic means elevated one week and normal or nearly normal the next week.

Night sweats: drenching in nature, requiring a change of bed clothes

Weight loss: greater than 10% of body weight in the six months prior to diagnosis, not accounted for by changes in diet or exercise.

Minor symptoms include pruritus and generalized malaise, but these by themselves are insufficient to be classified as B symptoms. The same is true of alcohol intolerance (painful lymph nodes following consumption of alcohol), fatigue, or a short illness due to a suspected infection with associated fever.

The presence of these symptoms is more important prognostically for Hodgkin lymphoma than for non-Hodgkin lymphoma. Up to 30% of non-Hodgkin lymphoma patients and up to 33% of Hodgkin lymphoma patients will present with one or more of these adverse symptoms.

Code the description of the patient's systemic symptoms based on statements in the medical record.

a. Use code 000 when there is a statement in the record that:
   - there are no B symptoms
   - the patient is asymptomatic
   - there is no mention of B symptoms in the history, physical exam, or other clinician notes

b. Use code 010 when the medical record indicates:
   - any one or more of the following symptoms as defined above are present: fever, night sweats, weight loss
   - the patient has B symptoms

c. Use code 020 when there is a statement that the patient has pruritus *only*. Pruritus is generalized, recurrent, unexplained itching, which is not a B symptom by itself.

d. Use code 030 when pruritus and one or more of the symptoms listed in 010 are present.

e. Code 988 should not be used by any registry in the US or Canada, as all standards setters require this field.

f. Use code 999 when:
   - there is no information about lymphoma-related symptoms in the medical record
   - it is unknown whether the patient is asymptomatic or has B symptoms

Ophthalmic Sites
SkinEyelid, Conjunctiva, MelanomaConjunctiva. MelanomaChoroid, MelanomaCiliaryBody, MelanomaIris, LacrimalGland, LacrimalSac,
Retinoblastoma, LymphomaOcularAdnexa

Eye Structures
The major structures of the eye (globe) are the retina, conjunctiva, and uvea, each of which has one or more schemas in CS version 2 (see Figure I-2-14). The uvea consists of the iris and ciliary body (C69.4, also called the anterior uvea) and choroid (C69.3, also known as the posterior uvea). The conjunctiva (C69.0) is a clear mucous membrane that covers the white part of the eye (sclera) and lines the inside of the eyelids. The retina (C69.2) is the innermost layer of the eye containing the neurons that result in vision. The orbit (C69.6) is the bony structure surrounding the soft tissues of the eye. The lacrimal gland (C69.5) is located in the orbit superior and lateral to the globe and produces the tears that keep the eye moist.

Schema Discriminators for Ophthalmic Sites
Site-Specific Factor 25 – Schema discriminator: Melanoma
Ciliary Body/Melanoma Iris C S N c
Iris and ciliary body have the same ICD-O topography code (C69.4). However, for purposes of stage grouping in AJCC seventh edition, iris has its own T category definitions, which were carried over into CS version 2. Ciliary body has a separate schema. Consequently, a schema discriminator is necessary to distinguish between primary sites is in the iris and ciliary body so that the appropriate CS tables will be presented to the coder.

a. Use code 020 for originating in the iris.

b. Use code 010 for tumors originating in all other structures included in code C69.4 (ciliary body, lens, sclera, uveal tract) and the general terms intraocular and eyeball.

c. Code 100 is reserved for cases coded to C69.4 in CS version 1 (before these structures were split

into separate schemas).

Site-Specific Factor 25 – Schema discriminator: Lacrimal Gland/Lacrimal Sac C S N c
The lacrimal (also spelled lachrymal) gland is the only epithelial structure normally present within the orbit. Its composition is the same as epithelial salivary glands and TNM staging parallels that of the major salivary gland classification. Lacrimal gland and lacrimal sac have the same ICD-O topography code (C69.5). However, AJCC seventh edition staging is limited to lacrimal gland. Consequently, a schema discriminator is necessary so that the CS computer algorithm knows whether the primary site is lacrimal gland versus the lacrimal sac and nasolacrimal duct so that the correct derived T values will be assigned by the mapping algorithm. No stage grouping is presently recommended for carcinoma of the lacrimal gland.

Code the specific site of origin for the primary tumor in the lacrimal gland or lacrimal sac. Read the codes and definitions carefully, as some codes were made obsolete in CS version 0203 and the definitions were assigned to other codes.

a. Use code 015 when the medical record indicates:
   - the primary tumor arose in the lacrimal gland
   - the primary site is lacrimal with no further information
b. Use code 025 when the medical record states:
   - the primary tumor arose in the lacrimal sac
   - the primary tumor arose in the lacrimal duct (also called nasal lacrimal duct or nasolacrimal duct)
c. Code 100 is reserved for cases coded to C69.5 in CS version 1 (before these structures were split into separate schemas).

Site-Specific Factor 1 – Tumor Size (Conjunctiva) C S N c

*Source documents**:*** pathology report, slit lamp examination report

The size of the conjunctival tumor is a predictor of recurrence and helps to determine the type of treatment. This site-specific factor codes the tumor size on a different scale than CS Tumor Size, which was made obsolete for this schema in CS version 2. Tumor size recorded in SSF1 is used to derive T1 and T2 values for AJCC staging for this schema.

Code the largest tumor dimension in *tenths* of millimeters as documented in the medical record, in the code range 001 to 979. This is a three-digit field with an implied decimal point between the second and third digits.

Examples:

Diameter 1.74 mm: *Code as 017 (round down)*

Tumor size 4.86 mm: *Code as 049 (round up)*

Lesion 12 mm in diameter: *Code as 120*

Microscopic focus: *Code as 990*

Stated as T1: *Code as 991*

a. Use code 000 when there is a statement in the medical record:
   - that no mass was found
   - that no tumor was found

b. Use code 980 when the largest dimension of the tumor is stated to be 98.0 millimeters or larger.

c. Code 988 should not be used by any registry in the US or Canada, as all standards setters require this field.

d. Use code 990 when the tumor is stated to be microinvasive described as a microscopic focus or foci only with no size of focus given

e. Use code 991 when:
   - the tumor size is described as "less than 5 mm"
   - the only documentation of tumor size is the clinician's statement of T1 with no other information on tumor size

f. Use code 992 when:
   - the tumor size is described as "greater than 5 mm"
   - the only documentation of tumor size is the clinician's statement of T2 with no other information on tumor size

g. Use code 999 when the tumor size is:
   - unknown
   - not stated
   - not documented in the medical record

Site-Specific Factor 1 – Measured Thickness (Depth) (MelanomaConjunctiva) C S N c
See *Measured Thickness/Depth* in *SKIN* section for information on measured thickness.

The thickness of a lesion for melanoma of the conjunctiva is measured in *hundredths* of millimeters and the MelanomaConjunctiva schema contains more codes than the MelanomaSkin schema. Read the codes and definitions carefully, as some of the codes have been made obsolete in CS version 2 and the definitions were assigned to different codes.

Code the measured thickness or depth of the tumor from the pathology report in *hundredths* of millimeters in the range 001 to 979.

Examples:
Thickness .5 mm: *Code as 050*

Depth of tumor 1.05 mm: *Code as 105*

Breslow thickness 2.3 mm: *Code as 230*

a. Use code 980 for any tumor 9.8 mm thick or larger.

b. For MelanomaConjunctiva, code 988 should not be used by any registry in the US or Canada, as all standards setters require this field.

c. Use code 991 when:
   - the tumor depth is described as "less than 0.5 mm"
   - the tumor was resected and the only documentation of tumor depth is the clinician's statement of pathologic T1a with no other information on tumor depth
   - the tumor was resected and the only documentation of tumor depth is the clinician's statement of pathologic T2a with no other information on tumor depth
   - there is a statement of microinvasion but no depth is given
   - there is a description of a microscopic focus or foci but no depth is given

d. Use code 992 when the tumor depth is described as "less than 0.8 mm".

e. Use code 993 when:
   - the tumor depth is described as "greater than 0.5 mm"
   - the tumor was resected and the only documentation of tumor depth is the clinician's statement of pathologic T1b with no other information on tumor depth
   - the tumor was resected and the only documentation of tumor size is the clinician's statement of pathologic T2b with no other information on tumor size

f. Use code 994 when the tumor depth is described as "greater than 0.8 mm".

g. Use code 995 when the tumor depth is described as "less than 1.5 mm".

h. Use code 996 when:
   - the tumor depth is described as "greater than 1.5 mm"
   - the tumor was resected and the only documentation of tumor depth is the clinician's statement of pathologic T1c with no other information on tumor depth

- the tumor was resected and the only documentation of tumor depth is the clinician's statement of pathologic T2c with no other information on tumor depth

i. Use code 998 when there is no resection of the primary site tumor.

j. Use code 999 when:
   - tumor depth or thickness information is unknown, including cases in which the primary tumor is removed but the measurement of thickness cannot be determined from the pathology report
   - tumor thickness or depth is not documented in the medical record

Note: In CS version 2, this site-specific factor was made obsolete for melanoma of the choroid, ciliary body, and iris because the scale of measurement changed. For these sites, thickness in *tenths* of a millimeter is recorded in Site-Specific Factor 3.

Site-Specific Factor 2 – Quadrants (MelanomaConjunctiva) C S N c
Source documents: slit lamp examination report, physical exam (inspection of eye), pathology report, other documentation in medical record

This site-specific factor codes the amount or area of the conjunctiva involved by the melanoma. Since the conjunctiva is essentially round or spherical, the extent of involvement can be described in quadrants. A quadrant is defined by clock position starting at the limbus (border between conjunctiva and cornea) extending from the central cornea to and beyond the eyelid margin. Similar to breast anatomy, the borders of the quadrants are 12, 3, 6, and 9 o'clock. The quadrants are labeled by combinations of the directions superior, inferior, nasal (the side by the nose) and temporal (the side by the ear). Thus the quadrant above and by the nose would be superonasal (superior-nasal) in both eyes, but would be 12:00-3:00 on the left eye and 9:00-12:00 on the right.

Code how many quadrants are clinically involved by the conjunctival melanoma as documented in the medical record. There are two groups of codes in this site-specific factor: quadrants and statements of the clinical T value. If there is a conflict between the number of quadrants stated and the T value given by the clinician, the number of quadrants takes priority. If the number of quadrants is stated, use one of the following codes:

010 ≤ 1 quadrant

020 > 1 and ≤ 2 quadrants

030 > 2 and ≤ 3 quadrants

040 > 3 quadrants

If the number of quadrants is not stated but the clinician assigns a clinical T, select from codes 015, 025, 035, and 045.

a. Use code 015 when there is no other information on the quadrants involved AND:
   - a statement of clinical T1a

- a statement of clinical T2a
- a statement of clinical T2c

b. Use code 025 when there is no other information on the quadrants involved AND
   - a statement of clinical T1b
   - a statement of clinical T2b
   - a statement of clinical T2d

c. Use code 035 when there is no other information on the quadrants involved AND a statement of clinical T1c.

d. Use code 045 when there is no other information on the quadrants involved AND a statement of clinical T1d.

e. For MelanomaConjunctiva, code 988 should not be used by any registry in the US or Canada, as all standards setters require this field.

f. Use code 999 when:
   - there is no information in the medical record about the number of quadrants involved
   - there is no statement of T category in the medical record

Site-Specific Factor 2 – Measured Basal Diameter (MelanomaChoroid, MelanomaCiliaryBody) C S N c

Source documents: pathology report, ultrasound report, wide-angle fundus camera measurement, clinician report or other documentation in medical record

Other names: largest tumor diameter (LTD), tumor basal size; do not code tumor basal area (measured in square millimeters)

Clinical research has shown that as a uveal tumor becomes larger, the risk of hematogenous metastases and death increases. In addition, knowing the size of the melanoma is important for treatment planning.

The basal diameter is the width (horizontal measurement) of the melanoma at its base (in contact with sclera). This is not the same as the depth of invasion (see site-specific factor 3, Measured Thickness).

Code the actual tumor diameter in *tenths* of millimeters as documented in the medical record, in the code range 001 to 979. This is a three-digit field with an implied decimal point between the second and third digits. If surgery was performed and the basal diameter is available from the pathology report, use that measurement as priority.

Examples:

Basal diameter 0.74 mm: *Code as 007*

Lesion 1 mm in diameter: *Code as 010*

Largest tumor dimension 2.7 mm: *Code as 027*

Basal size 13.6 mm: *Code as 136*

a. Use code 980 for a basal diameter of 98.0 mm or larger.

b. Code 988 should not be used by any registry in the US or Canada for MelanomaChoroid or MelanomaCiliaryBody, as all standards setters require this field.

c. Use a code in the 991 to 997 range when:
   - the tumor is described in a range
   - to describe size ranges associated with the "tumor size categories" that comprise the T1 – T4 categories in the AJCC seventh edition.

Table A.17 Site-Specific Factor 2 – Measured Basal Diameter Codes

CODE	DESCRIPTION
991	Described as "≤ 3 mm"
992	Described as "> 3 mm" or "≤ 6 mm"
993	Described as "> 6 mm" or "≤ 9 mm"
994	Described as "> 9 mm" or "≤ 12 mm"
995	Described as "> 12 mm" or "≤ 15 mm"
996	Described as "> 15 mm" or "≤ 18 mm"
997	Described as "> 18 mm"

d. Use code 999 when:
   - there is no information in the medical record about the measured basal diameter
   - the measured basal diameter is unknown

Site-Specific Factor 3 – Measured Thickness (Depth) (MelanomaChoroid, MelanomaCiliaryBody)
C S N c

Source document: pathology report

Other names: maximum tumor thickness, depth of invasion; perpendicular tumor diameter (PTD); tumor height

This site-specific factor measures tumor thickness or depth (vertical dimension), rather than size (lateral dimension). The depth of invasion or tumor thickness measurement for melanomas of the choroid, ciliary body, and iris is collected in *tenths* of millimeters as stated in the pathology report for the resected specimen. (This is similar to, but not the same as, Breslow depth of invasion, which is measured in hundredths of millimeters.) The thickness measurement should only be taken from a pathology specimen, not from a radiology report or other clinical measurement. Code a measurement specifically labeled as "thickness" or "depth" in the pathology. In the absence of this label, a measurement described as taken from the cut surface of the specimen can be coded. And in the absence of either of these labels, the third dimension in a statement of tumor size (length x width x depth) can be used by the registrar to code this field.

Code the actual tumor thickness or tumor depth in tenths of millimeters as stated in the pathology report, in the code range 001 to 979. Because the thickness table is similar to many other tables that collect a measurement, it is important to identify the correct unit of measurement. This is a three-digit field with an implied decimal point between the second and third digits.

Examples:

Tumor thickness 0.1 mm: *Code as 001*

Depth 0.74 mm: *Code as 007*

Lesion 1 mm thick: *Code as 010*

Thickness 2.7 mm: *Code as 027*

Depth 10.6 mm: *Code as 106*

a. Use code 980 for any tumor 98.0 mm thick or larger.

b. Code 988 should not be used by any registry in the US or Canada for MelanomaChoroid or MelanomaCiliaryBody, as all standards setters require this field.

c. Use code 990 when:
   - there is a statement of microinvasion but no depth is given
   - there is a description of a microscopic focus or foci but no depth is given

d. Use a code in the 991 to 996 range to describe size ranges associated with the "tumor size categories" that comprise the T1 – T4 categories in the AJCC seventh edition.

Table A.18 Site-Specific Factor 3 – Measured Thickness Codes

CODE	DESCRIPTION
991	Described as "≤ 3 mm"
992	Described as "> 3 mm" or "≤ 6 mm"
993	Described as "> 6 mm" or "≤ 9 mm"
994	Described as "> 9 mm" or "≤ 12 mm"
995	Described as "> 12 mm" or "≤ 15 mm"
996	Described as "> 15 mm"

e. Use code 999 when:
   - tumor depth or thickness information is unknown, including cases in which the primary tumor is removed but the measurement of thickness cannot be determined from the pathology report
   - tumor thickness or depth is not documented in the medical record

Site-Specific Factor 4 – Size of Largest Metastasis (MelanomaChoroid, MelanomaCiliaryBody, MelanomaIris) C S N c

Source document: pathology report, imaging, other documentation in medical record

The liver is the most common site of distant metastases for uveal melanoma, but hematogenous spread can occur to any solid organ. This site-specific factor documents the size of the largest metastasis in any site except in regional lymph nodes. This information is needed for mapping to the M1 subcategories.

Code the diameter of the largest metastasis in a distant lymph node or distant site in whole millimeters in the range 001 to 979. The measurement can be clinical or pathologic.

a. Use code 000 when there is no metastatic disease (CS Mets at DX code 00).

b. Use code 980 for any metastasis larger than 980 millimeters.

c. Code 988 should not be used by any registry in the US or Canada, as all standards setters require this field.

d. Use a code in the range 991 to 993 if an exact size is not stated, but the size of the largest metastasis is described in one of the code ranges corresponding to the M1 subcategories.

   "less than 3 cm" – maps to M1a

   "less than 8 cm," or "greater than 3 cm," or "between 3 cm and 8 cm" – maps to M1b

   "greater than 8 cm" – maps to M1c

e. Use code 999 when:
   - the size of the largest metastasis is not stated in the medical record
   - it is unknown whether distant metastases are present at the time of diagnosis

Retinoblastoma
Site-Specific Factor 1 – Extension Evaluated at Enucleation (Retinoblastoma) C S N c

Source documents: pathology report

Enucleation (removal of the eyeball or globe) is necessary for pathologic staging of retinoblastoma to determine the amount of choroidal involvement. This site-specific factor must be coded whether or not an enucleation was performed in order to be used with CS Extension to generate the T value in both sixth and seventh editions of TNM. Retinoblastoma site-specific factor 1 has been completely revised for CS version 2. Codes 000 to 100 have been made obsolete and converted to higher codes. If displayed in abstracting software and used, these codes will generate an error in the mapping to the T category.

Involvement of the choroid (the vascular layer between the sclera and retina) differentiates T2 and T3 lesions in the TNM system. True invasion of the choroid is defined as one or more solid nests of tumor cells that fills or replaces the choroid and has pushing borders. This is different the presence of groups of tumor cells in the open spaces between intraocular structures, extraocular tissues, and/or subarachnoid space. Focal choroidal invasion (T2) is a solid nest of tumor measuring less than 3 mm in maximum diameter. Massive choroidal invasion (T3) is a solid tumor nest 3 mm or more in maximum diameter. Codes 300 to 950 are pathologic extension codes that describe involvement of various structures within the eye. For example, focal choroidal invasion is described in codes 460, 470 and 490; massive choroidal invasion is described in codes 550, 560, 570, and 590.

Code the description of extent of primary tumor from the enucleation pathology report *only* in this site-specific factor. Do not use enucleation information to code the CS Extension field.

- Use code 960 if it is unknown whether enucleation was performed.
- Use code 970 if no enucleation was performed.
- Code 988 should not be used by any registry in the US or Canada, as this field is required by all standards setters.
- Use code 999 if enucleation was performed but the pathologic extension is unknown

Ocular Adnexal Lymphoma
Site-Specific Factor 2 – Systemic Symptoms at Diagnosis C S N c
See *Systemic Symptoms at Diagnosis* under *Lymphoma* section.

COLLABORATIVE STAGING CODING GUIDELINES AND INSTRUCTIONS

Recording Information

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B

APPENDIX B

REPORTING LAW RULES

THE LAW

Chapter 82, Health and Safety Code
(Amended September 1, 2001)

Section 82.001. Short Title

This Chapter may be cited as the Texas Cancer Incidence Reporting Act.

Section 82.002. Definition

In this chapter:

A) Cancer includes:

1) a large group of diseases characterized by uncontrolled growth and spread of abnormal cells;

2) any condition of tumors having the properties of anaplasia, invasion, and metastasis;

3) a cellular tumor the natural course of which is fatal, including malignant and benign tumors of the central nervous system; and

4) malignant neoplasm, other than nonmelanoma skin cancers such as basal and squamous cell carcinomas.

B) Clinical laboratory means an accredited facility in which:

1) tests are performed identifying findings of anatomical changes; and

2) specimens are interpreted and pathological diagnoses are made.

C) Health care facility means:

1) a general or special hospital as defined by Chapter 241 (Texas Hospital Licensing Law);

2) an ambulatory surgical center licensed under Chapter 243;

3) an institution licensed under Chapter 242; or

4) any other facility, including an outpatient clinic, that provides diagnosis or treatment services to patients with cancer.

D) Health care practitioner means:

1) a physician as defined by Section 151.002, Occupations Code; or

2) a person who practices dentistry as described by Section 251.003, Occupations Code.

Section 82.003. Applicability of Chapter

This chapter applies to records of cases of cancer, diagnosed on or after January 1, 1979, and to records of all ongoing cancer cases diagnosed before January 1, 1979.

Section 82.004. Registry Required

The board shall maintain a cancer registry for the state.

Section 82.005. Content of Registry

A) The cancer registry must be a central data bank of accurate, precise, and current information that medical authorities agree serves as an invaluable tool in the early recognition, prevention, cure, and control of cancer.

B) The cancer registry must include:

1) a record of the cases of cancer that occur in the state; and

2) information concerning cancer cases as the board considers necessary and appropriate for the recognition, prevention, cure, or control of cancer.

Section 82.006. Board Powers

To implement this chapter, the board may:

1) adopt rules that the board considers necessary;

2) execute contracts that the board considers necessary;

3) receive the data from medical records of cases of cancer that are in the custody or under the control of clinical laboratories, health care facilities, and health care practitioners to record and analyze the data directly related to those diseases;

4) compile and publish statistical and other studies derived from the patient data obtained under this chapter to provide, in an accessible form, information that is useful to physicians, other medical personnel, and the general public;

5) comply with requirements as necessary to obtain federal funds in the maximum amounts and most advantageous proportions possible;

6) receive and use gifts made for the purpose of this chapter; and

7) limit cancer reporting activities under this chapter to specified geographic areas of the state to ensure optimal use of funds available for obtaining the data.

Section 82.007. Annual Report

A) The department shall publish an annual report to the legislature of the information obtained under this chapter.

B) The department, in cooperation with other cancer reporting organizations and research institutions may publish reports the department determines are necessary or desirable to carry out the purpose of this chapter.

Section 82.008. Data From Medical Records

A) To ensure an accurate and continuing source of data concerning cancer, each health care facility, clinical laboratory, and health care practitioner shall furnish to the board or its representative, on request, data the board considers necessary and appropriate that is derived from each medical record pertaining to a case of cancer that is in the custody or under the control of the health care facility, clinical laboratory, or health care practitioner. The department may not request data that is more than three years old unless the department is investigating a possible cancer cluster.

B) A health care facility, clinical laboratory, or health care practitioner shall furnish the data requested under Subsection (a) in a reasonable format prescribed by the department and within six months of the patient's admission, diagnosis, or treatment for cancer unless a different period is prescribed by the United States Department of Health and Human Services.

C) The data required to be furnished under this section must include patient identification and diagnosis.

D) The department may access medical records that would identify cases of cancer, establish characteristics or treatment of cancer, or determine the medical status of any identified patient from the following sources:

(1) a health care facility or clinical laboratory providing screening, diagnostic, or therapeutic services to a patient with respect to cancer; or

(2) a health care practitioner diagnosing or providing treatment to a patient with cancer, except as described by Subsection (g).

E) The board shall adopt procedures that ensure adequate notice is given to the healthcare facility, clinical laboratory, or health care practitioner before the department accesses data under Subsection (d).

F) A health care facility, clinical laboratory, or health care practitioner that knowingly or in bad faith fails to furnish data as required by this chapter shall reimburse the department or its authorized representative for the costs of accessing and reporting the data. The costs reimbursed under this subsection must be reasonable, based on the actual costs incurred by the department or by its authorized representative in the collection of data under Subsection (d), and may include salary and travel expenses. The department may assess a late fee on an account that is 60 days or more overdue. The late fee may not exceed one and one-half percent of the total amount due on the late

account for each month or portion of a month the account is not paid in full. A health care facility, clinical laboratory, or health care practitioner may request that the department conduct a hearing to determine whether reimbursement to the department under this subsection is appropriate.

G) The department may not require a health care practitioner to furnish data or provide access to records if:

1) the data or records pertain to cases reported by a health care facility providing screening, diagnostic, or therapeutic services to cancer patients that involve patients referred directly to or previously admitted to the facility; and

2) the facility reported the same data the practitioner would be required to report.

H) The data required to be furnished under this section may be shared with cancer registries of health care facilities subject to the confidentiality provisions in Section 82.009.

Section 82.009. Confidentiality

A) Reports, records, and information obtained under this chapter are confidential and are not subject to disclosure under Chapter 552, Government Code, are not subject to subpoena, and may not otherwise be released or made public except as provided by this section or Section 82.008(h). The reports, records, and information obtained under this chapter are for the confidential use of the department and the persons or public or private entities that the department determines are necessary to carry out the intent of this chapter.

B) Medical or epidemiological information may be released:

1) for statistical purposes in a manner that prevents identification of individuals, health care facilities, clinical laboratories, or health care practitioners;

2) with the consent of each person identified in the information; or

3) to promote cancer research, including release of information to other cancer registries and appropriate state and federal agencies, under rules adopted by the board to ensure confidentiality as required by state and federal laws.

C) A state employee may not testify in a civil, criminal, special, or other proceeding as to the existence or contents of records, reports, or information concerning an individual whose medical records have been used in submitting data required under this chapter unless the individual consents in advance.

D) Data furnished to a cancer registry or a cancer researcher under Subsection (b) or Section 82.008 (h) is for the confidential use of the cancer registry or the cancer researcher, as applicable, and is subject to Subsection (a).

Section 82.010. Immunity From Liability

The following persons subject to this chapter that act in compliance with this chapter are not civilly or

criminally liable for furnishing the information required under this chapter:

1) a health care facility or clinical laboratory;

2) an administrator, officer, or employee of a health care facility or clinical laboratory

3) a health care practitioner or employee of a health care practitioner; and

4) an employee of the department.

Section 82.011. Examination and Supervision Not Required

This chapter does not require an individual to submit to any medical examination or supervision or to examination or supervision by the board or its representatives.

This Act takes effect September 1, 2001.

THE RULES

Texas Administrative Code
Title 25, Health Services
Part 1, Department of State Health Services
Chapter 91, Cancer Subchapter A, Cancer Registry Effective Date: July 9, 2006

§91.1. Purpose.

These sections implement the Texas Cancer Incidence Reporting Act, Health and Safety Code, Chapter 82, concerning the reporting of cases of cancer for the recognition, prevention, cure or control of those diseases, and to facilitate participation in the national program of cancer registries established by 42 United States Code §§280e to 280e-4. Nothing in these sections shall preempt the authority of facilities or individuals providing diagnostic or treatment services to patients with cancer to maintain their own cancer registries.

§91.2. Definitions.

The following words and terms, when used in these sections, shall have the following meanings, unless the context clearly indicates otherwise.

1) Act-The Texas Cancer Incidence Reporting Act, Texas Health and Safety Code, Chapter 82.

2) Branch-Cancer Epidemiology and Surveillance Branch of the department.

3) Cancer-Includes a large group of diseases characterized by uncontrolled growth and spread of abnormal cells; any condition of tumors having the properties of anaplasia, invasion, and metastasis; a cellular tumor the natural course of which is fatal, including intracranial and central nervous system malignant, borderline, and benign tumors as required by the national program of cancer registries; and malignant neoplasm, other than non-melanoma skin cancers such as basal and squamous cell carcinomas.

4) Cancer reporting handbook-The branch's manual for cancer reporters that documents reporting procedures and format.

5) Clinical laboratory-An accredited facility in which tests are performed identifying findings of anatomical changes; specimens are interpreted and pathological diagnoses are made.

6) Department-Department of State Health Services.

7) Health care facility-A general or special hospital as defined by the Health and Safety Code Chapter 241; an ambulatory surgical center licensed under the Health and Safety Code, Chapter 243; an institution licensed under the Health and Safety Code, Chapter 242; or any other facility, including an outpatient clinic, that provides diagnostic or treatment services to patients with cancer.

8) Health care practitioner-A physician as defined by Occupations Code, §151.002 or a person

who practices dentistry as described by the Occupations Code, §251.003.

9) Personal cancer data-Information that includes items that may identify an individual.

10) Quality assurance-Operational procedures by which the accuracy, completeness, and timeliness of the information reported to the department can be determined and verified.

11) Report-Information provided to the department that notifies the appropriate authority of the occupancy of a specific cancer in a person, including all information required to be provided to the department.

12) Research-A systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.

13) Statistical data-Aggregate presentation of individual records on cancer cases excluding patient identifying information.

14) Texas Cancer Registry-The cancer incidence reporting system administered by the Cancer Epidemiology and Surveillance Branch.

§91.3. Who Reports, Access to Records.

A) Each health care facility, clinical laboratory or health care practitioner shall report to the department, by methods specified in §§91.4-91.7 of this title (relating to Cancer Registry), required data from each medical record pertaining to a case of cancer in its custody or under its control except for cases to which subsection (d) of this section would apply.

B) A health care facility or clinical laboratory providing screening, diagnostic or therapeutic services to patients with cancer shall grant the department or its authorized representative access to but not removal of all medical records which would identify cases of cancer, establish characteristics or treatment of cancer, or determine the medical status of any identified cancer patient.

C) A health care practitioner providing diagnostic or treatment services to patients with cancer shall grant the department or its authorized representative access to but not removal of all medical records which would identify cases of cancer, establish characteristics or treatment of cancer, or determine the medical status of any identified cancer patient except for cases to which subsection (d) of this section would apply.

D) The department may not require a health care practitioner to furnish data or provide access to records if:

(1) the data or records pertain to cases reported by a health care facility providing screening, diagnostic, or therapeutic services to cancer patients that involve patients referred directly to or previously admitted to the facility; and

(2) the facility reported the same data the practitioner would be required to report.

E) Health care facilities, clinical laboratories, and health care practitioners are subject to federal law known as the Health Insurance Portability and Accountability Act of 1996 found at Title 42 United States Code §1320d et seq.; the federal privacy rules adopted in Title 45 Code of Federal Regulations (C.F.R.) Parts 160 and 164; and applicable state medical records privacy laws. Because state law requires reporting of cancer data, persons subject to this chapter are permitted to provide the data to the department without patient consent or authorization under 45 C.F.R. §164.512(a) relating to uses and disclosures required by law and §164.512(b)(1) relating to disclosures for public health activities. Both of these exceptions to patient consent or authorization are recognized in the state law.

§91.4. What to Report.

A) Reportable conditions.

1) The cases of cancer to be reported to the branch are as follows:

a) All neoplasms with a behavior code of two or three in the most current edition of the International Classification on Diseases for Oncology (ICD-O) of the World Health Organization with the exception of those designated by the branch as non-reportable in the cancer reporting handbook; and

b) All benign and borderline intracranial and central nervous system neoplasms as required by the national program of cancer registries.

c) Codes and taxa of the most current edition of the International Classification of Diseases, Clinical Modification of the World Health Organization which corresponds to the branch's reportable list are specified in the cancer reporting handbook.

B) Reportable information.

1) The data required to be reported for each cancer case shall include:

a) name, address, zip code, and county of residence;

b) social security number, date of birth, gender, race and ethnicity, marital status, birthplace, and primary payer at time of diagnosis, to the extent such information is available from the medical record;

c) information on industrial or occupational history, to the extent such information is available from the medical record;

d) diagnostic information including the cancer site and laterality, cell type, tumor behavior, grade and size, stage of disease, date of diagnosis, diagnostic confirmation method, sequence number, and other primary tumors;

e) first course of cancer-related treatment, including dates and types of procedures;

f) text information to support cancer diagnosis, stage and treatment codes, unless

another method acceptable to the branch is used to confirm these codes;

g) Health care facility or practitioner related information including reporting institution number, casefinding source, type of reporting source, medical record number, registry number, tumor record number, class of case, date of first contact, date of last contact, vital status, facility referred from, facility referred to, managing physician, follow-up physician, date abstracted, abstractor, and electronic record version; and

h) clinical laboratory related information including laboratory name and address, pathology case number, pathology report date, pathologist, and referring physician name and address.

2) Each report shall:

a) be electronically readable and contain all data items required in paragraph (1) of this subsection;

b) be fully coded and in a format prescribed by the branch;

c) meet all quality assurance standards utilized by the branch;

d) in the case of individuals who have more than one form of cancer, be submitted separately for each primary cancer diagnosed;

e) be submitted to the branch electronically; and

f) be transmitted by secure means at all times to protect the confidentiality of the data.

§91.5. When to Report.

A) All reports shall be submitted to the department within six months of the patient's admission, initial diagnosis or treatment for cancer.

B) Data shall be submitted no less than quarterly by health care facilities with annual caseloads of 400 or less. Monthly submissions are required for all other health care facilities.

C) Data shall be submitted no less than quarterly by health care practitioners initially diagnosing a patient with cancer and performing the in-house pathological tests for that patient. Otherwise, data shall be submitted within 2 months of the request to a health care practitioner by the department or its authorized representative for a report or subset of a report on a patient diagnosed or treated elsewhere and for whom the same cancer data has not been reported.

D) Data shall be submitted no less than quarterly by clinical laboratories.

§91.6. How to Report.

A) Facilities with an annual caseload greater than 400 shall submit their reports of cancer via the Internet using TCR or other acceptable software assuring security of case information.

B) Reports of cancer from facilities with an annual caseload less than 400 shall be submitted to the branch using one of the following methods:

1) three and one half inch disk;

2) compact disc; or

3) the Internet.

§91.7. Where to Report.

Data reports should be submitted to the branch as specified in the cancer reporting handbook.

§91.8. Compliance.

A) Each health care facility, clinical laboratory or health care practitioner that reports to the department, by methods specified in §§91.4-91.7 of this title (relating to Cancer Registry), is considered compliant.

B) A person will be notified in writing if the person has not reported in compliance with this chapter within 30 days following the end of the required monthly or quarterly reporting timeframe and will be given an opportunity to take corrective action within 60 days from the date of the notification letter. A second notification letter will be sent 30 days after the date of the original notification letter if no corrective action has been taken.

C) If a person is non-compliant and takes no corrective action within 60 days of the original notification letter, the department or its authorized representative may access the information from the health care facility, clinical laboratory or health care practitioner as provided in §91.3 of this title (relating to Who Reports, Access to Records) and report it in the appropriate format.

1) The health care facility, clinical laboratory or health care practitioner shall be notified at least two weeks in advance before a scheduled arrival for collection of the information.

2) A health care facility, clinical laboratory or health care practitioner that knowingly or in bad faith fails to furnish data as required by this chapter shall reimburse the department or its authorized representative for its cost to access and report the information. The costs must be reasonable, based on the actual costs incurred by the department or by its authorized representative in the collection of the data and may include salary and travel expenses. It is presumed that a health care facility, clinical laboratory or health care practitioner acted knowingly or in bad faith if it failed to take corrective action within 60 days of the date of the original notification letter.

3) A health care facility, clinical laboratory or health care practitioner may request the

department to conduct a hearing under the department's fair hearing rules to determine whether reimbursement to the department is appropriate.

D) Any health care facility, clinical laboratory or health care practitioner which is required to reimburse the department or its authorized representative for the cost to access and report the information pursuant to subsection (c)(2) of this section shall provide payment to the department or its authorized representative within 60 days of the day this payment is demanded. In the event any health care facility, clinical laboratory or health care practitioner fails to make payment to the department or its authorized representative within 60 days of the day the payment is demanded, the department or its authorized representative may, at its discretion, assess a late fee not to exceed 1-1/2 % per month of the outstanding balance.

§91.9. Confidentiality and Disclosure.

A) Pursuant to the Act, Chapter 82, §82.009, all data obtained is for the confidential use of the department and the persons or public or private entities that the department determines are necessary to carry out the intent of the Act.

B) Limited release of the data is allowed by the Act, §82.008(h) and §82.009(b).

C) Any requests for confidential or statistical data shall be made in accordance with §§91.11 or 91.12 of this title (relating to Cancer Registry).

D) The Texas Cancer Registry is subject to state law that requires compliance with portions of the federal law and regulations cited in §91.3(e) of this title (relating to Who Reports, Access to Records). The department is authorized to use and disclose, for purposes described in the Act, cancer data without patient consent or authorization under 45 C.F.R§164.512 (a) relating to uses and disclosures required by law, §164.512(b)(1) and (2) relating to uses and disclosures for public health activities, and §164.512(i) relating to uses and disclosures for research purposes.

§91.10. Quality Assurance.

The department shall cooperate and consult with persons required to comply with this chapter so that such persons may provide timely, complete and accurate data. The department will provide:

A) reporting training, technical assistance, on-site case-finding studies, and reabstracting studies;

B) quality assessment reports to ascertain that the computerized data utilized for statistical information and data compilation is accurate; and

C) educational information on cancer morbidity and mortality statistics available from the Texas Cancer Registry and the department.

§91.11. Requests for Statistical Cancer Data.

A) Statistical cancer data previously analyzed and printed are available upon written or oral

request to the branch. All other requests for statistical data shall be in writing and directed to: Cancer Epidemiology and Surveillance Branch, Department of State Health Services, 1100 West 49th Street, Austin Texas 78756-3199.

B) To ensure that the proper data are provided, the request shall include, but not be limited to, the following information:

1) name, address, and telephone number of the person requesting the information;

2) type of data needed and for what years (e.g. lung cancer incidence rates, Brewster County, 1998-2002); and

3) name and address of person(s) to whom data and billings are to be sent (if applicable).

§91.12. Requests and Release of Personal Cancer Data.

A) Data requests for research.

1) Requests for personal cancer data shall be in writing and directed to: Department of State Health Services, Institutional Review Board (IRB), 1100 West 49th Street, Austin, Texas 78756-3199.

2) Written requests for personal data shall meet the submission requirements of the department's IRB before release.

3) The branch may release personal cancer data to state, federal, local, and other public agencies and organizations if approved by the IRB.

4) The branch may release personal cancer data to private agencies, organizations, and associations if approved by the IRB

5) The branch may release personal cancer data to any other individual or entities for reasons deemed necessary by the department to carry out the intent of the Act if approved by the IRB

B) Data requests for non-research purposes.

1) The branch may provide reports containing personal data back to the respective reporting entity from records previously submitted to the branch from each respective reporting entity for the purposes of case management and administrative studies. These reports will not be released to any other entity.

2) The branch may release personal data to other areas of the department, provided that the disclosure is required or authorized by law. All communications of this nature shall be clearly labeled “Confidential” and will follow established departmental internal protocols and procedures.

3) The branch may release personal cancer data to state, federal, local, and other public agencies and organizations in accordance with subsection (a) of this section.

4) The branch may release personal cancer data to any other individual or entities for reasons deemed necessary to carry out the intent of the Act and in accordance with subsection (a) of this section.

5) An individual who submits a valid authorization for release of an individual cancer record shall have access to review or obtain copies of the information described in the authorization for release.

Texas Cancer Incidence Reporting Act and Reporting Rules also available on the web at: http://www.dshs.state.tx.us/tcr/reporting.shtm.

C

APPENDIX C

FIPS COUNTY CODES

FIPS COUNTY CODES - TEXAS COUNTIES

Anderson	001	Comal	091	Grayson	181
Andrews	003	Comanche	093	Gregg	183
Angelina	005	Concho	095	Grimes	185
Aransas	007	Cooke	097	Guadalupe	187
Archer	009	Coryell	099	Hale	189
Armstrong	011	Cottle	101	Hall	191
Atascosa	013	Crane	103	Hamilton	193
Austin	015	Crockett	105	Hansford	195
Bailey	017	Crosby	107	Hardeman	197
Bandera	019	Culberson	109	Hardin	199
Bastrop	021	Dallam	111	Harris	201
Baylor	023	Dallas	113	Harrison	203
Bee	025	Dawson	115	Hartley	205
Bell	027	Deaf Smith	117	Haskell	207
Bexar	029	Delta	119	Hays	209
Blanco	031	Denton	121	Hemphill	211
Borden	033	De Witt	123	Henderson	213
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APPENDIX D

CONFIDENTIAL CANCER REPORTING FORM

Appendix D Confidential Cancer Reporting Form

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APPENDIX E

COMMON ACCEPTABLE ABBREVIATIONS

Common Acceptable Abbreviations
(In order of Abbreviation)

When abbreviating words in an address, refer to the Address Abbreviations section of the National Zip Code and Post Office Directory, published by the U.S. Postal Service. For short names of antineoplastic drugs, consult SEER*RX Interactive Antineoplastic Drugs Database. http://www.seer.cancer.gov/seertools/seerrx/

ABBREVIATION	DESCRIPTION
A	Allergy
A	Annum
A	Anode
A	Anterior
A	Aortic
A	Artery
A	Axial
AA	Aplastic anemia
AB	Abort (miscarry)
AB	About
AB	Antibody
AB	Asthmatic bronchitis
ABD, ABDOM	Abdomen
ABG	Arterial Blood Gas
ABN	Abnormal
ABP	Arterial blood pressure
ABST	Abstract
AC	Adrenal cortex
AC	Air contrast
AC	Anterior chamber
ACH	Adrenal cortical hormone
ACID PHOS	Acid phosphatase
ACID P'TASE	Acid phosphatase
A-COLON	Ascending Colon
ACTH	Adrenocorticotrophic hormone
ADENOCA	Adenocarcinoma
ADH	Antidiuretic hormone (vasopressin)
ADJ	Adjacent
ADL	Activities of Daily Living

ABBREVIATION	DESCRIPTION
ADM	Admission
ADM	Admit
ADR	Adverse drug reaction
AFF	Afferent
AFF	Affirmative
AFP	Alpha-fetoprotein
AG	Atrial gallop
AG	Antigen
AG	Argentum (silver, chemical symbol for)
AGL	Acute granulocytic leukemia
A/G RATIO	Albumin-globulin ratio
AGNO3	Silver Nitrate
AIDS	Acquired immunodeficiency syndrome
AIL	Angioimmunoblastic lymphadenopathy
AILD	Angioimmunoblastic lymphadenopathy with dysprotinemia
AIN	Anal intraepithelial neoplasia
AK(A)	Above knee (amputation)
AKA	Also known as
ALB	Albumin
ALCL	Anaplastic large cell lymphoma
ALK PHOS	alkaline phosphatase
ALL	Acute lymphocytic leukemia
AMA	Against medical advice
AMB	ambulatory
AMKL	Acute megakaryocytic leukemia
AML	Acute myelogenous leukemia
AMP	Amputation
ANAP	Anaplastic
ANAT	Anatomy
ANO	Axillary node dissection
ANED	Alive no evidence of disease
ANES(TH)	Anesthesia, anesthetic
ANT	Anterior
ANTE	Before
A&P	Auscultation & percussion

ABBREVIATION	DESCRIPTION
AP	Abdominal perineal
AP	Anteroposterior
AP	Anterior pituitary
AP&LAT	Anteroposterior & lateral
ARC	Aids Related Complex
ARMS	Alveolar Rhabdomyosarcoma
APP	Appendix
APPROX	Approximately
ASP	Aspiration
AUT	Autopsy
AV	Arteriovenous
AX	Axilla(ry)
B	Bacillus
B	Black
B	Blue
B	Born
B	Brother
BA	Bachelor of Arts
BA	Barium (chemical symbol for)
BA	Bronchial asthma
BALT	Bronchial-associated lymphoid tissue
BAS	Basal
BASOS	Basophil(s) (granular leukocyte)
BBB	Blood-brain block
BBB	Bundle-branch block
BBT	Basal body temperature
BC	Birth control
BC	Bone conduction
BC	Buccocervical
BCC	Basal cell carcinoma
B-CELLS	Special lymphocytes formed in bone marrow (derived from bursa of Fabricius)
BCG	Bacillus Calmette-Guerin
BD	Bile duct
BE	Barium enema
B/F	Black female

ABBREVIATION	DESCRIPTION
BIO	Twice a day
BIL	Bilateral
BK(A)	Below knee (amputation)
BM	Bone marrow
BM	Bowel movement
B/M	Black male
BMR	Basal metabolic rate
BMT	Bone marrow transplant
BP	Blood pressure
BPH	Benign prostatic hypertrophy/hyperplasia
BRB(PR)	Bright Red Blood (per Rectum)
BRM	Biological response modifier
BSC	Bone scan
BSE	Breast self-examination
BS	Bowel Sounds
BS, BRS	Breath Sounds
BSO	Bilateral salpingo-oophorectomy
BT	Brain tumor
BUN	Blood urea nitrogen
BUS	Bartholin's, urethral & Skene's glands
BX	Biopsy
C	Centigrade
Ca	Ca-Journal of the American Cancer Society
C1-C7	Cervical vertebrae
CA	Calcium
CA	Carcinoma
CAT	Computerized axial tomography
CBC	Complete blood count
CBD	Common bile duct
CC	Chief complaint
CC	Cubic centimeter
CHEMO	Chemotherapy
CHF	Congestive heart failure
CHR	Chronic
CIG	Cigarettes

ABBREVIATION	DESCRIPTION
CIN	Cervical intraepithelial neoplasia
CIS	Carcinoma-in situ
CLL	Chronic lymphocytic leukemia
CLR	Clear
CM	Centimeter
CM	Costal margin
CML	Chronic myeloid/myelocytic leukemia
CMML	Chronic myelomonocytic leukemia
CMV	Cytomegalovirus
CNS	Central nervous system
C/O	Complaining of
CO2	Carbon dioxide
Co60	Cobalt 60
Cont	Continue
Contra	Contralateral
COR	Heart
CPK	Creatine Phosphokinase
CR	Complete remission
CRF	Chronic renal failure
CS	Cesium
CS	Collaborative Stage
CSF	Cerebrospinal fluid
CSF	Colony-stimulating factor
C-SPINE	Cervical spine
CTCL	Cutaneous T cell lymphoma
CTR	Certified Tumor Registrar
CT SC, CAT Scan	Computerized (axial) tomography scan
CVA	Cerebrovascular accident
CVA	Costovertebral angle
C/W	Consistent with
CX	Cervix
CXR	Chest x-ray
CYSTO	Cystoscopy
CYTO	Cytology
D1, D2 ETC	First dorsal vertebra, second, etc.

ABBREVIATION	DESCRIPTION
D&C	Dilatation and curettage
DC	Discharge
DC	Discontinued
DCIS	Ductal carcinoma in situ
D-Colon	Descending Colon
DECR (or <)	Decreased
DERM	Dermatology
DD	Discharge diagnosis
DDX	Differential diagnosis
DERM	Dermatology
DIAM	Diameter
DIFF	Differentiated, differential
DIS, DISCH	Disease; Discharge
DLS	Date last seen
DNA	Deoxyribonucleic acid
DNR	Do not resuscitate
DO	Doctor of Osteopathy
DOA	Dead on arrival
DOB	Date of birth
DOD	Date of death
DOE	Dyspnea on exertion
DP	Dorsalis Pedis
DR	(Medical) doctor
DRE	Digital Rectal Exam
DS	Discharge
DTR	Deep tendon reflex
DX	Diagnosis
ECF	Extended care facility
ECG, EKG	Electrocardiogram
EEG	Electroencephalogram
EENT	Eyes, ears, nose, & throat
EGD	Esophagogastroduodenoscopy
EMG	Electromyogram
ENL	Enlarged
ENT	Ear, nose & throat

ABBREVIATION	DESCRIPTION
EPA	Erect (standing), posterior, anterior
ER(A)	Estrogen receptor (assay)
ERCP	Endoscopic retrograde cholangiopancreatography
EST	Electroshock therapy
ETOH	Alcohol
EUA	Exam under anesthesia
EVAL	Evaluation
EXAM	Examination
EXC	Excision
EXP LAP	Exploratory laparotomy
EXT	Extend, extension
EXT	External; Extremity
F	Fahrenheit
FAB	French American and British Classification Scheme for Leukemia
FB	Fingerbreadth
FBS	Fasting blood sugar
FDA	Food and Drug Administration in USA
FIGO	International Federation of Gynecology and Obstetrics
F(M)H	Family (medical) history
FLURO	Fluoroscopy
FNA	Fine Needle Aspiration
FOM	Floor of mouth
FP	Flat plate
FS	Frozen Section
FU	Follow up
FUO	Fever unknown origin
FX	Fracture
FX	Frozen section
GA	Gastric analysis
GB	Gallbladder
GBM	Glioblastoma multiforme
GCT	Germ cell tumor
GE	Gastroenterostomy
GE	Gastroesophageal
GEN	Generalized

ABBREVIATION	DESCRIPTION
GI	Gastrointestinal
GM	Gram
GP	General practitioner
GR	Grade, grain(s)
GU	Genitourinary
GYN	Gynecology
HB	Hemoglobin
HCG	Human Chorionic Gonadotropin
HCL	Hairy cell leukemia
HCT	Hematocrit
HCVD	Hypertensive cardiovascular disease
HD	Heart disease
HD	Heart disease
HEENT	Head, eyes, ears, nose & throat
HGB	Hemoglobin
HIV	Human immunodeficiency virus
HN2	Nitrogen mustard
H2O	Water
H/O	History of
HORM	Hormone
HOSP	Hospital
H&P	History and physical
HPF	High power field
HPI	History of present illness
HPV	Human papilloma virus
HR(S)	Hour(s)
HRT	Hormone Replacement therapy
HTLV-III	Human T-Lymphotrophic virus type III
HVD	Hypertensive vascular disease
HX	History
HYST	Hysterectomy
I	Iodine
IARC	International Agency for Research on Cancer
ICD-O-1	International Classification of Diseases for Oncology, 1st Ed., 1976
ICD-O-2	International Classification of Diseases, for Oncology, 2nd Ed., 1992

ABBREVIATION	DESCRIPTION
ICD-O-3	International Classification of Diseases, for Oncology, 3rd Ed., 2000
ICF	Intercellular fluid
ICM	Intercostal margin
ICS	Intercostal space
ICU	Intensive care unit
IG	Immunoglobulin
IM	Intramuscular
IMA	Internal mammary artery
IMP	Impression
INCL	Includes, including
INCR	Increase
INF	Inferior
INF	Infraction
INF	Infusion
INFILT	Infiltrating
INJ	Injection
INT MED	Internal medicine
INPT, IP	Inpatient
INV	Invade(s)/invading/invasion
INVL	Involve(s)/involvement
IPPB	Intermittent positive pressure breathing
IPSI	Ipsilateral
IRREG	Irregular
IT	Intrathecal
IV	Intravenous
IVC	Inferior vena cava
IVP	Intravenous pyelogram
IVU	Intravenous Urography
JVD	Jugular venous distention
K	Potassium
KG	Kilogram
KJ	Knee jerk
KK	Knee kick
KUB	Kidneys, ureters, bladder
KV	Kilovolt

ABBREVIATION	DESCRIPTION
L	Left
L	Liter
L	Lower
L1-L5	Lumbar vertebrae
LAD	Lymphadenopathy
LAP	Laparotomy
LAT	Lateral
LAV	Lymphadenopathy-associated virus
LCIS	Lobular carcinoma in-situ
LCM	Left costal margin
LDH	Lactic dehydrogenase
LE	Lower extremity; Lupus erythematosus
LFT	Liver function test
LG	Large
LIF	Left iliac fossa
LINAC	Linear accelerator
LIQ	Lower inner quadrant (breast)
LKS(B)	Liver, kidney, spleen, (bladder)
LLE	Left lower extremity
LLL	Left lower lobe (lung)
LLQ	Left lower quadrant (abdomen)
LMD	Local medical doctor
LMP	Last menstrual period
LN(S)	Lymph node(s)
LND	Lymph Node Dissection
LOP	Lower outer quadrant (breast)
LP	Lumbar puncture
LPF	Lower power field
LPN	Licensed practical nurse
LS	Lumbosacral
LSK, LKS	Liver, spleen, kidneys
LSO	Left salpingo-oophorectomy
L-SPINE	Lumbar spine
LT	Left
LUE	Left upper extremity

ABBREVIATION	DESCRIPTION
LUL	Left upper lobe (lung)
LUQ	Left upper quadrant (abdomen)
L&W	Living and well
M	Monocytes, meter
MAB	Monoclonal antibody
MAL	Malignant
MALT	mucosal-associated lymphoid tissue
MALIG	Malignant
MAND	Mandible
MAST	Mastectomy
M-CSF	Macrophage Colony-Stimulating Factor
MC	Millicurie
MCH	Mean corpuscular hemoglobin
MCHC	Mean corpuscular hemoglobin count
MCL	Mid clavicular line
MCV	Mean corpuscular volume
MD	Medical doctor
MD	Moderately differentiated
MED	Medicine
MOS	Myelodysplastic syndrome
MET, METS	Metastatic, metastases
MEV	Million electron volts
MH	Marital history
MH	Mental health
MI	Myocardial infarction
MIN	Minimum
MG	Milligram
MICRO	Microscopic
ML	Middle lobe
ML	Milliliter
MM	Millimeter
MOD	Moderate
MOD DIFF	Moderately differentiated
MO	Month
MPNST	Malignant peripheral nerve sheath tumor

ABBREVIATION	DESCRIPTION
MRI	Magnetic resonance imaging
MRM	Modified radical mastectomy
MSL	Mid sternal line
MULT	Multiple
MX	Microscopic
MX	Maxilla(ry), maximum
NA	Not applicable
NBS	Normal bowel sounds
NEC	Not elsewhere classified
NED	No evidence of disease
NEG or -	Negative
NEMD	No Evidence of Metastatic Disease
NERD	No evidence of recurrent disease
NEURO	Neurology
NHL	Non Hodgkin lymphoma
NK	Natural killer
NL	Normal
NOS	Not otherwise specified
NR	Not recorded
NR	Not reportable
NSCLC	Non-small cell lung carcinoma
NSF	N significant findings
NTP	Normal temperature and pressure
N&V	Nausea and vomiting
NVD	neck vein distention
OB	Obstetrics
OBST	Obstructed (ing, ion)
OD	Right eye (oculus dexter)
OH	Occupational history
OP	Operation
OP	Outpatient
OPD	Outpatient clinic; department
OPHTH	Ophthalmology
OP RPT	Operative Report
OR	Operating room

ABBREVIATION	DESCRIPTION
ORTH	Orthopedics
OS	Bone
OS	Left eye (oculus sinister)
OS	Mouth
OS	Opening
OSTEO	Osteomyelitis
OT	Occupational therapy
OTO	Otology
OU	Each eye (oculus uterque)
OV	Office visit
OZ	Ounce
P	Pulse
P&A	Percussion and auscultation
PA	Posteroanterior
PA	Pulmonary artery
PA	Physician assistant
PALP	Palpable, palpated, palpation
PAP	Papanicolaou smear
PAP	Papillary
PAR	Post anesthesia room
PARA	Number of pregnancies resulting in viable infants
PATH	Pathology
PCV	Packed cell volume
PD	Poorly differentiated
PDR	Physician's Desk Reference
PE	Physical examination
PED	Pediatrics
PEG	Pneumoencephalography
PEG	Percutaneous gastrostomy tube
PERC	Percutaneous
PET	Positron emission tomography
PH	Past or personal history
PI	Present illness
PID	Pelvic inflammatory disease
PIN	Prostatic intraepithelial neoplasia

ABBREVIATION	DESCRIPTION
PLT	Platelets
PM	Post mortem (after death)
PMD	Personal (primary) medical doctor
PMH	Past medical history
PND	Postnasal drip
PNET	Peripheral neuroectodermal tumor (bone tumors)
PNET	Primitive neuroectodermal tumor (CNS tumors)
PO, POSTOP	Postoperative(ly)
POD	Postoperative day
POOR DIFF	Poorly differentiated
POS or +	Positive
POSS	Possible
POST	Posterior
POST	Postmortem examination
POSTOP	Postoperative(ly)
PPD	Purified protein derivative (Tuberculin skin test)
PPD	Packs per day
PR	Partial response
PR(A)	Progesterone receptor (assay)
PREOP	Preoperative(ly)
PTA	Prior to Admission
PROB	Probable(ly)
PSA	Prostate specific antigen
PT	Patient
PT	Physiotherapy
PTA	Prior to examination
PUO	Pyrexia of undetermined origin
PULM	Pulmonary
Q	Quadrant
QID	Four times a day
R	Roentgen
R	Respiration
R	Right
RA	Radium
RAD	Radiation

ABBREVIATION	DESCRIPTION
RAD	Radiation Absorbed Dose
RAD	Radical
RAEB (-T)	Refractory anemia with excess blasts (in transformation)
RAIU	Radioactive iodine (I 131) uptake
RARS	Refractory anemia with ringed sideroblasts
RBC	Red blood cells
RCM	Right costal margin
RCS	Reticulum cell sarcoma
REG	Radioencephalogram
RES	Reticuloendothelial system
RESEC	Resection
RESP	Respiratory
RH	Rhesus (monkey) factor in blood
RIA	Radioimmunoassay
RIF	Right iliac fossa
RIQ	Right inner quadrant (abdomen)
RLE	Right lower extremity
RLL	Right lower lobe (lung)
RLQ	Right lower quadrant
RML	Right middle lobe (lung)
RMS	Rhabdomyosarcoma
RN	Registered nurse
RNP	Registered nurse practitioner
RNA	Ribonucleic acid
RO, R/O	Rule out
ROF	Review of outside films
ROM	Range of motions
ROS	Review of slides
ROS	Review of outside slides
ROS	Review of Systems
ROQ	Right outer quadrant (abdomen)
RSO	Right salpingo-oophorectomy
R-S cells	Reed-Sternberg cells
RT	Radiation therapy
RT	Right

ABBREVIATION	DESCRIPTION
RUE	Right upper extremity
RUL	Right upper lobe
RUQ	Right upper quadrant
R-V	Rectovaginal
RX	Treatment
S1S5	Sacral vertebra
SALT	Skin-associated lymphoid tissue
SARC	Sarcoma
SB	Small bowel
SBE	Subacute bacterial endocarditis
SCC	Squamous cell carcinoma
S-COLON	Sigmoid Colon
SEER	Surveillance Epidemiology and End Results
SGOT	Serum glutamic oxaloacetic
SGPT	Serum glutamic pyruvic transaminase
SS	Social Security
SH	Serum hepatitis
SM	Small
SMA	Sequential multiple analysis (Biochem profile)
SML BWL	Small bowel
SNF	Skilled nursing facility
SO	Salpingo-oophorectomy
SOB	Shortness of breath
SOL	Solution
S/P	Status post
SPEC	Specimen
SP GR	Specific gravity
S-Q, SQ	Subcutaneous
SQ, SQUAM	Squamous
SQ CELL CA	Squamous cell carcinoma
SR	Sedimentation rate
S-SPINE	Sacral spine
STAPH	Staphylococcus
STAT	Immediately (statim)
STREP	Streptococcus

ABBREVIATION	DESCRIPTION
STSG	Split thickness skin graft
SUBCU	Subcutaneous
SUB-Q, SUBQ	Subcutaneous
SURG	Surgery, surgical
SUSP	Suspicious/Suspected
SVC	Superior vena cava
SX	Symptoms
SYMP	Symptoms
T	Temperature
T	Thoracic
TA	Toxin-antitoxin
T1-T2	Thoracic vertebra
T&A	Tonsillectomy and adenoidectomy
TAH	Total abdominal hysterectomy
TAH-BSO	Total abdominal hysterectomy-bilateral salpingo oophorectomy
TB, TBC	Tuberculosis
TCC	Transitional cell carcinoma
T-COLON	Transverse Colon
TD	Tumor dose
TID	Three times a day
TNM	Tumor, Nodes, Metastasis
TP	Total protein
TPN	Total parenteral nutrition
TPR	Temperature, pulse and respiration
TS	Tumor size
TSH	Thyroid stimulating hormone
T-SPINE	Thoracic spine
TUR	Transurethral resection
TURB	Transurethral resection-Bladder
TURP	Transurethral resection-Prostate
TVH	Total vaginal hysterectomy
TX	Treatment
U	Unit
UCHD	Usual childhood diseases
UE	Upper extremity

ABBREVIATION	DESCRIPTION
UGI	Upper gastrointestinal
UIQ	Upper inner quadrant (breast)
ULCC	Undifferentiated large cell carcinoma
UMB	Navel (umbilicus)
UNDIFF	Undifferentiated
UOQ	Upper outer quadrant (abdomen)
UR	Urine
URI	Upper respiratory infection
UROL	Urology
UTI	Urinary tract infection
VAG	Vagina, Vaginal
VAG HYST	Vaginal hysterectomy
VAIN	Vaginal intraepithelial neoplasia
VASC	Vascular
VD	Venereal Disease
VIN	Vulvar intraepithelial neoplasia
VS	Vital signs
W/	With
WBC	White blood cells
W/D	Well developed
WD, WELL DIFF	Well differentiated
W/F	White female
W/M	White male
WN	Well nourished
WNL	Within normal limits
W/O	Without
WT	Weight
W/U	Work-up
XR	X-ray
Y/O	Year old
YR	Year

Symbols

@	At
/	Comparison
<	Decrease, Less than
=	Equals
>	Increase, More than
-	Negative
#	Number*
+	Positive
#	Pounds**
x	Times

*If it appears before a numeral
**If it appears after a numeral

F

APPENDIX F

COMPARISON OF DATA SETS

COMPARISON OF DATA SETS

Definitions:

Required Data Set (R): Commission-approved programs must record the required data set items using the codes and definitions specified in the FORDS manual.

Supplementary Data Set (S): The supplementary data set contains additional data items that are important for the efficient operation of a cancer registry.

Surveillance, Epidemiology, and End Results Program (SEER): Required data elements for a central registry affiliated with the National Cancer Institute's SEER Program.

National Program of Cancer Registries (NPCR): Refers to requirements and recommendations of the NPCR regarding data items that should be collected or computed by NPCR state registries.

Commission on Cancer (CoC): Refers to requirements and recommendations of the Commission on Cancer of ACoS.

Texas Cancer Registry (TCR): Refers to the requirements and recommendations of the Texas Cancer Registry.

Exchange Elements for Hospital to Central and Central to Central: Items required for facilities reporting to central registries (labeled Hosp>Central), and items that central registries should use when sending cases to other central registries (labeled Central>Central).

Codes for Recommendations:

Left blank indicates that this data field is not currently collected by the TCR and other entities.
D = Derived
R = Required
RH = historically collected and currently transmitted
RC = Collected by SEER from CoC-approved hospitals
RS = Required, site specific
S = Supplementary/recommended
T = Data is vital to complete exchange record
TH = Cases diagnosed before 2004, transmit data if available in exchange record
***** = When available
^ = These text requirements may be met with one or several text block fields
• = No recommendations
= Central registries may code using SEER or COC data item and associated rules
+ = Central registries ma collect either SER Summary Stage 2000 or Collaborative Stage
√ = Populated by TCR

Table F.1 Comparison of Data Sets

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
Revised	10	Record Type	√	R	•	R	•	R	T	T	NAACCR
	20	Patient ID Number	√	R	•	•	R	R	•	T	Reporting Registry
	21	Patient System ID-Hosp	•	•	•	•	•	•	T	•	NAACCR
	30	Registry Type	•	•	•	•	•	•	•	T	NAACCR
Retired	35	FIN Coding System									
	37	Reserved 00									
Revised	40	Registry ID	R	R	•	•	R	R	T	T	NAACCR
	45	NPI-Registry ID	•	•	•	•	R*	•	•	•	CMS
	50	NAACCR Record Version	R	R	•	R	•	•	T	T	NAACCR
	60	Tumor Record Number	•	•	•	•	S	S	T	T	NAACCR
	70	Addr at DX-City	R	R	R	R	R	•	T	T	COC
	80	Addr at DX-State	R	R	R	R	R	•	T	T	COC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
	90	County at DX	R	R	R	R	R	R	T	T	FIPS/SEER
	100	Addr at DX-Postal Code	R	R	R	R	R	•	T	T	COC
New	102	Addr at DX-Country	•	•	R	R	R	•	•		NAACCR
	110	Census Tract 1970/80/90	D	RH*	•	•	RH	RH	•	T*	SEER
	120	Census Cod Sys 1970/80/90	D	RH*	•	•	RH	RH	•	T*	SEER
Revised	130	Census Tract 2000	D	R	•	•	R	R	•	T*	NAACCR
Revised	135	Census Tract 2010	D	R	•	•	R	R	•	•	NAACCR
Retired	140	Census Tract Cod Sys-Alt									
	150	Marital Status at DX	•	•	•	•	R	R	•	•	SEER
	160	Race 1	R	R	R	R	R	R	T	T	SEER/COC
	161	Race 2	R	R	R	R	R	R	T	T	SEER/COC
	162	Race 3	R	R	R	R	R	R	T	T	SEER/COC
	163	Race 4	R	R	R	R	R	R	T	T	SEER/COC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
	164	Race 5	R	R	R	R	R	R	T	T	SEER/COC
	170	Race Coding Sys-Current	•	•	R	R	•	•	T	T	NAACCR
	180	Race Coding Sys-Original	•	•	R	R	•	•	T	T	NAACCR
	190	Spanish/Hisp Origin	R	R	R	R	R	R	T	T	SEER/COC
	191	NHIA Derived Hisp Origin	D	D	•	•	D	R	•	•	NAACCR
	192	IHS Link	√	R*	•	•	•	R	•	•	NPCR
	193	Race NAPIIA (derived API)	D	R	•	•	D	R	•	•	NAACCR
	200	Computed Ethnicity	R	R	•	•	D	R	•	•	SEER
	210	Computed Ethnicity Source	R	R	•	•	R	R	•	•	SEER
	220	Sex	R	R	R	R	R	R	T	T	SEER/COC
	230	Age at Diagnosis	• √	R	R	R	R	R	•	•	SEER/COC
	240	Birth Date	R	R	R	R	R	R	T	T	SEER/COC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
	241	Date of Birth Flag	D	R	R	R	R	R	T	T	NAACCR
Revised	250	Birthplace	RH*	RH*	RH	RH	RH	RH	T*	T	SEER/COC
New	252	Birthplace-State	R*	R*	R	R	R	R	•	•	NAACCR
New	254	Birthplace-Country	R*	R*	R	R	R	R	•	•	NAACCR
Retired	260	Religion									
Revised	270	Occupation Code-Census 1970-2000	√	R*	•	•	•	•	•	•	Census/ NPCR
New	272	Census Ind Code 2010	R*	R*	•	•	•	•	•	•	Census/ NPCR
	280	Industry Code-Census 1970-2000	√	R*	•	•	•	•	•	•	Census/ NPCR
New	282	Census Occ Code 2010	R*	R*	•	•	•	•	•	•	Census/ NPCR
	290	Occupation Source	√	R*	•	•	•	•	•	•	NPCR
	300	Industry Source	√	R*	•	•	•	•	•	•	NPCR
	310	Text-Usual	R	R*	•	•	•	•	T*	T*	NPCR

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
		Occupation									
	320	Text-Usual Industry	R	R*	•	•	•	•	T*	T*	NPCR
Revised	330	Occup/Ind Coding System 70-00	√	R*	•	•	•	•	•	•	NPCR
Retired	340	Tobacco History									
Retired	350	Alcohol History									
Retired	360	Family History of Cancer									
	362	Census Tract Block Group 2000	D	•	•	•	S	•	•	•	Census
Revised	363	Census Block Group 2010	•	•	•	•	R	•	•	•	Census
	364	Census Tr Cert 1970/80/90	D	RH*	•	•	RH	RH	•	•	SEER
Revised	365	Census Tr Certainty 2000	D	R	•	•	R*	R*	•	•	NAACCR
	366	GIS Coordinate	R*	R*	•	•	S	•	•	•	NAACCR

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
		Quality									
Revised	367	Census Tr Certainty 2010	D	R	•	•	R	R	•	•	NAACCR
Revised	368	CensusBlockGroup 70/80/90	•	•	•	•	S	•	•	•	Census
	370	Reserved 01									
	380	Sequence Number-Central	R	R	•	•	R	R	•	T	SEER
	390	Date of Diagnosis	R	R	R	R	R	R	T	T	SEER/COC
Revised	391	Date of Diagnosis Flag	D	R	•	•	R	R	T	T	NAACCR
Revised	400	Primary Site	R	R	R	R	R	R	T	T	SEER/COC
	410	Laterality	R	R	R	R	R	R	T	T	SEER/COC
	419	Morph-Type & Behav ICD-O-2	•	•	•	•	•	•	•	•	
	420	Histology (92-00) ICD-O-2	RH	RH	RH	RH	RH	RH	TH	TH	SEER/COC
	430	Behavior (92-00) ICD-O-2	RH	RH	RH	RH	RH	RH	TH	TH	SEER/COC
Revised	439	Date of Mult	•	•	RH	RH	R*	R*	•	•	NAACCR

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
		Tumors Flag									
	440	Grade	R	R	R	R	R	R	T	T	SEER/COC
	441	Grade Path Value	R*	R*	R	R	R	R	T*	T*	AJCC
Revised	442	Ambiguous Term DX	•	•	RH	RH	•	•	•	•	SEER
Revised	443	Date of Conclusive DX	•	•	RH	RH	•	•	•	•	SEER
Revised	444	Mult Tum Rpt as One Prim	•	•	RH	RH	•	•	•	•	SEER
Revised	445	Date of Multiple Tumors	•	•	RH	RH	•	•	•	•	SEER
Revised	446	Multiplicity Counter	•	•	RH	RH	•	•	•	•	SEER
Retired	447	Number of Tumors/ Hist									
Revised	448	Date Conclusive DX Flag	•	•	RH	RH	•	•	•	•	NAACCR
	449	Grade Path	R*	R*	R	R	R	R	T*	T*	AJCC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
		System									
	450	Site Coding Sys-Current	• D	R	R	R	•	•	T	T	NAACCR
	460	Site Coding Sys-Original	•	•	R	R	•	•	T	T	NAACCR
	470	Morph Coding Sys-Current	• D	R	R	R	•	•	T	T	NAACCR
	480	Morph Coding Sys-Origin 1	•	•	R	R	•	•	T	T	NAACCR
Revised	490	Diagnostic Conf	R	R	R	R	R	R	T	T	SEER/COC
	500	Type of Reporting Source	R	R	•	•	R	R	T	T	SEER
	501	Casefind. Source	R*	R*	•	•	•	•	T*	T*	NAACCR
Retired	510	Screening Date									
Retired	520	Screening Result									
	521	Morph Type & Behav ICD-O-3	•	•	•	•	•	•			
Revised	522	Histologic Type	R	R	R	R	R	R	T	T	SEER/COC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
		ICD-O-3									
Revised	523	Behavior Code ICD-O-3	R	R	R	R	R	R	T	T	SEER/COC
	530	Reserved 02									
Retired	538	Reporting Hospital FAN									
	540	Reporting Facility	R	R	R	R	R	•	T	•	COC
	545	NPI-Reporting Facility	D	R*	R	R	R*	•	•	•	CMS
	550	Accession Number-Hosp	R	•	R	R	R	•	T*	•	COC
	560	Sequence Number-Hospital		•	R	R	R	•	T	•	COC
	570	Abstracted By	R	•	R	R	R	•	•	•	COC
	580	Date of 1st Contact	R	R	R	R	•	•	T	•	COC
	581	Date of 1st Contact Flag	D	R	R	R	•	•	T	•	NAACCR
Revised	590	Date of	•	•	•	•	•	•	•	•	NAACCR

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
		Inpatient Adm									
	591	Date of Inpt Adm Flag	•	•	•	•	•	•	•	•	NAACCR
Revised	600	Date of Inpatient Disch	•	•	•	•	•	•	•	•	NAACCR
	601	Date of Inpt Disch Flag	•	•	•	•	•	•	•	•	NAACCR
	605	Inpatient Status	•	•	•	•	•	•	•	•	NAACCR
	610	Class of Case	R	R	R	R	RC	•	T	•	COC
Retired	620	Year First Seen This CA									
	630	Primary Payer at DX	R*	R*	R	R	R	R	•	•	COC
Retired	640	Inpatient/ Output Status									
Retired	650	Present. at CA Conf									
Retired	660	Date of CA Conference									
Retired	665	RX Hosp-ASA Class	•	•	•	•	•	•	•	•	

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
	668	RX Hosp-Surg App 2010	•	•	R	R	•	•	T*	•	COC
	670	RX Hosp-Surg Prim Site	•	•	R	R	R	•	T*	•	COC
	672	RX Hosp-Scope Reg LN Sur	•	•	R	R	R	•	T*	•	COC
	674	RX Hosp-Surg Oth Reg/Dis	•	•	R	R	R	•	T*	•	COC
	676	RX Hosp-Reg LN Removed	•	•	RH	RH	•	•	T*	•	COC
Retired	678	RX Hosp-Surg Timing									
	680	Reserved 03									
	690	RX Hosp-Radiation	•	•	•	•	RH	•	TH*	•	SEER
	700	RX Hosp-Chemo	•	•	R	R	R	•	T*	•	COC
	710	RX Hosp-Hormone	•	•	R	R	R	•	T*	•	COC
	720	RX Hosp-BRM	•	•	R	R	R	•	T*	•	COC
	730	RX Hosp-Other	•	•	R	R	R	•	T*	•	COC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
	740	RX Hosp-DX/Stg Proc	•	•	R	R	•	•	•	•	COC
Retired	742	RX Hosp-Screen/BX Proc1									
Retired	743	RX Hosp-Screen/BX Proc2									
Retired	744	RX Hosp-Screen/BX Proc3									
Retired	745	RX Hosp-Screen/BX Proc4									
	746	RX Hosp-Surg Site 98-02	•	•	RH	RH	RH	•	TH*	•	COC
	747	RX Hosp-Scope Reg 98-02	•	•	RH	RH	RH	•	TH*	•	COC
	748	RX Hosp-Surg Oth 98-02	•	•	RH	RH	RH	•	TH*	•	COC
	750	Reserved 04	•	•	•	•	•	•	•	•	

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
	759	SEER Summary Stage 2000	RH	R+	RH	RH	•	S	TH*	TH*	SEER
	760	SEER Summary Stage 1977	RH	RH	RH	RH	•	S	TH*	TH*	SEER
Retired	770	Loc/Reg/ Distant Stage									
	779	EOD 10-Dig									
	780	EOD-Tumor Size	RH	•	RH	RH	RH	RH	TH*	TH*	SEER/COC
	790	EOD-Extension	•	•	•	•	RH	RH	TH*	TH*	SEER
	800	EOD-Extension Prost Path	•	•	•	•	RH	RH	TH*	TH*	SEER
	810	EOD-Lymph Node Involv	•	•	•	•	RH	RH	TH*	TH*	SEER
Revised	820	Regional Nodes Positive	R	R	R	R	R	R	T*	T*	SEER/COC
Revised	830	Regional Nodes Examined	R	R	R	R	R	R	T*	T*	SEER/COC
	840	EOD-Old 13 Digit	•	•	•	•	RH	RH	•	•	SEER
	850	EOD-Old 2	•	•	•	•	RH	RH	•	•	SEER

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
		Digit									
	860	EOD-Old 4 Digit	•	•	•	•	RH	RH	•	•	SEER
	870	Coding System for EOD	•	•	•	•	RH	RH	•	TH*	SEER
	880	TNM Path T	•	•	R*	R*	•	•	T*	T*	AJCC
	890	TNM Path N	•	•	R*	R*	•	•	T*	T*	AJCC
	900	TNM Path M	•	•	R*	R*	•	•	T*	T*	AJCC
	910	TNM Path Stage Group	•	•	R*	R*	•	•	T*	T*	AJCC
	920	TNM Path Descriptor	•	•	R*	R*	•	•	T*	T*	COC
	930	TNM Path Staged By	•	•	R*	R*	•	•	T*	T*	COC
	940	TNM Clin T	D	•	R	R	•	•	T*	T*	AJCC
	950	TNM Clin N	D	•	R	R	•	•	T*	T*	AJCC
	960	TNM Clin M	D	•	R	R	•	•	T*	T*	AJCC
	970	TNM Clin Stage Group	D	•	R	R	•	•	T*	T*	AJCC
	980	TNM Clin Descriptor	D	•	R	R	•	•	T*	T*	COC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
	990	TNM Clin Staged By	•	•	R	R	•	•	T*	T*	COC
Retired	1000	TNM Other T									
Retired	1010	TNM Other N									
Retired	1020	TNM Other M									
Retired	1030	TNM Other Stage Group									
Retired	1040	TNM Other Staged By									
Retired	1050	TNM Other Descriptor									
	1060	TNM Edition Number	•	•	R	R	•	•	T*	T*	COC
Retired	1070	Other Staging System									
Retired	1080	Date of 1st Positive BX	•	•	•	•	•	•	•	•	
Retired	1090	Site of Distant Met 1	•	•	•	•	•	•	•	•	
Retired	1100	Site of Distant Met 2	•	•	•	•	•	•	•	•	

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
Retired	1110	Site of Distant Met 3	•	•	•	•	•	•			
	1120	Pediatric Stage	•	•	•	•	•	•	•	•	COC
	1130	Pediatric Staging System	•	•	•	•	•	•	•	•	COC
	1140	Pediatric Staged By	•	•	•	•	•	•	•	•	COC
	1150	Tumor Marker 1	•	•	RH	RH	RH	RH	TH*	TH*	SEER
	1160	Tumor Marker 2	•	•	RH	RH	RH	RH	TH*	TH*	SEER
	1170	Tumor Marker 3	•	•	RH	RH	RH	RH	TH*	TH*	SEER
	1180	Reserved 05									
	1182	Lymph-vascular Invasions	RS*	RS*	R	R	RS	RS	T*	T*	AJCC
	1190	Reserved 06									
Revised	1200	RX Date-Surgery	R	R	R	R	S	•	T*	T*	COC
Revised	1201	RX Date-Surgery Flag	R	R	R	R	S	•	T*	T*	NAACCR

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
Revised	1210	RX Date-Radiation	RS	RS	R	R	S	•	T*	T*	COC
Revised	1211	RX Date-Radiation Flag	RS	RS	R	R	S	•	T*	T*	NAACCR
Revised	1220	RX Date-Chemo	RS	RS	R	R	•	•	T*	T*	COC
Revised	1221	RX Date-Chemo Flag	RS	RS	R	R	•	•	T*	T*	NAACCR
Revised	1230	RX Date-Hormone	RS	RS	R	R	•	•	T*	T*	COC
Revised	1231	RX Date-Hormone Flag	RS	RS	R	R	•	•	T*	T*	NAACCR
Revised	1240	RX Date-BRM	RS	RS	R	R	S	•	T*	T*	COC
Revised	1241	RX Date-BRM Flag	RS	RS	R	R	S	•	T*	T*	NAACCR
Revised	1250	RX Date-Other	RS	RS	R	R	S	•	T*	T*	COC
Revised	1251	RX Date-Other Flag	RS	RS	R	R	S	•	T*	T*	NAACCR
Revised	1260	Date of Initial RX-SEER	D	R#	•	•	R	R	T*	T*	SEER
Revised	1261	Date of Initial	D	R#	•	•	R	R	T*	T*	NAACCR

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
		RX Flag									
Revised	1270	Date of 1st Crs RX-COC	R#	R#	R	R	•	•	T*	T*	COC
Revised	1271	Date of 1st Crs RX Flag	R#	R#	R	R	•	•	T*	T*	NAACCR
Revised	1280	RX Date-DX/Stg Proc	•	•	R	R	•	•			COC
Revised	1281	RX Date-Dx/Stg Proc Flag	•	•	R	R	•	•	•	•	NAACCR
	1285	RX Summ-Treatment Status	RS#	RS#	R	R	R	R	T*	T*	SEER/COC
	1290	RX Summ-Surg Prim Site	R	R	R	R	R	R	T	T*	SEER/COC
	1292	RX Summ-Scope Reg LN Sur	R	R	R	R	R	R	T	T*	SEER/COC
	1294	RXSumm-Surg Oth Reg/Dis	R	R	R	R	R	R	T	T*	SEER/COC
	1296	RX Summ-Reg	•	•	RH	RH	RH	RH	TH*	TH*	SEER/COC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
		LN Examined									
	1300	Reserved 07	•	•	•	•	•	•	•	•	
	1310	RXSumm-Surgical Approach	•	•	RH	RH	•	•	•	•	COC
	1320	RX Summ-Surgical Margins	•	•	R	R	•	•	•	•	COC
	1330	RX Summ-Reconstruct 1st	•	•	RH	RH	RH	RH	•	•	SEER
	1340	Reason for No Surgery	R	R	R	R	R	R	T	T*	SEER/COC
	1350	RX Summ-DX/Stg Proc	•	•	R	R	•	•	•	•	COC
	1360	RX Summ-Radiation	RH	RH	•	•	R	R	TH*	TH*	SEER
	1370	RX Summ-Rad to CNS	•	•	•	•	R	R	•	•	SEER/COC
	1380	RX Summ-Surg/Rad Seq	RS	RS	R	R	R	R	T	T*	SEER/COC
	1390	RX Summ-	RS	RS	R	R	R	R	T*	T*	SEER/COC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
		Chemo									
	1400	RX Summ-Hormone	RS	RS	R	R	R	R	T*	T*	SEER/COC
	1410	RX Summ-BRM	RS	RS	R	R	R	R	T*	T*	SEER/COC
	1420	RX Summ-Other	RS	RS	R	R	R	R	T*	T*	SEER/COC
	1430	Reason for No Radiation	RS	RS	R	R	•	•	•	•	COC
Retired	1440	Reason for No Chemo									
Retired	1450	Reason for No Hormone									
	1460	RX Coding System-Current	• D	R	R	R	•	RH	T*	T*	NAACCR
Retired	1470	Protocol Eligibility Stat									
Retired	1480	Protocol Participation									
Retired	1490	Referral to Support Serv									

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
Retired	1500	First Course Calc Method									
	1510	Rad-Regional Dose: cGy	•	•	R	R	•	•	T	•	COC
	1520	Rad-No of Treatment Vol	•	•	R	R	•	•	T	•	COC
Retired	1530	Rad-Elapsed RX Days	•								
	1540	Rad-Treatment Volume	•	•	R	R	•	•	T	•	COC
	1550	Rad-Location of RX	•	•	R	R	•	•	T	•	COC
Retired	1560	Rad-Intent of Treatment									
	1570	Rad-Regional RX Modality	RS	RS	R	R	RC	•	T	T*	COC
Retired	1580	Rad- RX Completion Status									
Retired	1590	Rad-Local Control Status									

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
Retired	1600	Chemo Field 1									
Retired	1610	Chemo Field 2									
Retired	1620	Chemo Field 3									
Retired	1630	Chemo Field 4									
	1639	RX Summ-Systemic/ Surg Seq	RS	RS	R	R	R	R	T	T	COC
Revised	1640	RX Summ-Surgery Type	•	•	•	•	RH	RH	•	•	SEER
Retired	1642	RX Summ-Screen/BX Proc1									
Retired	1643	RX Summ-Screen/BX Proc2									
Retired	1644	RX Summ-Screen/BX Proc3									
Retired	1645	RX Summ-Screen/BX Proc4									

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
	1646	RX Summ-Surg Site 98-02	•	•	RH	RH	RH	RH	TH*	TH*	SEER/COC
	1647	RX Summ-Scope Reg 98-02	•	•	RH	RH	RH	RH	TH*	TH*	SEER/COC
	1648	RX Summ-Surg Oth 98-02	•	•	RH	RH	RH	RH	TH*	TH*	SEER/COC
	1650	Reserved 08	•	•	•	•	•	•	•	•	
	1660	Subsq RX 2nd Course Date	•	•	•	•	•	•	•	•	COC
	1661	Subsq RX 2nd Crs Date Flag	•	•	•	•	•	•	•	•	NAACCR
Revised	1670	Subsq RX 2nd Course Codes	•	•	•	•	•	•	•	•	
	1671	Subsq RX 2nd Course Surg	•	•	•	•	•	•	•	•	COC
	1672	Subsq RX 2nd Course Rad	•	•	•	•	•	•	•	•	COC
	1673	Subsq RX 2nd Course Chemo	•	•	•	•	•	•	•	•	COC
	1674	Subsq RX 2nd	•	•	•	•	•	•	•	•	COC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
		Course Horm									
	1675	Subsq RX 2nd Course BRM	•	•	•	•	•	•	•	•	COC
	1676	Subsq RX 2nd Course Oth	•	•	•	•	•	•	•	•	COC
	1677	Subsq RX 2nd-Scope LN SU	•	•	•	•	•	•	•	•	COC
	1678	Subsq RX 2nd-Surg Oth	•	•	•	•	•	•	•	•	COC
	1679	Subsq RX 2nd-Reg LN Rem	•	•	•	•	•	•	•	•	COC
	1680	Subsq RX 3rd Course Date	•	•	•	•	•	•	•	•	COC
	1681	Subsq RX 3rd Crs Date Flag	•	•	•	•	•	•	•	•	NAACCR
	1690	Subsq RX 3rd Course Codes	•								
	1691	Subsq RX 3rd Course Surg	•	•	•	•	•	•	•	•	COC
	1692	Subsq RX 3rd Course Rad	•	•	•	•	•	•	•	•	COC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
	1693	Subsq RX 3rd Course Chemo	•	•	•	•	•	•	•	•	COC
	1694	Subsq RX 3rd Course Horm	•	•	•	•	•	•	•	•	COC
	1695	Subsq RX 3rd Course BRM	•	•	•	•	•	•	•	•	COC
	1696	Subsq RX 3rd Course Oth	•	•	•	•	•	•	•	•	COC
	1697	Subsq RX 3rd-Scope LN Su	•	•	•	•	•	•	•	•	COC
	1698	Subsq RX 3rd-Surg Oth	•	•	•	•	•	•	•	•	COC
	1699	Subsq RX 3rd-Reg LN Rem	•	•	•	•	•	•	•	•	COC
	1700	Subsq RX 4th Course Date	•	•	•	•	•	•	•	•	COC
	1701	Subsq RX 4th Crs Date Flag	•	•	•	•	•	•	•	•	NAACCR
	1710	Subsq RX 4th Course Codes	•	•	•	•	•	•	•	•	
	1711	Subsq RX 4th	•	•	•	•	•	•	•	•	COC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
		Course Surg									
	1712	Subsq RX 4th Course Rad	•	•	•	•	•	•	•	•	COC
	1713	Subsq RX 4th Course Chemo	•	•	•	•	•	•	•	•	COC
	1714	Subsq RX 4th Course Horm	•	•	•	•	•	•	•	•	COC
	1715	Subsq RX 4th Course BRM	•	•	•	•	•	•	•	•	COC
	1716	Subsq RX 4th Course Oth	•	•	•	•	•	•	•	•	COC
	1717	Subsq RX 4th-Scope LN Su	•	•	•	•	•	•	•	•	COC
	1718	Subsq RX 4th-Surg Oth	•	•	•	•	•	•	•	•	COC
	1719	Subsq RX 4th-Reg LN Rem	•	•	•	•	•	•	•	•	COC
Retired	1720	Subsq RX 5th Course Date									
Retired	1730	Subsq RX 5th Course Codes									

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
Retired	1731	Subsq RX 5th Course Surg									
Retired	1732	Subsq RX 5th Course Rad									
Retired	1733	Subsq RX 5th Course Chemo									
Retired	1734	Subsq RX 5th Course Horm									
Retired	1735	Subsq RX 5th Course BRM									
Retired	1736	Subsq RX 5th Course Oth									
Retired	1737	Subsq RX 5th-Scope LN Su									
Retired	1738	Subsq RX 5th-Surg Oth									
Retired	1739	Subsq RX 5th-Reg LN Rem									
	1740	Reserved 09	•	•	•	•	•	•	•	•	
	1741	Subsq RX-Reconstruct Del	•	•	•	•	•	•	•	•	COC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
	1750	Date of Last Contact	R	R	R	R	R	R	T	T	SEER/COC
	1751	Date of Last Contact Flag	D	R	R	R	R	R	T	T	NAACCR
	1760	Vital Status	R	R	R	R	R	R	T	T	SEER/COC
	1770	Cancer Status	•	•	R	R	•	•	•	•	COC
	1780	Quality of Survival	•	•	•	•	•	•	•	•	COC
	1790	Follow-Up Source	R*	R*	R	•	•	•	T*	•	COC
	1791	Follow-up Source Central	D	R	•	•	•	•	•	T*	NAACCR
	1800	Next Follow-Up Source	•	•	R	•	•	•	•	•	COC
	1810	Addr Current-City	•	•	R	•	R	•	T*	•	COC
	1820	Addr Current-State	•	•	R	•	R	•	T*	•	COC
	1830	Addr Current-Postal Code	•	•	R	•	R	•	T*	•	COC
New	1832	Addr Current -	•	•	R	•	R	•	•	•	NAACCR

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
		Country									
	1835	Reserved 10	•	•	•	•	•	•	•	•	
	1840	County-Current	•	•	•	•	•	•	•	•	NAACCR
Revised	1842	Follow-Up Contact-City	•	•	•	•	•	•	T*	•	SEER
Revised	1844	Follow-Up Contact-State	•	•	•	•	•	•	T*	•	SEER
Revised	1846	Follow-Up Contact-Postal	•	•	•	•	•	•	T*	•	SEER
Revised	1850	Unusual Follow-Up Method	•	•	•	•	•	•	•	•	NAACCR
	1860	Recurrence Date-1st	•	•	R	R	RC	•	T*	•	COC
	1861	Recurrence Date-1st Flag	•	•	R	R	RC	•	T*	•	NAACCR
Retired	1870	Recurrence Distant Sites									
Retired	1871	Recurrence Distant Site 1	•	•	•	•	•	•			
Retired	1872	Recurrence	•	•	•	•	•	•			

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
		Distant Site 2									
Retired	1873	Recurrence Distant Site 3	•	•	•	•	•	•			
	1880	Recurrence Type-1st	•	•	R	R	RC	•	T*	•	COC
Retired	1890	Recurrence Type-1st-Oth									
	1900	Reserved 11									
	1910	Cause of Death	√	R	•	•	R	R	•	T	SEER
	1920	ICD Revision Number	√	R	•	•	R	R	•	T	SEER
Revised	1930	Autopsy	•	•	•	•	•	•	•	•	NAACCR
Revised	1940	Place of Death	√	RH	•	•	•	•	T*	T*	NPCR
New	1942	Place of Death-State	R	R	•	•	•	•	•	•	NAACCR
New	1944	Place of Death-Country	R*	R*	•	•	•	•	•	•	NAACCR
	1960	Site (73-91) ICD-O-1	•	•	•	•	RH	RH			SEER
	1970	Morph (73-01) ICD-O-1									

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
	1971	Histology (73-91) ICD-O-1	•	•	•	•	RH	RH	•	•	SEER
	1972	Behavior (73-91) ICD-O-1	•	•	•	•	RH	RH	•	•	SEER
	1973	Grade (73-91) ICD-O-1	•	•	•	•	RH	RH	•	•	SEER
	1980	ICD-O-2 Conversion Flag	•	•	RH	RH	R	R	T*	T*	SEER
	1981	Over-ride SS/Nodes Pos	•	•	•	•	•	•	T*	T*	NAACCR
	1982	Over-ride SS/TNM-N	•	•	•	•	•	•	T*	T*	NAACCR
	1983	Over-ride SS/ TNM-M	•	•	•	•	•	•	T*	T*	NAACCR
Retired	1984	Over-ride SS/Dis Met1	•								
	1985	Over-ride Acsn/Class/Seq	•	•	R	R	•	•	T*	T*	COC
	1986	Over-ride HospSeq/	•	•	R	R	•	•	T*	T*	COC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
		DxConf									
	1987	Over-ride COC-Site/Type	•	•	R	R	•	•	T*	T*	COC
	1988	Over-ride HospSeq/ Site	•	•	R	R	•	•	T*	T*	COC
	1989	Over-ride Site/TNM-StgGrp	•	•	R	R	•	•	T*	T*	COC
	1990	Over-ride Age/Site/ Morph	D	R	R	R	R	R	T*	T*	SEER
	2000	Over-ride SeqNo/DxConf	D	R	•	•	R	R	T*	T*	SEER
	2010	Over-ride Site/Lat/ SeqNo	D	R	•	•	R	R	T*	T*	SEER
	2020	Over-ride Surg/ DxConf	D	R	R	R	R	R	T*	T*	SEER
	2030	Over-ride Site/Type	D	R	R	R	R	R	T*	T*	SEER
	2040	Over-ride Histology	D	R	R	R	R	R	T*	T*	SEER

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
	2050	Over-ride Report Source	D	R	•	•	R	R	T*	T*	SEER
	2060	Over-ride Ill-define Site	D	R	•	•	R	R	T*	T*	SEER
	2070	Over-ride Leuk, Lymphoma	D	R	R	R	R	R	T*	T*	SEER
	2071	Over-ride Site/ Behavior	D	R	R	R	R	R	T*	T*	SEER
	2072	Over-ride Site/EOD/DX Dt	D	•	•	•	R	R	T*	T*	SEER
	2073	Over-ride Site/Lat/ EOD	D	•	•	•	R	R	T*	T*	SEER
	2074	Over-ride Site/Lat/ Morph	D	R	R	R	R	R	T*	T*	SEER
	2080	Reserved 13									
	2081	CRC CHECK SUM	•	•	•	•	S	S	•	•	NAACCR
	2085	Date Case Initiated	•	•	•	•	•	•	•	•	NAACCR
	2090	Date Case	R	•	•	•	•	•	•	•	NAACCR

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
		Completed									
	2092	Date Case Complete-COC		•	R	R	•	•	•	•	COC
	2100	Date Case Last Changed	√	•	D	R	•	•	•	•	NAACCR
	2110	Date Case Report Exported	√	R	•	•	•	•	T	•	NPCR
	2111	Date Case Report Received	√	R	•	•	•	•	•	•	NPCR
	2112	Date Case Report Loaded	√	R	•	•	•	•	•	•	NPCR
	2113	Date Tumor Record Available	R	R	•	•	•	•	•	•	NPCR
Retired	2114	Future Use Timeliness 1									
Retired	2115	Future Use Timeliness 2									
	2116	ICD-O-3	D	R	•	•	R	R	T	T	SEER/COC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
		Conversion Flag									
	2120	SEER Coding Sys-Current	•	•	•	•	•	R	T*	T*	NAACCR
	2130	SEER Coding Sys-Original	•	•	•	•	•	R	T*	T*	NAACCR
	2140	COC Coding Sys-Current	•	•	R	R	•	•	T*	T*	COC
	2150	COC Coding Sys-Original	•	•	R	R	•	•	T*	T*	COC
Retired	2160	Subsq Report for Primary									
New	2161	Reserved 18									
	2170	Vendor Name	√	•	R	R	•	•	T	T	NAACCR
	2180	SEER Type of Follow-Up	•	•	•	•	R	R	•	•	SEER
	2190	SEER Record Number	•	•	•	•	•	R	•	•	SEER
	2200	Diagnostic Proc 73-87	•	•	•	•	RH	RH	•	•	SEER
	2210	Reserved 14							•	•	

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
	2220	State/Requestor Items	•	•	•	•	•	•	•	•	Varies
	2230	Name-Last	R	R	R	•	R	•	T	T	COC
	2240	Name-First	R	R	R	•	R	•	T	T	COC
	2250	Name-Middle	R	R	R	•	R	•	T*	T*	COC
	2260	Name-Prefix	•	•	•	•	•	•	•	•	NAACCR
	2270	Name-Suffix	•	•	•	•	R	•	T*	T*	NAACCR
	2280	Name-Alias	R	R	•	•	R	•	T*	T*	NAACCR
	2290	Name-Spouse/ Parent	•	•	•	•	•	•	•	•	NAACCR
	2300	Medical Record Number	R	R	R	•	R	•	T	•	COC
	2310	Military Record No Suffix	•	•	•	•	•	•	•	•	COC
	2320	Social Security Number	R	R	R	•	R	•	T	T	COC
	2330	Addr at DX-No & Street	R	R	R	•	R	•	T	T	COC
	2335	Addr at DX-Suppl	R	R	R*	•	R	•	T*	T*	COC
	2350	Addr Current-	•	•	R	•	R	•	T*	T*	COC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
		No & Street									
	2352	Latitude	D	R*	•	•	S	•	•	•	NAACCR
	2354	Longitude	D	R*	•	•	S	•	•	•	NAACCR
	2355	Addr Current-Suppl	•	•	R*	•	R	•	T*	•	COC
	2360	Telephone	•	•	R	•	R	•	T*	T*	COC
Retired	2370	DC State									
	2380	DC State File Number	R	R	•	•	R*	•	•	T*	State
Revised	2390	Name-Maiden	R √	R	•	•	R	•	T*	T*	NAACCR
Revised	2392	Follow-Up Contact-No & St	•	•	•	•	•	•	•	•	SEER
Revised	2393	Follow-Up Contact-Suppl	•	•	•	•	•	•	•	•	SEER
Revised	2394	Follow-Up Contact-Name	•	•	•	•	•	•	•	•	SEER
	2400	Reserved 15									
	2410	Institution Referred From	•	•	•	•	•	•	T*	•	COC
	2415	NPI-Inst	•	•	R	•	•	•	•	•	CMS

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
		Referred From									
	2420	Institution Referred To	•	•	•	•	•	•	T*	•	COC
	2425	NPI-Inst Referred To	•	•	R*	•	•	•	•	•	CMS
Retired	2430	Last Follow-Up Hospital									
	2440	Following Registry	•	•	•	•	R	•	•	•	COC
	2445	NPI-Following Registry	•	•	•	•	R*	•	•	•	CMS
	2450	Reserved 16									
	2460	Physician-Managing	•	•	•	•	•	•	•	•	NAACCR
	2465	NPI-Physician-Managing	•	•	R	•	•	•	•	•	CMS
	2470	Physician-Follow-Up	R	•	•	•	R	•	T*	T*	COC
	2475	NPI-Physician-Follow-Up	•	•	R	•	R*	•	•	•	CMS
	2480	Physician-	•	•	•	•	•	•	•	•	COC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
		Primary Surg									
	2485	NPI-Physician-Primary Surg	•	•	R	R	•	•	•	•	CMS
	2490	Physician 3	•	•	•	•	•	•	•	•	COC
	2495	NPI-Physician 3	•	•	R	R	•	•	•	•	CMS
	2500	Physician 4	•	•	•	•	•	•	•	•	COC
	2505	NPI-Physician 4	•	•	R	R	•	•	•	•	CMS
	2510	Reserved 12									
	2520	Text-DX Proc-PE	R^	R^	•	•	R	•	T*	T*	NPCR
	2530	Text-DX Proc-X-ray/scan	R^	R^	•	•	R	•	T*	T*	NPCR
	2540	Text-DX Proc-Scopes	R^	R^	•	•	R	•	T*	T*	NPCR
	2550	Text-DX Proc-Lab Tests	R^	R^	•	•	R	•	T*	T*	NPCR
	2560	Text-DX Proc-Op	R^	R^	•	•	R	•	T*	T*	NPCR
	2570	Text-DX Proc-Path	R^	R^	•	•	R	•	T*	T*	NPCR
	2580	Text-Primary	R	R^	•	•	R	•	T*	T*	NPCR

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
		Site Title									
	2590	Text-Histology Title	R	R^	•	•	R	•	T*	T*	NPCR
	2600	Text-Staging	R	R^	•	•	R	•	T*	T*	NPCR
	2610	RX Text-Surgery	R	R^	•	•	R	•	T*	T*	NPCR
	2620	RX Text-Radiation (Beam)	R	R^	•	•	R	•	T*	T*	NPCR
	2630	RX Text-Radiation Other	R	R^	•	•	R	•	T*	T*	NPCR
	2640	RX Text-Chemo	R	R^	•	•	R	•	T*	T*	NPCR
	2650	RX Text-Hormone	R	R^	•	•	R	•	T*	T*	NPCR
	2660	RX Text-BRM	R	R^	•	•	R	•	T*	T*	NPCR
	2670	RX Text-Other	R	R^	•	•	R	•	T*	T*	NPCR
	2680	Text-Remarks	•	•	•	•	R	•	T*	T*	NPCR
	2690	Place of Diagnosis	•	•	•	•	•	•	•	•	NPCR
New	2700	Reserved 17									

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
	2730	CS PreRX Tumor Size	•	•	•	•	•	•	•	•	AJCC
	2735	CS PreRx Extension	•	•	•	•	•	•	•	•	AJCC
	2740	CS PreRX Tum Sz/Ext Eval	•	•	•	•	•	•	•	•	AJCC
	2750	CS PreRx Lymph Nodes	•	•	•	•	•	•	•	•	AJCC
	2755	CS PreRx Reg Nodes Eval	•	•	•	•	•	•	•	•	AJCC
	2760	CS PreRx Mets at Dx	•	•	•	•	•	•	•	•	AJCC
	2765	CS PreRX Mets Eval	•	•	•	•	•	•	•	•	AJCC
	2770	CS PostRx Tumor Size	•	•	•	•	•	•	•	•	AJCC
	2775	CS Post Rx Extension	•	•	•	•	•	•	•	•	AJCC
	2780	CS Post Rx Lymph Nodes	•	•	•	•	•	•	•	•	AJCC
	2785	CS PostRx	•	•	•	•	•	•	•	•	AJCC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
		Mets Dx									
	2800	CS Tumor Size	R	R	R	R	R	R	T	T	AJCC
	2810	CS Extension	R+	R	R	R	R	R	T	T	AJCC
	2820	CS Tumor Size/Ext Eval	R+	R	R	R	R	R	T*	T*	AJCC
	2830	CS Lymph Nodes	R+	R	R	R	R	R	T	T	AJCC
	2840	CS Reg Nodes Eval	R*	R*	R	R	R	R	T*	T*	AJCC
	2850	CS Mets at DX	R+	R	R	R	R	R	T	T	AJCC
Revised	2851	CS Mets at Dx-Bone	•	•	R	R	R	R	T*	T*	AJCC
Revised	2852	CS Mets at Dx-Brain	•	•	R	R	R	R	T*	T*	AJCC
Revised	2853	CS Mets at Dx-Liver	•	•	R	R	R	R	T*	T*	AJCC
Revised	2854	CS Mets at Dx Lung	•	•	R	R	R	R	T*	T*	AJCC
	2860	CS Mets Eval	R*	R	R	R	R	R	T*	T*	AJCC
	2861	CS Site-Specific Factor	RS	RS*	RS	RS	RS	RS	T*	T*	AJCC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
		7									
	2862	CS Site-Specific Factor 8	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
	2863	CS Site-Specific Factor 9	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
	2864	CS Site-Specific Factor 10	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
	2865	CS Site-Specific Factor 11	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
	2866	CS Site-Specific Factor 12	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
	2867	CS Site-Specific Factor 13	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
	2868	CS Site-Specific Factor	RS	RS	RS	RS	RS	RS	T*	T*	AJCC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
		14									
	2869	CS Site-Specific Factor 15	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
	2870	CS Site-Specific Factor 16	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
	2871	CS Site-Specific Factor 17	RS	RS*	RS	RS	RS	RS	T*	T*	AJCC
	2872	CS Site-Specific Factor 18	RS*	RS*	RS	RS	RS	RS	T*	T*	AJCC
	2873	CS Site-Specific Factor 19	RS*	RS*	RS	RS	RS	RS	T*	T*	AJCC
	2874	CS Site-Specific Factor 20	RS*	RS*	RS	RS	RS	RS	T*	T*	AJCC
	2875	CS Site-Specific Factor	RS	RS*	RS	RS	RS	RS	T*	T*	AJCC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
		21									
	2876	CS Site-Specific Factor 22	RS	RS*	RS	RS	RS	RS	T*	T*	AJCC
	2877	CS Site-Specific Factor 23	RS	RS*	RS	RS	RS	RS	T*	T*	AJCC
	2878	CS Site-Specific Factor 24	RS*	RS*	RS	RS	RS	RS	T*	T*	AJCC
	2879	CS Site-Specific Factor 25	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
Revised	2880	CS Site-Specific Factor 1	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
Revised	2890	CS Site-Specific Factor 2	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
Revised	2900	CS Site-Specific Factor	RS	RS	RS	RS	RS	RS	T*	T*	AJCC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
		3									
Revised	2910	CS Site-Specific Factor 4	RS	RS*	RS	RS	RS	RS	T*	T*	AJCC
Revised	2920	CS Site-Specific Factor 5	RS	RS*	RS	RS	RS	RS	T*	T*	AJCC
Revised	2930	CS Site-Specific Factor 6	RS	RS*	RS	RS	RS	RS	T*	T*	AJCC
	2935	CS Version Original	D	R	R	R	D	R	•	•	AJCC
Revised	2936	CS Version Derived	D	R+	R	R	D	R	•	•	AJCC
Revised	2937	CS Version Input Current	D	R	R	R	D	R	T*	T*	AJCC
	2940	Derived AJCC-6 T	•	•	D	R	D	R	T*	T*	AJCC
	2950	Derived AJCC-6 T Descript	•	•	D	R	D	R	T*	T*	AJCC
	2960	Derived AJCC-	•	•	D	R	D	R	T*	T*	AJCC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
		6-N									
	2970	Derived AJCC-6-N Descript	•	•	D	R	D	R	T*	T*	AJCC
	2980	Derived AJCC-6 M	•	•	D	R	D	R	T*	T*	AJCC
	2990	Derived AJCC-6 M Descript	•	•	D	R	D	R	T*	T*	AJCC
	3000	Derived AJCC-6 Stage Group	•	•	D	R	D	R	T*	T*	AJCC
	3010	Derived SS1977	D	•	D	R	D	R	T*	T*	AJCC
Revised	3020	Derived SS2000	D	D+	D	R	D	R	T*	T*	AJCC
	3030	Derived AJCC-Flag		•	D	R	D	R	T*	T*	AJCC
	3040	Derived SS1977-Flag	^	•	D	R	D	R	T*	T*	AJCC
Revised	3050	Derived SS2000-Flag	^	D+	D	R	D	R	T*	T*	AJCC
	3100	Archive FIN	•	•	R	R	•	•	•	•	COC
	3105	NPI-Archive FIN	•	•	R	R	•	•	•	•	CMS
	3110	Comorbid/Com	•	•	R	R	•	•	T*	•	COC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
		plication 1									
	3120	Comorbid/Complication 2	•	•	R	R	•	•	T*	•	COC
	3130	Comorbid/Complication 3	•	•	R	R	•	•	T*	•	COC
	3140	Comorbid/Complication 4	•	•	R	R	•	•	T*	•	COC
	3150	Comorbid/Complication 5	•	•	R	R	•	•	T*	•	COC
	3160	Comorbid/Complication 6	•	•	R	R	•	•	T*	•	COC
	3161	Comorbid/Complication 7	•	•	R	R	•	•	T*	•	COC
	3162	Comorbid/Complication 8	•	•	R	R	•	•	T*	•	COC
	3163	Comorbid/Complication 9	•	•	R	R	•	•	T*	•	COC
	3164	Comorbid/Complication 10	•	•	R	R	•	•	T*	•	COC
	3165	ICD Revision Comorbid	•	•	R	R	•	•	T*	•	COC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
Revised	3170	RX Date-Mst Defn Srg	•	•	R	R	•	•	T*	•	COC
	3171	RX Date Mst Defn Srg Flag	•	•	R	R	•	•	T*	•	NAACCR
Revised	3180	RX Date-Surg Disch	•	•	R	R	•	•	•	•	COC
	3181	RX Date Surg Disch Flag	•	•	R	R	•	•	•	•	NAACCR
	3190	Readm Same Hosp 30 Days	•	•	R	R	•	•	•	•	COC
	3200	Rad-Boost RX Modality	•	•	R	R	RC	•	T*	T*	COC
	3210	Rad-Boost Dose cGy	•	•	R	R	•	•	•	•	COC
Revised	3220	RX Date Rad Ended	•	•	R	R	•	•	•	•	COC
	3221	RX Date Rad Ended Flag	•	•	R	R	•	•	•	•	NAACCR
Revised	3230	RX Date Systemic	D	•	R	R	S	•	T*	T*	COC
	3231	RX Date	D	•	R	R	S	•	T*	T*	NAACCR

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
		Systemic Flag									
	3250	RX Summ-Transplnt/ Endocr	RS	RS	R	R	R	R	T*	T*	COC
Retired	3260	Pain Assessment									
	3270	RX Summ-Palliative Proc	•	•	R	R	•	•	T*	•	COC
	3280	RX Hosp-Palliative Proc	•	•	R	R	•	•	T*	•	COC
	3300	RuralUrban Continuum 1993	D	D	•	•	•	•	•	•	NAACCR
	3310	RuralUrban Continuum 2003	D	D	•	•	•	•	•	•	NAACCR
	3400	Derived AJCC-7 T	D	D*	D	R	D	R	T*	T*	AJCC
	3402	Derived AJCC-7 T Descrip	D	D*	D	R	D	R	T*	T*	AJCC
	3410	Derived AJCC-	D	D*	D	R	D	R	T*	T*	AJCC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
		7 N									
	3412	Derived AJCC-7 N Descrip	D	D*	D	R	D	R	T*	T*	AJCC
	3420	Derived AJCC-7 M	D	D*	D	R	D	R	T*	T*	AJCC
	3422	Derived AJCC-7 M Descrip	D	D*	D	R	D	R	T*	T*	AJCC
Revised	3430	Derived AJCC-7 Stage Grp	D	D*	D	R	D	R	T*	T*	AJCC
Revised	3440	Derived PreRx-7 T	•	•	•	•	•	•	•	•	AJCC
Revised	3442	Derived PreRx-7 T Descrip	•	•	•	•	•	•	•	•	AJCC
Revised	3450	Derived PreRx-7 N	•	•	•	•	•	•	•	•	AJCC
Revised	3452	Derived PreRx-7 N Descrip	•	•	•	•	•	•	•	•	AJCC
Revised	3460	Derived PreRx-7 M	•	•	•	•	•	•	•	•	AJCC
Revised	3462	Derived PreRx-7 M Descrip	•	•	•	•	•	•	•	•	AJCC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
Revised	3470	Derived PreRx-7 Stage Grp	•	•	•	•	•	•	•	•	AJCC
Revised	3480	Derived PostRx-7 T	•	•	•	•	•	•	•	•	AJCC
Revised	3482	Derived PostRx-7 N	•	•	•	•	•	•	•	•	AJCC
Revised	3490	Derived PostRx-7 M	•	•	•	•	•	•	•	•	AJCC
Revised	3492	Derived PostRX-7 Stge Grp	•	•	•	•	•	•	•	•	AJCC
Revised	3600	Derived Neoadjuv Rx Flag	•	•	•	•	•	•	T*	T*	AJCC
	3700	SEER Site-Specific Fact 1	•	•	•	•	•	•	•	•	SEER
	3702	SEER Site-Specific Fact 2	•	•	•	•	•	•	•	•	SEER
	3704	SEER Site-Specific Fact 3	•	•	•	•	•	•	•	•	SEER
	3706	SEER Site-	•	•	•	•	•	•	•	•	SEER

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
		Specific Fact 4									
	3708	SEER Site-Specific Fact 5	•	•	•	•	•	•	•	•	SEER
	3710	SEER Site-Specific Fact 6	•	•	•	•	•	•	•	•	SEER
New	3720	NPCR Specific Field	•	•	•	•	•	•	•	•	NPCR
Revised	3750	Over-ride CS 1	R	R	R	R	R	R	•	•	AJCC
Revised	3751	Over-ride CS 2	R	R	R	R	R	R	•	•	AJCC
Revised	3752	Over-ride CS 3	R	R	R	R	R	R	•	•	AJCC
Revised	3753	Over-ride CS 4	R	R	R	R	R	R	•	•	AJCC
Revised	3754	Over-ride CS 5	R	R	R	R	R	R	•	•	AJCC
Revised	3755	Over-ride CS 6	R	R	R	R	R	R	•	•	AJCC
Revised	3756	Over-ride CS 7	R	R	R	R	R	R	•	•	AJCC
Revised	3757	Over-ride CS 8	R	R	R	R	R	R	•	•	AJCC
Revised	3758	Over-ride CS 9	R	R	R	R	R	R	•	•	AJCC
Revised	3759	Over-ride CS 10	R	R	R	R	R	R	•	•	AJCC
Revised	3760	Over-ride CS 11	R	R	R	R	R	R	•	•	AJCC
Revised	3761	Over-ride CS	R	R	R	R	R	R	•	•	AJCC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
		12									
Revised	3762	Over-ride CS 13	R	R	R	R	R	R	•	•	AJCC
Revised	3763	Over-ride CS 14	R	R	R	R	R	R	•	•	AJCC
Revised	3764	Over-ride CS 15	R	R	R	R	R	R	•	•	AJCC
Revised	3765	Over-ride CS 16	R	R	R	R	R	R	•	•	AJCC
Revised	3766	Over-ride CS 17	R	R	R	R	R	R	•	•	AJCC
Revised	3767	Over-ride CS 18	R	R	R	R	R	R	•	•	AJCC
Revised	3768	Over-ride CS 19	R	R	R	R	R	R	•	•	AJCC
Revised	3769	Over-ride CS 20	R	R	R	R	R	R	•	•	AJCC/NPCR
New	3780	Secondary Diagnosis 1							T*		CoC
New	3782	Secondary Diagnosis 2							T*		CoC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
New	3784	Secondary Diagnosis 3							T*		CoC
New	3786	Secondary Diagnosis 4							T*		CoC
New	3788	Secondary Diagnosis 5							T*		CoC
New	3790	Secondary Diagnosis 6							T*		CoC
New	3792	Secondary Diagnosis 7							T*		CoC
New	3794	Secondary Diagnosis 8							T*		CoC
New	3796	Secondary Diagnosis 9							T*		CoC
New	3798	Secondary Diagnosis 10							T*		CoC
	7010	Path Reporting Fac ID 1	•	•	•	•	•	•	•	•	HL7
	7011	Path Reporting Fac ID 2	•	•	•	•	•	•	•	•	HL7
	7012	Path Reporting	•	•	•	•	•	•	•	•	HL7

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
		Fac ID 3									
	7013	Path Reporting Fac ID 4	•	•	•	•	•	•	•	•	HL7
	7014	Path Reporting Fac ID 5	•	•	•	•	•	•	•	•	HL7
	7090	Path Report Number 1	•	•	•	•	•	•	•	•	HL7
	7091	Path Report Number 2	•	•	•	•	•	•	•	•	HL7
	7092	Path Report Number 3	•	•	•	•	•	•	•	•	HL7
	7093	Path Report Number 4	•	•	•	•	•	•	•	•	HL7
	7094	Path Report Number 5	•	•	•	•	•	•	•	•	HL7
	7100	Path Order Phys Lic No 1	•	•	•	•	•	•	•	•	HL7
	7101	Path Order Phys Lic No 2	•	•	•	•	•	•	•	•	HL7
	7102	Path Order Phys Lic No 3	•	•	•	•	•	•	•	•	HL7

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
	7103	Path Order Phys Lic No 4	•	•	•	•	•	•	•	•	HL7
	7104	Path Order Phys Lic No 5	•	•	•	•	•	•	•	•	HL7
	7190	Path Ordering Fac No 1	•	•	•	•	•	•	•	•	HL7
	7191	Path Ordering Fac No 2	•	•	•	•	•	•	•	•	HL7
	7192	Path Ordering Fac No 3	•	•	•	•	•	•	•	•	HL7
	7193	Path Ordering Fac No 4	•	•	•	•	•	•	•	•	HL7
	7194	Path Ordering Fac No 5	•	•	•	•	•	•	•	•	HL7
	7320	Path Date Spec Collect 1	•	•	•	•	•	•	•	•	HL7
	7321	Path Date Spec Collect 2	•	•	•	•	•	•	•	•	HL7
	7322	Path Date Spec Collect 3	•	•	•	•	•	•	•	•	HL7
	7323	Path Date Spec	•	•	•	•	•	•	•	•	HL7

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP> CENTRAL	CENTRAL> CENTRAL	
		Collect 4									
	7324	Path Date Spec Collect 5	•	•	•	•	•	•	•	•	HL7
	7480	Path Report Type 1	•	•	•	•	•	•	•	•	HL7
	7481	Path Report Type 2	•	•	•	•	•	•	•	•	HL7
	7482	Path Report Type 3	•	•	•	•	•	•	•	•	HL7
	7483	Path Report Type 4	•	•	•	•	•	•	•	•	HL7
	7484	Path Report Type 5	•	•	•	•	•	•	•	•	HL7

G

APPENDIX G

REPORTABLE LIST

REPORTABLE LIST

This listing provides documentation of all conditions the TCR considers reportable. Note the following changes:

Reportable conditions from both the *International Classification of Diseases for Oncology, Second Edition (ICD-O-2)* and the *Third Edition (ICD-O-3)* are included in the listing.

- Reportable conditions and terms with behavior changed from /1 (borderline) in *ICD-O-2* to /3 (malignant) in *ICD-O-3 are included*. These conditions are reportable only when diagnosed on or after January 1, 2001.

- Conditions which are newly reportable for cases diagnosed January 1, 2010 and forward are identified by *italics.* The complete list is on pages 31-33 in the Casefinding Section.

- Several terms changed behavior from /3 (malignant) in *ICD-O-2* to /1 (borderline) in *ICD-O-3*. These conditions are reportable only when diagnosed prior to January 1, 2001, and are identified in *[brackets and italics]*.

- New terms and synonyms for existing ICD-O codes were added.

- Terms followed by asterisks (**) indicate that the terms are reportable for benign and borderline behaviors (0 and 1) only when the primary site is listed in the table Required Sites for Benign and Borderline Primary Intracranial and Central Nervous System Tumors on page 18 in the Casefinding Section. If the behavior is malignant (2 or 3) the terms are reportable for any site.

- New reportable conditions for 2013 are included and identified by **bold font.**

Adamantinoma (long bones, malignant, tibial only)
Adenoacanthoma
Adenocarcinofibroma
Adenocarcinoma
Adenofibroma (malignant endometrioid only)
Adenoma**
Adenoma (carcinoid bronchial and cylindroid bronchial only)
Adenosarcoma
AIN III (anal intraepithelial neoplasia, grade III)
ALK positive large B-cell lymphoma
Ameloblastoma (malignant only)
Androblastoma (malignant only)
Anemia, refractory
Angioendotheliomatosis
Angiolipoma**
Angiomyosarcoma
Angiosarcoma
Argentaffinoma (malignant only)

Arrhenoblastoma (malignant only)
Astroblastoma
Astrocytoma**
Astroglioma
B lymphoblastic leukemia/lymphoma,
Blastoma
Cancer
Carcinoid,malignant (exclude benign tumor of appendix, strumal, argentaffin tumor NOS, enterochromaffin-like cell NOS, and tubular)
Carcinofibroma
Carcinoma
Carcinomatosis
Carcinosarcoma
CASTLE (Carcinoma showing thymus-like element)
Chloroma
Cholangiocarcinoma
Chondroblastoma
Chondrosarcoma
Chordoma
Choriocarcinoma
Chorioepithelioma
Chorionepithelioma
Chronic lymphoproliferative disorder of NK-cells
Class IV cytology
Class V cytology
Comedocarcinoma
CPNET (central primitive neuroectodermal, NOS)
Craniopharyngioma**
Cylindroma (exclude eccrine dermal, and skin)
Cyst (dermoid with malignant transformation only or dermoid with secondary tumor)
Cystadenocarcinofibroma
Cystadenocarcinoma
Cystadenofibroma (malignant endometrioid only)
[Cystadenoma (diagnosis date prior to January 1, 2001);
mucinous, borderline malignancy
papillary, borderline malignancy
papillary mucinous, borderline malignancy
papillary pseudomucinous, borderline malignancy
papillary serous, borderline malignancy
pseudomucinous, borderline malignancy
serous, borderline malignancy]
Cystosarcoma phyllodes (malignant only)
Cytopenia, refractory with multilineage dysplasia
Dermatofibrosarcoma
Diktyoma (exclude benign)
DIN III (ductal intraepithelial neoplasia, grade III)
Disease (include only):
alpha heavy chain

Bowen
Chronic myeloproliferative
Di Guglielmo
Franklin
Gamma heavy chain
Heavy chain NOS
Hodgkin
immunoproliferative [NOS and small
intestinal only]
Letterer-Siwe
Mast cell, systemic tissue
Mu heavy chain
Myeloproliferative, chronic, NOS
Paget [exclude of bone]
Sezary

Disorder, myeloproliferative, chronic
Disorder, primary cutaneous CD30+ T-cell lymphoproliferative
Dysgerminoma
Ectomesenchymoma
Endometriosis, stromal
Enteroglucagonoma (malignant only)
Ependymoblastoma
Ependymoma**
Epithelioma (NOS, basal cell, malignant, and squamous cell only)
Erythremia (acute and chronic only)
Erythroleukemia
Erythroplasia, Queyrat
Esthesioneuroblastoma
Esthesioneurocytoma
Esthesioneuroepithelioma
Fibroblastic reticular cell tumor
Fibrochondrosarcoma
Fibrodentinosarcoma
Fibroepithelioma, of Pinkus type or NOS
Fibrolipoma**
Fibroliposarcoma
Fibroma, NOS**
Fibromyxosarcoma
Fibro-odontosarcoma
Fibrosarcoma
Fibroxanthoma (malignant only)
Gangliocytoma**
Ganglioglioma**
Ganglioneuroblastoma
Ganglioneuroma**
Gastrinoma (malignant only)
Gemistocytoma
Germinoma

GIST-Gastrointestinal stromal tumor (malignant only)
Glioblastoma
Gliofibroma**
Glioma**
Gliomatosis cerebri
Gliosarcoma
Glomangiosarcoma
Glucagonoma (malignant only)
Granuloma (Hodgkin only)
Hemangioblastoma**
Hemangioendothelioma**
Hemangioma**
Hemangiopericytoma**
Hemangiosarcoma
Hepatoblastoma
Hepatocarcinoma
Hepatocholangiocarcinoma
Hepatoma (exclude benign)
Hidradenocarcinoma
Hidradenoma (malignant only)
Histiocytoma (malignant fibrous only)
Histiocytosis (malignant, and acute progressive X only)
Histiocytosis, Langerhans cell, disseminated or generalized
Hutchinson melanotic freckle (melanoma in situ only)
Hydroa vaccinforme-like lymphoma
Hypernephroma
Immunocytoma
Insulinoma (malignant only)
Intravascular large B-cell lymphoma
Langerhans cell histiocytosis, NOS
Langerhans cell histiocytosis, multifocal
Langerhans cell histiocytosis, unifocal
Large B-cell lymphoma arising in HHV8-associated multicentric Castleman disease
LCIS, NOS (lobular carcinoma in situ)
Leiomyoma (NOS)**
Leiomyomatosis (NOS)**
Leiomyosarcoma
Lentigo maligna
Leukemia
Linitis plastica
Lipoma (atypical or NOS)**
Liposarcoma (exclude well differentiated liposarcoma, superficial)
LN2 (of breast also called lobular neoplasia, grade 2 only)
Lymphangioendothelioma (malignant only)
Lymphangiosarcoma
Lymphoblastoma
Lymphoepithelioma
Lymphoma

Lymphosarcoma
Macroglobulinemia, Waldenstrom
Malignancy
Malignant
Malignant Poorly Differentiated neuroendocrine tumors
Mastocytoma (malignant only)
Mastocytosis (malignant only)
Medulloblastoma
Medulloepithelioma
Medullomyoblastoma
Melanocytoma, meningeal
Melanoma (exclude juvenile)
Melanocytoma, meningial**
Melanocytosis, diffuse**
Melanomatosis, meningeal
Melanosis (precancerous only)
Meningioma**
Meningiomatosis**
Mesenchymoma (malignant only)
Mesonephroma (exclude benign)
Mesothelioma (exclude benign and cystic)
Metaplasia, agnogenic myeloid
Microglioma
Mixed phenotype acute leukemia
MPNST, NOS (malignant peripheral nerve sheath tumor)
Multiple neurofibromatosis
Mycosis fungoides
Myeloid and lymphoid neoplasms
Myelodysplastic/Myeloproliferative neoplasm
Myelofibrosis (acute, chronic idiopathic, with myeloid metaplasia or as a result of myeloproliferative disease only)
Myeloma
Myelomatosis
Myelosclerosis (megakaryocytic, acute, malignant or with myeloid metaplasia)
Myelosis
Myoblastoma (malignant granular cell only)
Myoepithelioma (malignant only)
Myosarcoma
Myosis, stromal NOS or endolymphatic stromal
Myxoliposarcoma
Myxosarcoma
Neoplasia, ductal intraepithelial, grade 3 (of breast, also called DIN III)
Neoplasia, intratubular germ cell
Neoplasia, lobular, grade 2 of breast only (also called LN2)
Neoplasia, squamous intraepithelial, grade 3 (of anus, vulva and vagina only- also called, AIN III, VIN III and VAIN III)
Neoplasm (malignant only)
Neoplasm**

Nephroblastoma
Nephroma (exclude mesoblastic)
Neurilemmoma**
Neurilemmosarcoma
Neuroblastoma
Neurocytoma**, olfactory
Neuroepithelioma
Neurofibroma**
Neurofibromatosis (NOS)**
Neurofibrosarcoma
Neuroma (NOS)**
Neurosarcoma
Neurothekeoma**
Nevus (malignant blue only)
Odontosarcoma
Oligoastrocytoma, mixed
Oligodendroblastoma
Oligodendroglioma
Orchioblastoma
Osteochondrosarcoma
Osteoclastoma (malignan only)
Osteofibrosarcoma
Osteosarcoma
Pancreatoblastoma
Panmyelosis, acute only
Papilloma**
Papulosis, lymphomatoid
Paraganglioma **
Paragranuloma, Hodgkin
Perineural MPNST
Perineurioma**
Pheochromoblastoma
Pheochromocytoma (malignant only)
Pilomatrixoma (malignant only)
Pinealoma (NOS)**
Pineoblastoma
Pineocytoma**
Pituitary Adenoma
Plasmacytoma
Plasmablastic lymphoma
PNET (primitive neuroectodermal tumor)
Pneumoblastoma
Polycythemia (proliferative, rubra vera, or vera)
Polyembryoma
Polymorphic PTLD
Polyposis (malignant lymphomatous only)
Porocarcinoma
Poroma, eccrine (malignant only)

PPNET (peripheral primitive neuroectodermal tumor)
Preleukemia
Primary cutaneous follicle centre lymphoma
Primary cutaneous gamma-delta T-cell lymphoma
Prolactinoma**
Pseudomyxoma peritonei
Queyrat erythroplasia
Rathke Pouch Tumor
Refractory neutropenia
Refractory thrombocytopenia
Reticuloendotheliosis
Reticulosarcoma
Reticulosis (histiocytic medullary, malignant, pagetoid, and polymorphic only)
Retinoblastoma
Rhabdomyoma (NOS)**
Rhabdomyosarcoma
Rhabdosarcoma
Sarcoma (exclude well differentiated liposarcoma, superficial)
Sarcomatosis (meningeal only)
Schwannoma
Secondary Neuroendocrine tumors
Seminoma
SETTLE (spindle epithelial tumor with thymus-like element)
Somatostatinoma (malignant only)
Spermatocytoma
Spiradenoma (malignant only)
Spongioblastoma
Spongioneuroblastoma
Stromatosis, endometrial
Struma (malignant ovarii and Wuchernde Langhans only)
Subependymoma**
Subependymoma-ependymoma, mixed
Sympathicoblastoma
Syndrome,
- 5q deletion with Myelodysplastic (5q-) syndrome
- Hypereosinophilic
- Myelodysplastic
  - NOS
  - with 5q deletion syndrome
  - therapy-related, NOS
  - therapy-related, alkylating agent related
  - therapy-related, epidopophyllotoxin related
- Preleukemic
- Sezary

Synovioma (NOS and malignant only)
Syringoma chondroid, (malignant only)
Systemic EBV positive T-cell Lymphoproliferative disease of childhood
T-cell/histiocyte rich large B-cell lymphoma

T-cell large granular lymphocytic leukemia
T lymphoblastic leukemia/lymphoma
Teratoblastoma, malignant
Teratocarcinoma
Teratoma**
Thecoma (malignant only)
Thrombocythemia (essential, essentialhemorrhagic, idiopathic, or idiopathic hemorrhagic)
Thymoma (malignant or type C only)
Tumor (include only):
- adenocarcinoid
- adrenal cortical (malignant only)
- alpha cell (malignant only)
- Askin
- Bednar
- beta cell (malignant only)
- Brenner (malignant only)
- Burkitt
- carcinoid, NOS (except of appendix)
- carcinoid (malignant only)
- cells**
- desmoplastic small round cell
- dysembryoplastic neuroepithelial**
- embolus
- endodermal sinus
- epithelial**
- Ewing
- fibrous, solitary**
- follicular dendritic cell
- fusiform cell type (malignant only)
- G cell (malignant only)
- gastrin cell (malignant only)
- gastrointestinal stromal (malignant only)
- germ cell
- giant cell (malignant only)
- glomus (malignant only)
- granular cell**
- granulosa cell (malignant or sarcomatoid only)
- Grawitz
- interstitial cell (malignant only)
- intravascular bronchial alveolar
- Klatskin
- Krukenberg
- Leydig cell (malignant only)
- malignant (any type)
- mast cell (malignant only)
- Merkel cell
- mesenchymal (malignant only)
- mesodermal, mixed

metastatic
mixed pineal
mixed salivary gland type (malignant only)
[mucinous, of low malignant potential; *diagnosis date prior to January 1, 2001]*
mucocarcinoid
Mullerian mixed
neuroectodermal (exclude melanotic)
nonencapsulating sclerosing
odontogenic (malignant only)
olfactory, neurogenic
Pancoast
[papillary mucinous, of low malignant potential; diagnosis date prior to January 1, 2001]
[papillary serous, of low malignant potential; diagnosis date prior to January 1, 2001]
peripheral neuroectodermal or peripheral primitive neuroectodermal, NOS
peripheral nerve sheath (malignant only)
phyllodes (malignant only)
pineal parenchymal of intermediate differentiation
Pinkus
plasma cell
polyvesicular vitelline
primitive neuroectodermal
rhabdoid, NOS
rhabdoid/teratoid, atypical
round cell, desmoplastic, small
Schminke
Secondary
[serous, NOS, of low malignant potential serous, papillary, of low malignant potential diagnosis date prior to January 1, 2001]
Sellar region granular cell tumor
Sertoli-Leydig cell (poorly differentiated, with heterologous elements, sarcomatoid (malignant only)
sinus, endodermal
small cell type (malignant only)
smooth muscle (NOS)**
soft tissue**
spindle cell type (malignant only)
spindle epithelial with thymus-like element or thymus-like differentiation
steroid cell (malignant only)
sweat gland (malignant only)
teratoid/rhabdoid, atypical
transitional pineal
Triton, malignant
trophoblastic, epithelioid
vitelline, polyvesicular
Wilms
yolk sac or yolk sac, hepatoid
Ulcer, rodent
VAIN III (vaginal intraepithelial neoplasia, grade 3)
VIN III (vulvar intraepithelial neoplasia, grade 3)

Vipoma (malignant only)
Xanthoastrocytoma, pleomorphic

Resource: NAACCR's *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, March 2013*

H

APPENDIX H

QUICK REFERENCE

Department of State Health Services
Texas Cancer Registry
Chapter 2 Handbook Quick Reference Sheet

The Sample Abstract Form can be found in Appendix D in the 2013 CRH.

Data Field 540 REPORTING FACILITY NUMBER (pg 46)**:** Enter 3 digit code assigned by TCR. If you do not know your facility number, contact your regional office or call 1-800-252-8059.

Data Field 500 REPORTING SOURCE (pg 46)**:** Enter code for the source documents and/or facility used to abstract the case.
1 - Hospital inpatient; Managed health plans with comprehensive, unified medical records
2 - Radiation Treatment Centers or Medical Oncology Centers (Facility or Private)
3 - Laboratory Only (Facility or Private)
4 - Physician's Office/Private Medical Practitioner
5 - Nursing/Convalescent Home, Hospice
6 - Autopsy Only
7 - Death Certificate Only
8 – Other hospital outpatient units/surgery centers
Note: *Assign codes in priority order: 1, 2, 8, 4, 3, 5, 6 and 7 (if more than one source is used)*

Data Field 580 DATE OF ADMIT/FIRST CONTACT/ADMIT (YYYYMMDD) (pg 48)**:** Enter year, month and day of the patient's first admission to your facility for diagnosis and/or treatment of this reportable cancer or, if previously diagnosed/treated elsewhere, the date of the first admission to your facility with active cancer or receiving cancer treatment.

Data Field 550 REGISTRY NUMBER (pg 50): The first four digits identify the calendar year the patient was first seen at the facility with a reportable diagnosis. The following five digits identify the numerical order in which the case was entered into the registry. Each year's accession/registry number will start with **00001**.mk

Data Field 2300 MEDICAL RECORD NUMBER (pg 50)**:** Enter the medical record number (MRN) used for the patient's first admission with a DX of cancer. MRN's less than 11 digits and alpha characters are acceptable. If the MRN is not available (for example, outpatient clinic charts) enter "OP" in this field.

Special Codes:
RT: Radiation Therapy department patient without a medical record number
SU: One-day surgery clinic patient without a medical record number
UNK: Medical Record Number Unknown

Data Field 610 CLASS OF CASE (pg 51)**:** Divides data into analytical and non-analytical categories.

Data Field 2230 PATIENT LAST NAME (pg 56)**:** Enter the name of the patient in capital letters. Hyphens, other special characters, and spaces are allowed. **Do not leave blank.**

Data Field 2240 PATIENT FIRST NAME (pg 57)**:** Enter first name of patient in capital letters. Hyphens, other special characters, and spaces are allowed. **Do not leave blank.**

Data Field 2250 PATIENT MIDDLE NAME (pg 57)**:** Enter the middle name of the patient in capital letters. Hyphens, other special characters, and spaces are allowed. Enter middle initial if full name is unknown. Leave blank if unknown.

Data Field 2390 PATIENT MAIDEN NAME (pg 58)**:** Enter the maiden name of female patients who are or have been married. Hyphens, other special characters and spaces are allowed. Leave blank if unknown.

Data Field 2280 NAME-ALIAS (pg 58): Enter an alternative name or "AKA" used by the patient, if known. If unknown, leave blank.

Data Field 2330 STREET ADDRESS (pg 59)**:** Enter the number and street of the patient's residence at the time the cancer is diagnosed in 25 characters or less. If address is not known, enter "NO ADDRESS" or "UNKNOWN". **DO NOT LEAVE BLANK**. Punctuation marks are not allowed in this field. Abbreviate, as needed using standard address abbreviations listed in the *U.S. Postal Service National Zip Code and Post Office Directory* published by the U.S. Postal Service or on the website at https://www.usps.com/

Data Field 2335 ADDRESS AT DX SUPPLEMENTAL (pg 61)**:** If the name of a facility is provided instead of an address enter the facility name here. If this space is not needed **leave it blank**.

Data Field 70 PATIENT CITY (pg 62)**:** Enter the city of residence at the time the cancer is diagnosed. If no address is known, record "Unknown". **Do not leave blank.**

Data Field 80 PATIENT STATE (pg 62)**:** Enter the two letter abbreviation for state of residence at time of diagnosis. Record US for resident of United States, NOS. If resident of foreign country, other than Mexico (MX) or Canada (CD), record either XX if the country is known or YY if the country is unknown. If no address is known, enter "ZZ".

Data Field 100 PATIENT ZIP CODE (pg 64)**:** Enter patient's zip code at time of diagnosis. If known, enter nine digit extended zip code. If unavailable, refer to National Zip Code Directory or the USPS website: http://zip4.usps.com/zip4/welcome.jsp
If resident of foreign country, code all "8's." If address is not available enter "99999".

Data Field 90 FIPS COUNTY CODE: (pg 66 & APPENDIX C) Enter the three digit Federal Information Processing Standards code found in Appendix C. Code "998" for out-of-state or foreign residents. If address is not available enter "999".

Data Field 102 ADDRESS AT DX-COUNTRY: (pg 66) Enter the appropriate alpha-3-digit code for the country of residence. Use codes issued by the United States Postal Service. Use USA for United States.

Data Field 2320 PATIENT SSN (pg 67)**:** Every resource should be exhausted to obtain social security number. If not available, code all "9's" **as a last resort only**. Take caution to enter the patient's number and not the spouse's number. Dashes and slashes are not allowed in this field.

Data Field 240 PATIENT DATE OF BIRTH (YYYYMMDD) (pg 68)**:** DOB must be coded. Enter year, month and day of patient's birth. **Unknown date of birth will not be accepted**

Data Field 254 PLACE OF BIRTH-COUNTRY (pg 69): Record the patient's country of birth (if available) using the US Postal Service. If the country of birth is unknown, code to ZZU.

Data Field 252 PLACE OF BIRTH-COUNTRY-STATE (pg 69): Record the patient's state of birth (if available) using the US Postal Service. If the state of birth is unknown, code to ZZ.

Table H.1 Data Field 160 RACE CODES 1 – 5 (page 70)**:**
Enter the 2 digit code to identify the primary race of the patient.

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

Data Field 161, 162, 163 & 164 RACE 2, **RACE 3, RACE 4, & RACE 5** (pg 73)**:** If the patient is multi-racial, code all the races using items (RACE 2) through (RACE 5) Use code "88" for no further race documented.

Table H.2 Data Field 190 SPANISH/HISPANIC ORIGIN (pg 75): This code identifies persons of Spanish or Hispanic origin. The information may be coded from the medical record or may be based on Spanish/Hispanic names. Persons of Spanish or Hispanic origin may be of any race. A list of Spanish/Hispanic surnames is in the 2013 CRH within the TCR website.

CODE	DESCRIPTION
0	Non-Spanish; non-Hispanic (includes Portuguese and Brazilian)
1	Mexican (includes Chicano, NOS)
2	Puerto Rican
3	Cuban
4	South or Central American (except Brazil)
5	Other specified Spanish/Hispanic (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 other information the person is not Hispanic. Ordinarily for central registry use only.
8	Dominican Republic (effective with diagnosis on or after 1/1/2005)
9	Unknown whether Spanish or not; not stated in patient record

Table H.3 Data Field 220 PATIENT SEX CODES (pg 76):
Enter the code to identify the gender of the patient.

CODE	DESCRIPTION
1	Male
2	Female
3	Other (Hermaphrodite) (Intersexed)
4	Trans-sexual
9	Not Stated/Unknown

Data Field 320 TEXT USUAL INDUSTRY (pg 77) Document the patient's usual industry to the extent that the information is available in the medical record.

Data Field 310 TEXT USUAL OCCUPATION (pg 78): Document the patient's usual occupation to the extent that the information is available in the medical record.

Data Field 2680 OTHER PERTINENT INFORMATION (pg 79) Document other pertinent information for which adequate or appropriate space has not been provided on the reporting form. Such information may include additional staging or treatment information, history of disease or comments regarding lack of documentation in the medical record. Document the name of the facility that referred the patient or the name of the facility that the patient was referred to in this field. Document age and race of the patient in this field.

Data Field 2470 PHYSICIAN FOLLOW UP (pg 80)**:** Record the state license number of the physician currently responsible for following the patient. Physician license numbers for Texas can be found at the following website: http://www.docboard.org/tx/df/txsearch.htm

Table H.4 Data Field 560 SEQUENCE NUMBER (pg 80): Indicates the chronological sequence of this reportable neoplasm IN THE PATIENT'S LIFETIME. Each PRIMARY tumor is assigned a different number.

MALIGNANT PRIMARIES		BENIGN PRIMARIES	
CODE	**DESCRIPTION**	**CODE**	**DESCRIPTION**
00	Unspecified number of malignant primaries	60	One benign primary only
01	One malignant primary only	61	First of multiple benign primaries
02	First of multiple malignant primaries	62	Second of multiple benign primaries
03	Second of multiple malignant primaries	63	Third of multiple benign primaries
99	Third of multiple malignant primaries	88	Unspecified number of benign primaries

Data Field 2220 OTHER PRIMARY TUMORS (SITE, MORPHOLOGY, AND DATE) (pg 82)**:** Complete **if the patient has other reportable tumors during their lifetime.** Record the site, morphology, and date of any other primaries. DO NOT INCLUDE SECONDARY/METASTATIC LESIONS.

Table H.5 Data Field 630 PRIMARY PAYER AT DX (pg 83): Record patient's insurance.

CODE	DESCRIPTION
01	Not insured
02	Not insured, self-pay
10	Insurance, NOS
20	Private Insurance: Managed Care, HMO, or PPO
21	Private Insurance: Fee-for-Service
31	Medicaid
35	Medicaid-Administered through a Managed Care plan
60	Medicare without supplement, Medicare, NOS
61	Medicare with supplement, NOS
62	Medicare-Administered through a Managed Care plan
63	Medicare with private supplement
64	Medicare with Medicaid eligibility
65	TRICARE
66	Military
67	Veterans Affairs
68	Indian/Public Health Services
99	Insurance status unknown

Data Fields 3110, 3120, 3130, 3140, 3150, 3160, 3161, 3162, 3163 and 3164 COMORBIDITIES AND COMPLICATIONS (pg 85)**:** Use only ICD-9-CM codes. Secondary diagnoses are found on the discharge abstract or coding summary. 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. **Do not leave the first data item blank.** If fewer than 10 secondary diagnoses are listed, then code the

diagnoses listed, and leave the remaining *Comorbidities and Complications* data items blank. For non-analytic cases code the first data item 00000 and leave the remaining data items blank.

Table H.6 Data Field 9970 SOURCE COMORBIDITY (pg 87)**:** Do not leave this data item blank. If no comorbid condition or complications are identified in the patient's record use code 0.

CODE	DESCRIPTION
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

Data Field 9960 HEIGHT (pg 88)**:** Enter height as a 2 digit number measured in inches. Round all inches values to the nearest whole number; values with decimal place x.5 and greater should be rounded up (code 62.5 inches as 63 inches). **Do not leave this field blank. If the information is not available use code 99 (Unknown).**

Data Field 9961 WEIGHT (pg 88)**:** Enter the weight as a 3 digits number measured in pounds. Round values to the nearest whole number. Values with decimal place x.5 should be rounded up (Code 155.5 pounds as 156). Code a weight of less than 100 pounds with a leading 0 (Code 95 pounds as 095) **Do not leave this field blank. If the information is not available use code 999 (Unknown).**

Table H.7 Non-NAACCR Standard Data Fields 9965 (TOBACCO USE CIGARETTES), 9966 (TOBACCO USE OTHER SMOKE), 9967 (TOBACCO USE SMOKELESS), and 9968 (TOBACCO USE NOS) (pg 89-91): Record the patient's past or current use of tobacco. Record from sections such as Nursing Interview Guide, Vital Stats, or Nursing Assessment section.

CODE	DESCRIPTION
0	Never used
1	Current user (as of Date of diagnosis)
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

Data Field 390 DATE OF INITIAL DIAGNOSIS (YYYYMMDD) (pg 93)**:** Enter the date of initial diagnosis of this cancer by a recognized medical practitioner **by any method** (for example, a positive finding from a radiology report); regardless of whether the diagnosis was made at this facility or elsewhere. The date of diagnosis for "Death Certificate Only" or "Autopsy Only" is the date of death. For vague dates, estimate month and year. For cases with unknown date of diagnosis code month and year of date of first contact (for June 2010 code 201006) and document "Date of dx unknown" in Other Pertinent Information Text Field. This should be used as a last resort after exhausting all available resources. Every effort must be made to obtain date of diagnosis.

Data Field 420, 430 MORPHOLOGY ICD-O-2: TYPE AND BEHAVIOR (pg 95)**:** The International Classification of Diseases for Oncology, (ICD-O) 2nd Edition, is to be used for coding and reporting the morphology and behavior of tumors diagnosed before January 1, 2001. **Adequate documentation of tumor cell type must be provided** in the **FINAL DIAGNOSIS** section of the reporting form. Use all pathology reports available; generally tissue from a resection or excision is most representative of the tumor's histology.

Data Field 522 & 523 MORPHOLOGY ICD-O-3: TYPE AND BEHAVIOR (pg 95)**:** The International Classification of Diseases for Oncology, (ICD-O) 3rd Edition is to be used for coding and reporting the morphology and behavior of tumors diagnosed on or after January 1, 2001. **Adequate documentation of tumor cell type must be provided** in the **FINAL DIAGNOSIS** section of the reporting form to support coding. Use all pathology reports available; generally tissue from a resection or excision is most representative of the tumor's histology.

Note: *Refer to Multiple Primary/Histology Rules (MP/H) for cases diagnosed on or after 1/1/2007:* http://seer.cancer.gov/tools/mphrules/download.html.

Refer to the SEER website for hematopoietic and lymphoid malignancies. Click on the following link for the 2010 and 2012 Databases and Manual: http://seer.cancer.gov/tools/heme/index.html.

Data Field 400 PRIMARY SITE (pg 99)**:** Record the specific topography code from ICD-O. **Adequate documentation must be provided** in the **FINAL DIAGNOSIS** (Data Fields 2590 and 2580) section of the reporting form to support coding.

Table H.8 Data Field 440 GRADE OF TUMOR (pg 106): The grade or differentiation of the tumor describes the resemblance of the tumor cells to their normal tissue counterparts. The more undifferentiated the tumor, the greater the incidence of metastases and the more rapid the clinical course. **Do not code the grade of a metastatic site.** If the grade for the primary is unknown enter "9" in this field.

CODE	GRADE	DESCRIPTION
1	Grade I	Well differentiated; differentiated, NOS
2	Grade II	Moderately differentiated, moderately well differentiated, intermediate differentiation, partially well differentiated, partially differentiated, low grade NOS
3	Grade III	Poorly differentiated, dedifferentiated, moderately undifferentiated, relatively undifferentiated, slightly undifferentiated, medium grade NOS
4	Grade IV	Undifferentiated; anaplastic, high grade NOS
9		Grade/differentiation not determined, not stated, not applicable; cell type not determined, not stated, not applicable

Table H.9 T-cell and B-cell designation for lymphomas and leukemia

CELL INDICATOR FOR LEUKEMIAS AND LYMPHOMAS	
CODE	**DESCRIPTION**
5	T-cell; T-precursor
6	B-cell; pre-B; B-precursor
7	Null cell; non T-non- B
8	NK (natural killer) cell

Note: For lymphomas, do not code the descriptions "high grade", "low grade", or "intermediate grade" in this field.

Refer to Appendix A of the CRH for specific coding guidelines on grade for Prostate, Breast, Kidney, Astrocytoma, Lymphoma, Leukemia, and Sarcoma primaries.

Table H.10 Data Field 441 GRADE PATH VALUE (pg 110): Documents the numerator (first number) of a tumor grade reported in a 2, 3, or 4 grade system.

CODE	DESCRIPTION
1	Recorded as Grade I or 1
2	Recorded as Grade II or 2
3	Recorded as Grade III or 3
4	Recorded as Grade IV or 4
Blank	No 2, 3, or 4 grade system available. Unknown.

Table H.11 Data Field 449 GRADE PATH SYSTEM (pg 111): Documents the denominator (second number) of a tumor grade reported in a 2, 3, or 4 grade system.

CODE	DESCRIPTION
2	Recorded as Grade II or 2
3	Recorded as Grade III or 3
4	Recorded as Grade IV or 4
Blank	No 2,3, or 4 grade system available Unknown

Table H.12 Data Field 410 LATERALITY (pg 112): Enter the code to identify the laterality of a paired site.

CODE	DESCRIPTION
0	Not a paired site
1	Right origin of primary
2	Left origin of primary
3	Only one side involved, right or left origin of primary not indicated
4	Bilateral involvement at time of diagnosis, lateral origin unknown for a single primary; or: Both ovaries simultaneously involved with a single histology, Bilateral, retinoblastomas, Bilateral Wilms' tumors. **Note**: If both lungs have nodules or tumors and the lung of origin is not known, assign code 4
5	Paired site: midline tumor
9	Unknown site; paired site, lateral origin unknown

Data Field 2580 & 2590 FINAL DIAGNOSIS- MORPHOLOGY/BEHAVIOR, GRADE, PRIMARY SITE, AND LATERALITY DOCUMENTATION (pg 117)**:** Record the morphology/behavior, grade, primary site, and laterality descriptions.

Table H.13 Data Field 1182 LYMPH-VASCULAR INVASION (pg 118): Indicates presence or absence of tumor cells in lymphatic channels.

CODE	DESCRIPTION
0	Lymph-vascular invasion not present (absent)/Not identified
1	Lymph-vascular invasion present/Identified
8	Not applicable
9	Unknown if lymph-vascular invasion present Indeterminate

Table H.14 Data Field 490 DIAGNOSTIC CONFIRMATION (pg 119): The best method of confirmation throughout the entire course of the disease. All diagnostic reports in the medical record must be reviewed to determine the most definitive method used to confirm the diagnosis of cancer.

CODE	DESCRIPTION
MICROSCOPICALLY CONFIRMED	
1	Positive histology
2	Positive cytology, no positive histology
3	Positive histology PLUS - positive immunophenotyping AND/OR positive genetic studies (Used only for hematopoietic and lymphoid neoplasms 9590-9992)
4	Positive microscopic confirmation, method not indicated
NOT MICROSCOPICALLY CONFIRMED	
5	Positive laboratory test/marker study
6	Direct visualization without microscopic confirmation
7	Radiography and other imaging techniques without microscopic confirmation
8	Clinical diagnosis only (other than 5, 6, or 7)
CONFIRMATION UNKNOWN	
9	Unknown whether or not microscopically confirmed

Data Field 2600 SUMMARY STAGE DOCUMENTATION (pg 126)**:** Text field for documentation of extent of disease to support coding. Include findings from radiology and pathology reports and descriptions of observations from history and physical and operative reports. Include dates and types of procedures and exams. Document information such as lymph node involvement, extent of invasion, extension to adjacent organs, and metastatic spread of disease. Both positive and negative findings that are pertinent to describing the spread of the tumor from the primary site should be recorded. All combined clinical and surgical assessment within **FOUR MONTHS** of diagnosis in the absence of disease progression should be documented. These findings may be obtained from diagnostic reports of radiology, endoscopy, surgery, and laboratory tests prior to treatment. Document both the date and the source of the staging information.

Data Fields 2520, 2530, 2540, 2550, 2560, 2570 DOCUMENTATION OF CANCER DIAGNOSIS, EXTENT OF DISEASE, AND TREATMENT (pg 127-133)**:** Text information to support cancer diagnosis, stage, and treatment codes **MUST BE PROVIDED BY ALL FACILITIES**. Document all

types of the **first course** of definitive treatment administered, regardless of where the treatment was received, in chronological order.

Data Field 2800 CS TUMOR SIZE (pg 134)**:** Record for cases diagnosed on or after January 1, 2004. Record the largest dimension or diameter of the **primary tumor** before systemic therapy unless the size of the tumor is greater after neoadjuvant treatment. Always record the size in millimeters.
Documentation in the Summary Stage field is required to support coding

Data Field 2810 CS EXTENSION (pg 134)**:** Record for cases diagnosed on or after January 1, 2004. Code the farthest extension of the primary tumor. Do not code discontinuous metastases in this field.
Documentation in the Summary Stage field is required to support coding.

Data Field 2820 CS /TUMOR SIZE/EXT EVAL (pg 134)**:** Identifies how codes for CS TUMOR SIZE and CS EXTENSION were determined based on the diagnostic methods employed. **Documentation in the Summary Stage text field is required to support coding.**

Data Field 2830 CS LYMPH NODES (pg 134)**:** Record for cases diagnosed on or after January 1, 2004. Identifies the regional lymph nodes involved with the cancer at the time of diagnosis. Record the specific regional lymph node chain farthest from the primary site that is involved by tumor either clinically or pathologically. Information can be obtained from; radiological reports, surgical reports, and pathology reports. If the patient receives preoperative (neoadjuvant) systemic therapy (chemotherapy, hormone therapy, and immunotherapy) or radiation therapy, code the farthest involved regional lymph nodes, based on information prior to surgery**. Exception**: In the infrequent event that clinically involved lymph nodes do not respond to neoadjuvant treatment, and are, in fact, more extensively involved at surgery as determined by the pathology report, code the lymph node involvement based on pathology/operative report after surgery.

Use code 988, not applicable, for the following sites or morphologies:

Placenta
Brain and Cerebral Meninges, Other Parts of Central Nervous System
Hodgkin and Non-Hodgkin Lymphoma
Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms
Other and Ill-Defined Primary Sites, Unknown Primary Sites

Data Field 2840 CS LYMPH NODES EVAL (pg 134)**:** Record how the code for the item *CS Lymph Nodes* was determined, based on the diagnostic methods employed and their intent. **Documentation in the Summary Stage text field is required to support coding.**

Data Field 820 REGIONAL NODES POSITIVE (pg 134)**:** Record the total number of regional lymph nodes pathologically examined and found to be positive. The number of regional lymph nodes positive is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment.

Use code 99 for sites or morphologies for which information about the field is unknown or not applicable:

Examples:

Brain
Intracranial Gland
Reticuloendotheliosis
Placenta
Leukemia, Lymphoma
Myeloma and Plasma Cell Disorder
Other and Ill-Defined Primaries, Unknown Primaries

Data Field 830 REGIONAL LYMPH NODES EXAMINED (pg 134)**:** Record the total number of regional lymph nodes removed. The number of regional lymph nodes removed is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment. If no regional lymph nodes are identified in the pathology report, code 00.

Use code 99 for sites or morphologies for which information about the field is unknown or not applicable:

Examples:

Brain
Intracranial Gland
Reticuloendotheliosis
Placenta
Leukemia, Lymphoma
Myeloma and Plasma Cell Disorder
Other and Ill-Defined Primaries, Unknown Primaries

Data Field 2850 CS METS AT DX (pg 134)**:** Record for cases diagnosed on or after January 1, 2004. Identifies the distant site(s) of metastatic involvement at time of diagnosis. Assign the highest applicable code for metastasis at the time of diagnosis. This can be determined clinically or pathologically. Information can be obtained from radiological reports, surgical reports, pathology reports, or physician notes. Metastasis known to have developed after extent of disease was established should not be considered for this field**.**
Documentation in the Summary Stage text field is required to support coding.

Data Field 2860 CS METS EVAL (pg 134)**:** Record how the code for the item *CS Mets at DX* was determined based on the diagnostic methods employed. **Documentation in the Summary Stage text field is required to support coding.**

Data Fields 2880, 2890, 2900, 2910, 2920, 2930, 2861, 2862, 2863, 2864, 2865, 2866, 2867, 2868, 2869, 2870, 2871, 2872, 2873, 2874, 2875, 2876, 2877, 2879 CS SITE-SPECIFIC FACTORS (pg 134)**:** Record for cases diagnosed on or after January 1, 2004. Identifies additional information needed to generate stage or prognostic factors that have an effect on stage or survival for certain primary sites.

Note: For the above Site-Specific Factors, refer to the specified site schemas in Appendix A for coding instructions.

Documentation in the Summary Stage text field is required to support coding.

Data Field 780 EOD-Tumor Size (pg 135): Site-specific EOD codes provide extensive detail describing disease extent. The EOD codes can be grouped into different stage categories for analysis (e.g., historical summary stage categories consistent with those used in published SEER data since 1973, or more recently, AJCC stage groupings). The codes are updated as needed, but updates are usually backward compatible with old categories. See *Comparative Staging Guide for Cancer*. See *SEER Extent of Disease, 1988: Codes and Coding Instructions*, Third Edition, for site-specific codes and coding rules for all EOD fields. The CoC codes for Tumor Size are in the *FORDS* manual.

Note: See Chapter V, Unresolved Issues, for a discussion of coding differences between CoC and SEER.

Table H.15 Data Field 760 Summary Stage 1977 (pg 135): To be used with cases diagnosed/admitted prior to 2001. Summary Stage refers to the extent of disease categorized as in-situ, localized, regional, and distant.

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

Note: Do not use Code “8” for Summary Stage.

Table H.16 Data Field 759 SUMMARY STAGE 2000 (pg 136): To be used with cases diagnosed/admitted January 1, 2001 and after. Summary Stage refers to the extent of disease categorized as in-situ, localized, regional, and distant.

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

Note: Do not use Code "8" for Summary Stage.

Data Field 1260 DATE OF INITIAL TREATMENT (YYYYMMDD) (pg 142)**:** Enter the date the first course of treatment (surgery, radiation, systemic or other) started at any facility. **Note: This field will no longer be derived.**

Table H.17 Data Field 1261 DATE OF INITIAL RX FLAG (pg 144): This flag explains why there is no appropriate value in the corresponding date field.

CODE	DESCRIPTION
10	No information whatsoever can be inferred from this exceptional value (unknown if therapy was administered)
11	No proper value is applicable in this context (for example, no treatment given or autopsy only)
(blank)	A valid date value is provided in item *Date of Initial Treatment* (NAACCR Item #1260).

Data Field 1292 SCOPE OF REGLN SURGERY (pg 144)**:** Enter the code that defines the removal of regional lymph nodes. If no cancer-directed procedure was performed code (0).

Data Field 1200 RX DATE-SURGERY (YYYYMMDD) (pg 149)**:** Document and enter the date of the **first** definitive cancer-directed surgery performed at any facility. If two or more cancer-directed surgeries are performed, enter the date for the first cancer-directed surgery. If surgery was done but the date is unknown record the year and month of diagnosis and leave the day blank.

Table H.18 Data Field 1201 RX DATE SURGERY FLAG (pg 150): This flag explains why there is no appropriate value in the corresponding date field.

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).
(blank)	A valid date value is provided in item *Date of First Surgical Procedure* (NAACCR Item #1200).

Data Field 1290 SURGERY RX CODE (pg 150)**:** Document and code the most definitive first course cancer-directed surgery at any facility. Cancer-directed surgery is an operative procedure that actually removes, excises, or destroys cancer tissue of the primary site. Surgery performed solely for the purpose of establishing a diagnosis/stage (exploratory surgery), the relief of symptoms (bypass surgery), or reconstruction is not considered cancer-directed surgery. Brushings, washings and aspiration of cells are not surgical procedures.

Table H.19 Data Field 1340 REASON FOR NO SURGERY (pg 152): If no cancer directed surgery to the primary site was performed record the reason.

CODE	DESCRIPTION
0	Surgery of the primary site was performed
1	Not part of the planned first course
2	Not recommended due to patient risk factors
5	Patient died prior to planned or recommended surgery
6	Surgery recommended and unknown why not performed
7	Patient or family refused surgery
8	Surgery recommended, unknown if performed
9	Unknown if surgery recommended or performed

Data Field 1294 RX SUMM-SURG.OTH REG/DIST RX CODE (pg 154)**:** Document and code the highest numbered code that describes the surgical resection of Regional/Distant Sites and Distant lymph nodes.

Data Fields 2610, 2620, 2640, 2650, 2660, 2670 TREATMENT DOCUMENTATION (pg 156, 162, 170, 174, 178, 187 respectively)**:** Text field used to support codes in the treatment fields. Document all planned treatment even if it is unknown if treatment was given. List dates and types of all treatment given, even if it was done at another facility.

Data Field 1210 DATE RADIATION STARTED (YYYYMMDD) (pg 156)**:** Document and enter the date radiation began at any facility as part of the first course of treatment. Record all zeros when no radiation therapy is delivered or the cancer was diagnosed at autopsy. Record all 9's when it is unknown whether any radiation therapy was delivered.

Table H.20 Data Field 1211 DATE RADIATION FLAG (pg 157): This flag explains why there is no appropriate value in the corresponding date field.

CODE	DESCRIPTION
10	No information whatsoever can be inferred from this exceptional value (unknown if radiation given).
11	No proper value is applicable in this context (for example, no radiation given)
15	Information is not available at this time, but it is expected that it will be available later.
(blank)	A valid date value is provided in item Date Radiation Started (NAACCR Item #1210).

Data Field 1570 RAD-REG RX MODALITY CODE (pg 158)**:** Document and code the dominant modality of radiation therapy used to deliver the clinically most significant dose to the primary volume of interest during first course of treatment.

Table H.21 Data Field 1360 RX SUMM-RAD (pg 160): Document and code type of radiation therapy performed as part of the first course of treatment

CODE	DESCRIPTION
0	None; Diagnosed at autopsy
1	Beam radiation
2	Radioactive implants
3	Radioisotopes
4	Combination of 1 with 2 or 3
5	Radiation, NOS-method of source not specified
7	Patient or patient's guardian refused radiation therapy
8	Radiation recommended, unknown if administered
9	Unknown if radiation administered

Table H.22 Data Field 1380 RX SUMM-SURG/RAD SEQ (pg 163): Code the sequence of radiation and surgical procedures given as part of the first course of treatment.

CODE	DESCRIPTION
0	No radiation therapy and/or surgical procedures
2	Radiation therapy before surgery
3	Radiation therapy after surgery
4	Radiation therapy both before and after surgery
5	Intraoperative radiation therapy
6	Intraoperative radiation therapy with other therapy administered before or after surgery
7	Surgery both before and after radiation
9	Sequence unknown, but both surgery and radiation were given

Table H.23 Data Field 1430 REASON NO RADIATION (pg 165): Code the reason no regional radiation therapy was administered to the patient.

CODE	DESCRIPTION
0	Radiation therapy was administered.
1	Radiation therapy was not administered because it was not part of the planned first course treatment.
2	Radiation therapy was not recommended/administered because it was contraindicated due to other patient risk factors.
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 and autopsy cases only.

Data Field 1220 CHEMOTHERAPY DATE STARTED (YYYYMMDD) (pg 166)**:** Record the first or earliest date of chemotherapy. If no chemotherapy was given or it is unknown if chemotherapy was given, leave the field blank.

Table H.24 Data Field 1221 CHEMOTHERAPY DATE STARTED FLAG (pg 167): This flag explains why there is no appropriate value in the corresponding date field.

CODE	DESCRIPTION
10	No information whatsoever can be inferred from this exceptional value (unknown if chemotherapy was given).
11	No proper value is applicable in this context (no chemotherapy given)
15	Information is not available at this time, but it is expected that it will be available later (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).

Data Field 1390 CHEMOTHERAPY CODE (pg 167)**:** Document and code the type of chemotherapy the patient received as part of the first course of treatment at any facility. Chemotherapy may involve the delivery of one or a combination of chemotherapeutic agents. Code 88 if the only information available is that the patient was referred to an oncologist. Code 00 if chemotherapy was not delivered

Data Field 1230 DATE HORMONE THERAPY STARTED (YYYYMMDD) (pg 170)**:** Record the first or earliest date on which hormone therapy was given as part of first course of treatment. If no hormone therapy was given or it is unknown if hormone therapy was given, leave this field blank.

Table H. 25 Data Field 1231 RX DATE HORMONE FLAG (pg 171): This flag explains why there is no appropriate value in the corresponding date field

CODE	DESCRIPTION
10	No information whatsoever can be inferred from this exceptional value (unknown if any hormone therapy was given).
11	No proper value is applicable in the context (no hormone therapy given).
15	Information is not available at this time, but it is expected that it will be available later.
(blank)	A valid date is provided in item Date Hormone Therapy Started (NAACCR Item #1230).

Data Field 1400 RX SUMM-HORMONE (pg 172)**:** Document and code the type of hormone therapy the patient received as part of the first course of treatment at any facility. Hormonal therapy may involve the delivery of one or a combination of agents. Code 88 when the only information available is the patient was referred to an oncologist. Code 00 if hormone therapy was not delivered

Data Field 1240 IMMUNOTHERAPY DATE STARTED (YYYYMMDD) (pg 175)**:** Record the date of initiation of immunotherapy or a biologic response modifier (BRM) that is part of the first course of therapy. If no immunotherapy was given or it is unknown if immunotherapy was given, leave this field blank.

Table H.26 Data Field 1241 IMMUNOTHERAPY DATE STARTED FLAG (pg 176)**:** This flag explains why there is no appropriate value in the corresponding date field.

CODE	DESCRIPTION
10	No information whatsoever can be inferred from this exceptional value (unknown if immunotherapy was given).
11	No proper value is applicable in this context (no immunotherapy given)
15	Information is not available at this time, but it is expected that it will be available later (immunotherapy is planned as part of first course treatment, but had not yet been started at the time of the last follow-up)
(blank)	A valid date is provided in item *Date Immunotherapy Started* (NAACCR Item #1240)

Data Field 1410 IMMUNOTHERAPY CODE (pg 176)**:** Document and code the type of Immunotherapy the patient received as part of the first course of treatment at any facility. Code to 88 when the only information is that the patient was referred to an oncologist. Code 00 if Immunotherapy was not delivered.

Data Field 3250 TRANSPLANT/ENDOCRINE CODE (pg 179)**:** Code the type of hematologic transplant and/or endocrine procedures the patient received as part of the first course of treatment at any facility. Code 88 if the only information is that the patient was referred to a specialist for hematologic transplant or endocrine procedures. Code 00 if a transplant or endocrine procedure was not done.

Table H.27 Data Field 1639 RX SUMM—SYSTEMIC SURG SEQ (pg 181): Code the administration of systemic therapy in sequence with the first surgery performed, described in the data item **Date of First Surgical Procedure.**

CODE	DESCRIPTION
0	No systemic therapy and/or surgical procedures
2	Systemic therapy before surgery
3	Systemic therapy after surgery
4	Systemic therapy both before and after surgery
5	Intraoperative systemic therapy
6	Intraoperative systemic therapy with other therapy administered before or after surgery
7	Surgery both before and after systemic therapy
9	Sequence unknown

Data Field 1250 DATE OTHER TREATMENT STARTED (YYYYMMDD) (pg 184)**:** Enter the date other treatment is delivered that is not included in surgery, radiation therapy, and systemic treatment. If no other treatment was given or it is unknown if other treatment was given, leave the field blank.

Table H.28 Data Field 1251 RX DATE OTHER FLAG (pg 185)**:** This flag explains why there is no appropriate value in the corresponding date field.

CODE	DESCRIPTION
10	No information whatsoever can be inferred from this exceptional value (unknown if any Other Treatment was given).
11	No proper value is applicable in this context (for example, no Other Treatment given).
(blank)	A valid date value is provided in item *Date Other Treatment Started* (NAACCR Item #1250).

Data Field 1420 OTHER TREATMENT CODE (pg 185)**:** Document and code the type of "other treatment" the patient received as part of the first course of treatment at any facility. "Other treatment" is designed to modify or control the cancer cells, but is not included in surgery, radiation, or systemic therapy.

Table H.29 Data Field 1285 RX SUMM-TREATMENT STATUS (pg 188)**:** Code whether or not first course treatment was given.

CODE	DESCRIPTION
0	No treatment given
1	Treatment given
2	Active surveillance (watchful waiting)
9	Unknown if treatment was given

Data Field 1750 DATE OF LAST CONTACT OR DEATH (YYYYMMDD**)** (pg 188)**:** Enter the date the patient was last seen at your facility, date of last contact, or date of death. If patient is known to be deceased, but date of death is not available, date of last contact should be recorded in this field. In the "Other Pertinent Information" text area, document the patient is deceased and the date of death is not available.

Table H.30 Data Field 1760 VITAL STATUS (pg 189)**:** Patient's vital status as of the date recorded in the "Date of last contact/death" field.

CODE	DESCRIPTION
0	Dead
1	Alive

Data Field 1942 PLACE OF DEATH - STATE (pg 189)**:**
See Appendix B of the *SEER Program Code Manual* for numeric and alphabetic lists of places and codes: http://seer.cancer.gov/tools/codingmanuals/index.html.

Table H.31 Data Field 1944 PLACE OF DEATH-COUNTRY (pg 190): Use the International Standards Organization (ISO) 3166-1 Country Three Character Codes, whenever possible, augmented by custom codes.

CODE	DESCRIPTION
USA	United States
ZZN	North America NOS
ZZC	Central America NOS
ZZX	Non-US NOS
ZZU	Unknown

Data Field 2090 DATE ABSTRACTED (YYYYMMDD) (pg 190)**:** Record year, month, and day reporting form is completed.

Data Field 570 ABSTRACTOR INITIALS (pg 191)**:** Record the initials of the abstractor.

DEPARTMENT OF STATE HEALTH SERVICES
TEXAS CANCER REGISTRY

CASEFINDING QUICK REFERENCE

Casefinding and Reportable List (Detailed instructions on pages 17-30)

1. Every inpatient and outpatient case with active disease and/or receiving cancer-directed therapy **must** be reported to the Department of State Health Services, Texas Cancer Registry (TCR) regardless of the state or country of residence.

2. Cases of cancer to be reported to the TCR include:

- All neoplasms with a behavior code of two or three in the International Classification of Diseases for Oncology (ICD-O) 3rd edition (with certain exceptions); and

- All benign and borderline neoplasms of the central nervous system with a morphology term and code listed in ICD-O-3 (includes brain and other CNS neoplasms)

Note: Benign and borderline CNS cases diagnosed prior to 2004 are no longer required to be submitted to the TCR.

3. Obtain disease indices including both inpatient and outpatient admissions after medical records are completed and coded (monthly or quarterly).

4. Check the indices against a list of cases previously reported to the TCR to identify new cases.

5. Complete an abstract for patients found on the disease index with a reportable diagnosis not previously submitted to the TCR. Patients who have been previously reported to the TCR need to be checked for possible multiple primaries. Refer to the *Multiple Primaries/Histology Rules* (MP/H) and to the *2010 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* for assistance.

6. To prevent reporting a primary for a patient twice, compare the patient name and primary cancer site from your registry database (accession list) to the TCR facility data report. The TCR facility data report lists all the patients a facility has reported to TCR for multiple years.

7. Other department logs/records (radiation therapy logs, emergency department logs, oncology unit records, surgery logs, etc.) are to be reviewed in the same method as the disease index to insure all reportable cases are submitted to the TCR.

8. Pathology reports, including all histology, cytology, hematology and autopsy reports, should be reviewed to identify all reportable neoplasms. These should also be reviewed against a list of records submitted to the TCR.

The following lists are intended to aid the appropriate personnel in creating a disease index with the required reportable neoplasms and ICD-9-CM codes. **A DI with the reportable ICD-9-CM codes will require a 100% review.**

Table H. 32 Reportable ICD-9-CM Codes

ICD-9-CM CODE (100% Review Required)	DESCRIPTION
140.0 - 208.92	Malignant neoplasms
209.0 - 209.29	Malignant carcinoid tumors
209.30 - 209.36	Malignant poorly differentiated neuroendocrine carcinoma; Merkel cell carcinoma
209.70 - 209.79	Secondary neuroendocrine tumors
225.0 - 225.9	Benign neoplasms of brain and spinal cord
227.3	Benign neoplasms of pituitary gland and craniopharyngeal duct (pouch) Reportable inclusion terms: Benign neoplasm of craniobuccal pouch, hypophysis, Rathke's pouch or sella turcica
227.4	Benign neoplasm of pineal gland
228.02	Hemangioma; of intracranial structures Reportable inclusion terms: Angioma NOS, Cavernous nevus, Glomus tumor, Hemangioma (benign)
228.1	Lymphangioma, any site This code includes Lymphangiomas of Brain, Other parts of nervous system and endocrine glands, which are reportable
230.0 - 234.9	Carcinoma in-situ (exclude 233.1, cervix)
236.0	Endometrial stroma, low grade (8931/1) Reportable inclusion terms: Stromal endometriosis (8931/3 per ICD-O-3) Stromal myosis (endolymphatic) (8931/3 per ICD-O-3) Stromatosis, endometrial (8931/3 per ICD-O-3)
237.0 - 237.1	Neoplasm of uncertain behavior (borderline) of pituitary gland, craniopharyngeal duct and pineal gland.
237.5 - 237.6	Neoplasm of uncertain behavior (borderline) of brain, spinal cord and meninges
237.72	Neurofibromatosis, type 2 (acoustic neurofibromatosis) **Note**: Acoustic neuromas growing along the acoustic nerve. See supplementary list for Neurofibromatosis, unspecified (237.70) and Neurofibromatosis, type 1 (237.71)
237.9	Neoplasm of other and unspecified parts of nervous system (cranial nerves)
238.4	Polycythemia vera (9950/3)

ICD-9-CM CODE (100% Review Required)	DESCRIPTION
238.6	Neoplasms of uncertain behavior of other and unspecified sites and tissues, Plasma cells (Plasmacytoma, extramedullary, 9734/3) Reportable inclusion terms: Plasmacytoma NOS (9731/3) Solitary myeloma (9731/3)
238.7	Other lymphatic and hematopoietic tissues **Note**: This code was expanded 10/2006. It is now a subcategory and is no longer valid for use for coding purposes. It should be included in extract programs for quality control purposes.
238.71	Essential thrombocythemia (9962/3) Reportable inclusion terms: Essential hemorrhagic thrombocythemia Essential thrombocytosis Idiopathic thrombocythemia Primary thrombocythemia Thrombocythemia vera ***Note:* Primary thrombocythemia, thrombocythemia vera and essential thrombocytosis are considered synonyms for essential thrombocythemia but are not listed in *ICD-O-3.* In the absence of a specific code for the synonym, code to the preferred term. Refer to *2012 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual.***
238.72	Low grade myelodysplastic syndrome lesions (includes 9980/3, 9982/3, 9983/3, 9985/3) Reportable inclusion terms: Refractory anemia (RA) (9980/3) Refractory anemia with excess blasts-1 (RAEB-1) (9983/3) Refractory anemia with ringed sideroblasts (RARS) (9982/3) Refractory cytopenia with multilineage dysplasia (RCMD) (9985/3) Refractory cytopenia with multilineage dysplasia and ringed sideroblasts (RCMD-RS) (9985/3)
238.73	High grade myelodysplastic syndrome lesions (includes 9983/3) Reportable inclusion terms: Refractory anemia with excess blasts-2 (RAEB-2)
238.74	Myelodysplastic syndrome with 5q deletion (9986/3) Reportable inclusion terms: 5q minus syndrome NOS
238.75	Myelodysplastic syndrome, unspecified (9985/3, 9987/3)

ICD-9-CM CODE (100% Review Required)	DESCRIPTION
238.76	Myelofibrosis with myeloid metaplasia (9961/3) Reportable inclusion terms: Agnogenic myeloid metaplasia Idiopathic myelofibrosis (chronic) Myelosclerosis with myeloid metaplasia Primary myelofibrosis Excludes: myelofibrosis NOS myelophthisis anemia (not reportable) myelophthisis(not reportable)
238.77	Post-transplant lymphoproliferative disorder (9987/3)
238.79	Other lymphatic and hematopoietic tissues (includes 9960/3, 9961/3, 9970/1, 9931/3) Reportable inclusion terms Lymphoproliferative disease (chronic) NOS (9970/1) Megakaryocytic myelosclerosis (9961/3) Myeloproliferative disease (chronic) NOS (9960/3) Panmyelosis (acute) (9931/3)
239.6	Neoplasms of unspecified nature, brain
239.7	Neoplasms of unspecified nature; endocrine glands, and other parts of nervous system
273.2	Other paraproteinemias Reportable inclusion terms: Franklin's disease (heavy chain) (9762/3) Heavy chain disease (9762/3) Mu heavy chain disease (9762/3)
273.3	Macroglobulinemia Reportable inclusion terms: Waldenstrom's macroglobulinemia (9761/3) Waldenstrom's (macroglobulinemia) syndrome
277.89	Other specified disorders of metabolism Hand-Schuller-Christian disease Histiocytosis (acute) (chronic) Histiocytosis (chronic)
288.4	Hemophagocytic Syndromes (9751/3, 9754/3) Reportable inclusion term: Histiocytic syndromes
V10.0-V10.89	Personal history of malignancy **Note**: Screen for recurrences, subsequent primaries, and/or subsequent treatment

ICD-9-CM CODE (100% Review Required)	DESCRIPTION
V10.90	Personal history of unspecified malignant neoplasm Screen for recurrences, subsequent primaries, and/or subsequent treatment.
V10.91	Personal history of malignant neuroendocrine tumor, carcinoid tumor, Merkel cell carcinoma Screen for recurrences, subsequent primaries, and/or subsequent treatment.
V12.41	Personal history of benign neoplasm of the brain

A DI with supplementary ICD-9-CM Codes should be reviewed based on the instructions on page 22 in the Casefinding Section of the TCR CRH.

Table H. 33 Supplementary ICD-9-CM Code List

ICD-9-CM CODE (5% Review Required)	EXPLANATION OF CODES
042	Acquired Immunodeficiency Syndrome (AIDS) **Note**: This is not a malignancy. Medical coders are instructed to add codes for AIDS-associated malignancies. Screen 042 for history of cancers that might not be coded.
079.4	Human papillomavirus (HPV)
079.50-079.59	Retrovirus (HTLV, types I, II and 2)
209.40 - 209.69	Benign carcinoid tumors
210.0-229.9	Benign neoplasms (except for 225.0-225.9, 227.3, 227.4, 228.02, and 228.1, which are listed in the Reportable list) **Note**: Screen for incorrectly coded malignancies or reportable by agreement tumors.
235.0-236.7 236.90-236.99	Neoplasms of uncertain behavior (except for 236.0, which is listed in the Reportable list) **Note**: Screen for incorrectly coded malignancies or reportable by agreement tumors.
237.2-237.4	Neoplasm of uncertain behavior of adrenal gland, paraganglia and other and unspecified endocrine glands **Note**: Screen for incorrectly coded malignancies or reportable by agreement tumors.
237.70-237.71	Neurofibromatosis, unspecified and Type 1 **Note**: An inherited condition with developmental changes in the nervous system, muscles, bones and skin; multiple soft tumors (neurofibromas) distributed over the whole body. (See Reportable list for Neurofibromatosis, type 2, 237.72)
237.73	Schwannomatosis **Note**: Screen for incorrectly coded malignancies or reportable by agreement tumors.

ICD-9-CM CODE (5% Review Required)	EXPLANATION OF CODES
237.79	Other neurofibromatosis **Note**: Screen for incorrectly coded malignancies or reportable by agreement tumors.
238.0-239.9	Neoplasms of uncertain behavior (except for 238.4, 238.6, 238.71-238.79, 239.6, 239.7, which are listed in the Reportable list.) **Note**: Screen for incorrectly coded malignancies or reportable by agreement tumors.
249.20	Secondary diabetes with hypersmolarity
253.6*	Syndrome of inappropriate secretion of antidiuretic hormone
259.2*	Carcinoid Syndrome
259.8*	Other specified endocrine disorders
273.0	Polyclonal hypergammaglobulinemia (Waldenstrom) **Note**: Review for miscodes
273.1	Monoclonal gammopathy of undetermined significance (9765/1) **Note**: Screen for incorrectly coded Waldenstrom's macroglobulinemia or progression.
273.8	Other disorders of plasma protein metabolism
273.9	Unspecified disorder of plasma protein metabolism **Note**: Screen for incorrectly coded Waldenstrom's macroglobulinemia
275.42*	Hypercalcemia
277.88	Tumor lysis syndrome/Tumor lysis syndrome following antineoplastic drug therapy
279.02-279.06	Selective IgM immunodeficiency **Note**: Associated with lymphoproliferative disorders
279.2-279.9	Combined immunity deficiency-Unspecified disorder of immune mechanism
284.1	Pancytopenia
284.81	Red cell aplasia (acquired, adult, with thymoma)
284.89	Other specified aplastic anemias due to drugs (chemotherapy or immunotherapy), infection, radiation
284.9	Aplastic anemia, unspecified **Note**: Review for miscodes
285.0	Sideroblastic anemia
285.3	Antineoplastic chemotherapy induced anemia (Anemia due to antineoplastic chemotherapy)
287.39, 287.49, 287.5	Other primary, secondary and unspecified thrombocytopenia
288.03	Drug induced neutropenia
288.3	Eosinophilia **Note:** This is the code for eosinophilia (9964/3). Not every case of eosinophilia is associated with a malignancy. Diagnosis must be "Hypereosinophilic syndrome" to be reportable.
289.6	Familial polycythemia **Note:** This is a symptom of polycythemia vera.

ICD-9-CM CODE (5% Review Required)	EXPLANATION OF CODES
289.89	Other specified diseases of blood and blood-forming organs **Note**: Review for miscodes
289.9	Unspecified diseases of blood and blood forming organs
323.81	Encephalomyelitis: specified cause NEC
337.9	Unspecified disorder of autonomic nervous system
338.3	Neoplasm related pain (acute) (chronic)
352.9	Unspecified disorder of cranial nerves
353.8	Other nerve root and plexus disorders
379.5_	Nystagmus and other irregular eye movements
512.82	Secondary spontaneous pneumothorax
516.5	Adult pulmonary Langerhans cell histiocytosis (Effective 10/1/2011)
528.01	Mucositis due to antineoplastic therapy
630	Hydatidiform Mole (9100/0) **Note**: This is a benign tumor that can become malignant. If malignant, it should be reported as Choriocarcinoma (9100/3) and will have a malignancy code in the 140-209 range.
648.9_	Other current conditions classifiable elsewhere
686.01*	Pyoderma gangrenosum
694.4*	Pemphigus
695.89*	Other specified erythematous conditions
701.2*	Acquired Acanthosis nigricans
710.3*	Dermatomyositis
710.4*	Polymyositis
713.8	Arthropathy associated with other conditions classified elsewhere
728.9	Unspecified disorder of muscle, ligament, and fascia
731.1	Osteitis deformans in diseases classified elsewhere
731.3	Major osseous defect
733.10-733.16	Pathologic fracture **Note**: pathologic fractures can be due to bone structure weakening by pathological processes (e.g. osteoporosis, neoplasms and osteomalacia)
758.0	Down's Syndrome **Note**: Screen for myeloid leukemia associated with Down's Syndrome (9898/3)
780.79	Neoplastic (malignant) related fatigue
785.6	Enlargement of lymph nodes **Note**: Screen for large B-cell lymphoma arising in HHV8-associated multicentric Castleman disease (9738/3)
789.51	
790.93	Elevated prostate specific antigen (PSA)
791.9	Other non-specific findings on examination of urine
792.0, 792.2, 792.4,	Non specified abnormal findings in specified and unspecified body

ICD-9-CM CODE (5% Review Required)	EXPLANATION OF CODES
792.9	structures
793.11	Solitary pulmonary nodule (Effective 10/1/2011)
793.8_	Non-specific (abnormal) findings on radiological and examination of body structure (breast)
795.0	Papanicolaou smear of cervix with cytologic evidence of malignancy
795.1	Papanicolaou smear of anus with cytologic evidence of malignancy
795.4	Other nonspecific abnormal histological findings
795.8_	Abnormal tumor markers: Elevated tumor associated antigens (TAA); Elevated tumor specific antigens (TSA); Excludes: elevated prostate specific antigen (PSA) (790.93)
962.1, 963.1	Poisoning by hormones, antineoplastic, immunosuppressive drugs
990	Effects of radiation, unspecified
996.54	Mechanical complication of other specified prosthetic device, implant, and graft-due to breast prosthesis
796.7	Papanicolaou smear of anus with cytologic evidence of malignancy
996.85	Complication of transplanted organ
999.3_	Other infection due to central venous catheter, transfusion, infusion (Effective 10/1/2011
E858.0-E858.2	Accidental poisonings
E873.2	Failure in dosage, overdose of radiation in therapy
E878.0	Abnormal reaction of surgical operation with transplant of whole organ
E879.2	Adverse effect of radiation therapy
E930.7	Adverse effect of antineoplastic therapy
E932.1	Adverse reaction to antineoplastic therapy
E933.1	Adverse effect of immunosuppressive drugs
V07.5_	Prophylactic use of agents affecting estrogen receptors and estrogen levels
V13.89	Personal history of unspecified malignant neoplasm and history of in-situ neoplasm of other site
V15.22	Personal history of undergoing in utero procedure during pregnancy
V15.3	Irradiation: previous exposure to therapeutic or ionizing radiation
V16._	Family history of malignant neoplasm
V42.81	Organ or tissue replaced by transplant, Bone marrow transplant
V42.82	Transplant; Peripheral stem cells
V51.0	Encounter for breast reconstruction following mastectomy
V52.4	Breast prosthesis and implant
V54.2	Aftercare for healing pathologic fracture
V58.0	Encounter for radiation therapy
V58.1_	Encounter for antineoplastic chemotherapy and immunotherapy **Note**: This code was discontinued as of 10/2006 but should be included

ICD-9-CM CODE (5% Review Required)	EXPLANATION OF CODES
	in extract programs for quality control purposes.
V58.11	Encounter for antineoplastic chemotherapy
V58.12	Encounter for antineoplastic immunotherapy
V58.42	Aftercare following surgery for neoplasm
V66.1	Convalescence following radiotherapy
V66.2	Convalescence following chemotherapy
V66.7	Encounter for palliative care
V67.1	Radiation therapy follow up
V67.2	Chemotherapy follow up
V71.1	Observation for suspected malignant neoplasm
V72.83	Other specified pre-operative examination
V76.0-V76.9	Special screening for malignant neoplasm
V78.0-V78.9	Special screening for disorders of blood and blood-forming organs
V86._	Estrogen receptor positive status
V87.41, V87.43, V87.46	Personal history of antineoplastic chemotherapy, estrogen therapy and immunosuppression therapy

***Note**: These diseases are part of the paraneoplastic syndrome. Paraneoplastic syndrome is not cancer. It is a disease or symptom that is the consequence of cancer but is not due to the local presence of cancer cells. A paraneoplastic syndrome may be the first sign of cancer.

Table H.34 The following are **exclusions** and **do not** need to be reported to the TCR:

ICD-O-3 MORPHOLOGY CODES	DIAGNOSIS/TERMINOLOGY
8000–8005	Neoplasms, malignant, NOS of the skin
8010/2	Carcinoma in-situ of cervix (CIN) **beginning with 1996 cases**
8010–8046	Epithelial carcinomas of the skin
8050–8084	Papillary and squamous cell carcinomas of the skin **except genital sites**
8077/2	Squamous Intraepithelial Neoplasia, grade III of cervix **beginning with 1996 cases; CIN**
8090–8110	Basal cell carcinomas of the skin **except genital sites**
8148/2	Prostatic Intraepithelial Neoplasia (PIN)

Ambiguous Terminology

The following terms are diagnostic of cancer: Apparent(ly), Appears, Comparable with, Compatible with, Consistent with, Favor(s), Malignant appearing, Most likely, Neoplasm (beginning with 2004 diagnosis and only for C700-C729, C751-C753), Presumed, Probable, Suspect(ed), Suspicious(for) Tumor (beginning with 2004 diagnosis and only for C700-C729, C751-C753), Typical (of).

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

Exception: If cytology is reported as "suspicious" do not interpret this as a diagnosis of cancer. Report the case only if there is either a positive biopsy, a physician's clinical diagnosis of cancer supporting the cytology findings, or cancer directed therapy is administered.

Note: This list should be used only for determining case reportability. Do not use this list to determine the appropriate histology or stage.

Cases To Report Only If Cancer-Directed Therapy Is Planned Or Given

- Cases diagnosed and/or treated for cancer prior to admission should be reported if there is evidence of active disease, whether or not diagnostic or therapeutic procedures were performed.

- Cases diagnosed at autopsy, with no suspicion prior to death that the cancer existed, should be reported.

- Abstract cases using the medical record from the first admission (inpatient or outpatient) to your facility with a reportable diagnosis. Use information from subsequent admissions to include all first course treatment information and to supplement documentation.

- Do not report cases diagnosed prior to 1995

- Do not complete a report for each admission; submit one report per primary tumor.

Examples:

a. A patient is diagnosed with prostate cancer and has several admissions for treatment of the prostate cancer. Only one abstract should be completed.

b. A patient is diagnosed with two separate primary tumors, such as adenocarcinoma of the prostate and squamous cell carcinoma of the lung. Complete one abstract for the prostate primary and another for the lung.

Helpful Hints:

- Report all cases of *active* cancer regardless of state of residence.

- Report all inpatients and outpatients.

- Do not report basal or squamous cell carcinomas of the skin, except skin of genital sites.

- To ensure case ascertainment, review the disease indexes; pathology, cytology, hematology, and autopsy reports.

- Do not complete an abstract for each admission.

- Report all benign and borderline neoplasms of the central nervous system.
- Cases in which the disease is no longer active (such as leukemia in remission) should only be reported if the patient is still receiving cancer-directed therapy.
- Do not report carcinoma in situ of cervix (any histology).
- Do not report intraepithelial neoplasia of the prostate (PIN III).

TREATMENT STANDARD TABLES

Table H.35 Scope of Regional Lymph Node Surgery Codes

CODE	DESCRIPTION
0	None
1	Biopsy or aspiration of regional lymph nodes, NOS
2	Sentinel lymph node biopsy (only)
3	Number of regional lymph nodes removed unknown or not stated; regional lymph nodes removed, NOS
4	1–3 regional lymph nodes removed
5	4 or more regional lymph nodes removed
6	Sentinel lymph node biopsy and code 3, 4, or 5 at same time, or timing not stated
7	Sentinel node biopsy and code 3, 4, or 5 at different times
9	Unknown or not applicable

Note: For specific instructions on coding this data field see page 144 of this manual.

Table H.36 Scope of Regional Lymph Node Surgery for Breast

Note: For specific instructions on coding this data field go to:
http://web2.facs.org/cstage0204/breast/Breastschema.html

CODE	DESCRIPTION
0	None
1	Biopsy or aspiration of regional lymph nodes, NOS
2	Sentinel lymph node biopsy (only)
3	Number of regional lymph nodes removed unknown or not stated; regional lymph nodes removed, NOS
4	1–3 regional lymph nodes removed
5	4 or more regional lymph nodes removed
6	Sentinel lymph node biopsy and code 3, 4, or 5 at same time, or timing not stated
7	Sentinel node biopsy and code 3, 4, or 5 at different times
9	Unknown or not applicable

Table H.37 Surgery Codes

CODE	DESCRIPTION
00	None
10-19	Site-specific codes; tumor destruction
20-80	Site-specific codes; resection
90	Surgery, NOS
98	Site-specific surgery codes; special
99	Unknown

Note: See Site Specific Surgery Codes in Appendix A

Table H.38 RX Summ—Radiation Codes

CODE	DESCRIPTION
0	None; Diagnosed at autopsy
1	Beam radiation
2	Radioactive implants
3	Radioisotopes
4	Combination of 1 with 2 or 3
5	Radiation, NOS-method of source not specified
7	Patient or patient's guardian refused radiation therapy
8	Radiation recommended, unknown if administered
9	Unknown if radiation administered

Note: For specific instructions on coding this data field see page 160 of this manual.

Table H.39 Radiation-Regional Treatment Modality Codes

CODE	DESCRIPTION
00	No radiation treatment
20	External beam, NOS
21	Orthovoltage
22	Cobalt-60, Cesium-137
23	Photons (2-5 MV)
24	Photons (6-10 MV)
25	Photons (11-19 MV)
26	Photons (>19 MV)
27	Photons (mixed energies)
28	Electrons
29	Photons and electrons mixed
30	Neutrons with or without photons/electrons
31	IMRT
32	Conformal or 3-D therapy
40	Protons
41	Stereotactic radiosurgery, NOS
42	Linac radiosurgery
43	Gamma knife
50	Brachytherapy, NOS
51	Brachytherapy, intracavitary, low dose rate (LDR)
52	Brachytherapy, intracavitary, high dose rate (HDR)
53	Brachytherapy, Interstitial, LDR
54	Brachytherapy, Interstitial, HDR
55	Radium
60	Radioisotopes, NOS
61	Strontium-89
62	Strontium-90
80*	Combination modality, specified
85*	Combination modality, NOS
98	Other, NOS
99	Unknown

Note: For specific instructions on coding this data field see page 159 of this manual.

Table H.40 Chemotherapy.Codes

CODE	DESCRIPTION
00	None; chemotherapy was not part of the first course of therapy
01	Chemotherapy administered as first course of therapy, but the type and number of agents is not documented in the patient record.
02	Single-agent chemotherapy administered as first course of therapy.
03	Multi-agent chemotherapy was delivered as first course of therapy.
82	Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors i.e., comorbid conditions, advanced age.
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 the patient record.
87	Chemotherapy was not delivered. 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.

Note: For specific instructions on coding this data field see page 169 of this manual

Table H.41 Hormone Therapy Codes

CODE	DESCRIPTION
00	None; hormone therapy was no not part of the planned first course of therapy.
01	Hormone therapy was delivered as first course of therapy.
82	Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age).
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 treatment. 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	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.

Note: For specific instructions on coding this data field see page 172 of this manual.

Table H.42 Immunotherapy Codes

CODE	DESCRIPTION
00	None, immunotherapy was not part of the first course of therapy.
01	Immunotherapy administered as first course of therapy
82	Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., 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 treatment. 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 immunotherapy agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Note: For specific instructions on coding this data field see page 177 of this manual.

Table H.43 RX Summ-Transplant/Endocrine Codes

CODE	DESCRIPTION
00	No transplant procedure or endocrine therapy was administered as part of the first course of therapy.
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
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 were not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age).
85	Hematologic transplant and/or endocrine surgery/radiation were 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 therapy. No reason was stated in patient's record.
87	Hematologic transplant and/or endocrine surgery/radiation were 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 were recommended, but it is unknown if it was administered.
99	It is unknown whether hematologic transplant and/or endocrine surgery/radiation were recommended or administered because it is not documented in the medical record. Death certificate only.

Note: For specific instructions on coding this data field see page 179 of this manual.

Table H. 44 Other Treatment Codes

CODES	DESCRIPTION
0	None
1	Other
2	Other-Experimental
3	Other-Double Blind
6	Other-Unproven
7	Refusal
8	Recommended; unknown if administered
9	Unknown

Note: For specific instructions on coding this data field see page 185 of this manual.

COLLABORATIVE STAGE STANDARD TABLES

CS TUMOR SIZE: Instructions for Coding

1. **Timing rule.** Refer to general guidelines for Collaborative Stage for timing rules for data collection.

2. **Schema-specific instructions:** Refer to site/histology-specific instructions (notes before the table) for additional information. Schema-specific instructions take priority over general instructions. Where there are no site/histology-specific instructions, the general instructions apply.

3. **Record the largest tumor diameter from reports in the following order**:

c. Record tumor size **from the pathology report**, if it is available, when the patient receives no radiation or systemic treatment prior to surgery. Tumor size is the diameter of the tumor, not the depth or thickness of the tumor. If there is a discrepancy among tumor size measurements in the various sections of the pathology report, code the size from the final diagnosis, synoptic report, (also known as CAP protocol or pathology report checklist), microscopic, then gross examination, in that order.

Example: Pathology report states lung carcinoma is 2.1 cm x 3.2 cm x 1.4 cm. *Record tumor size as 032.*

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*.

d. If the patient receives preoperative (neoadjuvant) systemic therapy (chemotherapy, hormone therapy, and immunotherapy) or radiation therapy, **code the largest size of tumor prior to neoadjuvant treatment unless the size of tumor is larger at surgery (see below)**.

Example: Patient has a 2.2 cm mass in the oropharynx; fine needle aspiration of mass confirms squamous cell carcinoma. Patient receives a course of neoadjuvant combination chemotherapy. Pathologic size of tumor after total resection is 0.8 cm. *Record tumor size as 022*.

e. **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, just above a physical exam.

f. **Tumor size discrepancies among reports:** If there is a difference in reported tumor size among imaging and radiographic techniques, record the largest size of tumor reported in the record, regardless of which imaging technique reports it.

g. **If no response to neoadjuvant treatment:** In the infrequent event that the tumor does not respond to neoadjuvant treatment and is, in fact, larger after preoperative treatment as determined by the operative or pathology report, code the greatest tumor size and code CS Tumor Size/Ext Eval as 6, based on pathology/operative report after treatment.

- If clinical tumor size is unknown but a pathologic tumor size is given after treatment and clinician states there was a response to neoadjuvant, code TS as 999 and TS/Ext Eval as 5.

- If clinical tumor size is unknown but a pathologic tumor size is given and clinician states no response to treatment, code TS from path report and TS Ext eval as 6.

4. **Record the exact size of the primary tumor** for all sites/histologies except those for which it is stated to be not applicable. Code the exact size in preference to a statement of a T category or a size range (see special codes below). If there is no reference at all about tumor size in the record, code as 999.

a. 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.

b. **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: A 3.3 cm tumor would be 33 millimeters and would be coded as 033.

Example: Tumor is described as 2.4 x 5.1 x 1.8 cm in size. *Record tumor size as 051.*

c. Record the size of the invasive component, if given.

d. 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.*

e. ***Additional rule for breast primaries:*** 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: Infiltrating duct carcinoma with extensive in situ component; total size 2.3 cm. *Record tumor size as 023.*

Example: Duct carcinoma in situ covering a 1.9 cm area with focal areas of invasive ductal carcinoma. *Record tumor size as 019.*

Note: For breast cancer, document how the size of the tumor was determined in Site Specific Factor 6. Information from the pathology report can be used to identify in situ versus invasive tumor even if exact size is not given. If tumor size is a clinical measurement only in the range 001-989, Site Specific Factor 6 must be coded as 987.

f. For purely ***in situ*** **lesions, code the size as stated**.

g. **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 field.

h. **Do not add 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 clinician gives a size not in agreement with the pathologist or pathology report, the clinician statement must be confirmed with pathology prior to reporting/coding.

i. **When residual tumor is larger than excisional biopsy:** If an excisional biopsy is performed and residual tumor at time of resection of the primary is found to be larger than the excisional biopsy, code the size of the residual tumor.

j. **No clinical size but incisional needle biopsy:** Code the size from an incisional needle biopsy only when no residual tumor is found on further resection **or** on the rare occasion when the size of the tumor on incisional needle biopsy is larger than the size of the tumor on resection. If there is no further resection, do not code the size from the incisional needle biopsy; code 999 in the absence of a clinical size.

k. **Malignant melanoma of skin, mucosal membrane, mucosa of head and neck sites, or eye.** Record tumor size (diameter or lateral dimension) for malignant melanoma. Depth of invasion (tumor thickness) is coded in a site-specific factor.

l. **Multifocal/multicentric tumors:** If the tumor is multi-focal or there are multiple tumors being reported as a single primary, code the size of the largest tumor.

m. **Size stated as T_:** If both a T category and exact tumor size are given, code the exact size. If the only information about tumor size given in the medical record is a physician statement of a T category, determine whether the T category is based on tumor size or extension.

- If the T category is based solely on tumor size, use the appropriate “Stated as T_, NOS” code in CS Tumor Size **or** select the appropriate code from the 99_ series (see below for special codes).

- If the T category is based on extension, use the appropriate “Stated as T_” code in CS Extension. iii. If the T category is based on both tumor size and extension, use the appropriate “Stated as T_, NOS” code in CS Extension. Code a specific tumor size as stated in the medical record. If an explicit tumor size is not given but there is a “Stated as

T_ value based on size, code the tumor size in the 99_ series in CS Tumor Size. Otherwise, use code 999.

5. Special codes

a. **Use field for tumor dimension only:** Tumor dimension is to be recorded for all schemas, except as noted below. Other information collected in this field in previous staging systems, such as depth of invasion for melanoma, has been moved to Site-Specific Factors for those sites/histologies.

b. **No size reported:** If size is not reported, code as 999, which means unknown size or not documented in the patient record.

c. **Use of Code 000:** Code 000 indicates no mass or no tumor was found at the primary site; for example, when a tumor has metastasized but no tumor can be found at the primary site.

d. **Use of code 990:** Code 990, Microscopic focus or foci only and no size is given, should be used when no gross tumor is seen and tumor is only identified microscopically.

Note: The terms microscopic focus, microfocus, and microinvasion are NOT the same as [macroscopic] focal or focus. A macroscopic focus or foci indicates a very small or isolated area, pinpoint, or spot of tumor that may be visible grossly. Only tumor identified microscopically should be coded to 990. If the tumor is described as both a microscopic focus and a specific size, code the specific size.

Example: Ovary specimen: extensive cystic disease with focal areas of tumor seeding. *Disregard "focal" and code tumor size to 999 unknown.*

Example: Cervix conization: severe dysplasia with focal areas of microinvasion. *Code tumor size as 990 microscopic focus, no size given.*

Example: Multicentric microscopic foci in breast, largest is 0.5 millimeters. *Code tumor size as 001.*

e. **Non-specific size descriptions:** Codes 991 through 995 are non-specific size descriptions that, for some sites, could still be used to determine a T category. However, if a specific size is given, code the more precise size in the range 001-989. If the tumor is described as "greater than 5 cm" and there is not an applicable code in the site-specific schema, record as 051.

f. **Site-specific special codes:** Other special codes in the range 996 to 997 are used on a site specific basis. See the individual site/histology schemas for further information and definitions.

g. **Use of code 998:** The descriptions in code 998 take precedence over any mention of size. Code 998 is used only for the following schemas sites:

Esophagus (C15.0-C15.5, C15.8-C15.9): Circumferential
EsophagusGEJunction (C16.0-C16.2): Diffuse; widespread: 3/4s or more; linitis plastica
Stomach (C16.0-C16.6, C16.8-C16.9): Diffuse; widespread; 3/4s or more; linitis plastica
Appendix (C18.1): Familial/multiple polyposis
Carcinoid of appendix (C18.1): Familial/multiple polyposis

Colon (C18.0, C18.2-C18.9): Familial/multiple polyposis
Rectosigmoid and rectum (C19.9, C20.9): Familial/multiple polyposis
Lung and main stem bronchus (C34.0-C34.3, C34.8-C34.9): Diffuse, entire lung or NOS
Breast (C50.0-C50.6, C50.8-C50.9): Diffuse

h. **Size not applicable.** For the following diagnoses and/or primary sites, size is not applicable. *Code as 988:*

Disseminated Langerhans cell histiocytosis (Letterer-Siwe disease)
Hematopoietic neoplasms
Immunoproliferative diseases
Kaposi sarcoma
Leukemia
Malignant lymphoma (Hodgkin lymphoma and non-Hodgkin lymphoma) other than ocular adnexal lymphoma
Mast cell tumors
Multiple myeloma and other plasma cell tumors
Myelodysplastic syndromes
Myeloproliferative diseases
Polycythemia Vera
Polymorphic Post-Transplant Lymphoproliferative Disorder (PTLD)
Refractory anemias
Other Hematopoietic, Reticuloendothelial, Immunoproliferative, and Myeloproliferative Neoplasms (*see HemeRetic schema for a complete list of codes and diagnoses)*
MelanomaChoroid
MelanomaCiliaryBody
MelanomaIris

i. **Use of CS Tumor Size/Ext Eval field with CS Tumor Size.** The source of the tumor size (radiographs, endoscopy, pathology specimen, etc.) is documented in the CS Tumor Size/Ext Eval field when tumor size is the determining factor for the T category.

Table H.45 Document tumor size code in text.

CODE	DESCRIPTION
000	No mass/tumor found
001-988	Exact size in millimeters
989	989 millimeters or larger
990	Microscopic focus or foci only and no size of focus is given
991	Described as “less than 1 cm”
992	Described as “less than 2 cm” or “greater than 1 cm,” or “between 1 cm and 2 cm”
993	Describes as “less than 3 cm,” or “greater than 2 cm,” or “between 2 cm and 3 cm”
994	Described as “less than 4 cm,” or “greater than 3 cm,” or “between 3 cm and 4 cm”
995	Described as “less than 5 cm,” or “greater than 4 cm,” or “between 4 cm and 5 cm”
996-998	**SITE-SPECIFIC CODES WHERE NEEDED**
999	Unknown; size not stated Not documented in patient record

Note: Remember to check individual schemas for site-specific codes

Table H.46 For schemas that do not use tumor size.

CODE	DESCRIPTION
988	Not applicable

CS EXTENSION

Instructions for Coding

1. **Code the farthest documented extension of the primary tumor.** Do not include discontinuous metastases to distant sites (these are coded in CS Mets at Dx) except for corpus uteri, ovary, fallopian tube, and female peritoneum (see 2f below).

Example: In the CS Extension table for colon, Note 2 states that codes 600-800 are used for contiguous extension from the site of origin, and discontinuous involvement is coded in CS Mets at Dx. Thus direct tumor extension from the transverse colon onto the surface of the liver would be coded as CS Extension 600, while hematogenous metastases within the liver would be coded as CS Mets at Dx 26.

Note: For a few schemas such as breast, lung, and kidney, some codes in CS Mets at Dx are distant direct (contiguous) extension either in the summary staging system or in TNM. If the structure involved by direct extension is not listed in CS Extension, look for a code in CS Mets at Dx. Code the involved structure wherever it is listed—the CS computer algorithm will derive the correct stage in both TNM and summary stage. If the specific structure involved by direct extension is not listed in either CS Extension or CS Mets at Dx, code as CS Extension 800, further contiguous extension.

2. **Record extension information in the following priority order**:

a. **No neoadjuvant treatment planned or administered.** Record extension **from the pathology report**, if it is available, when the patient receives no radiation or systemic treatment prior to surgery.

b. **Neoadjuvant treatment planned and administered.** If the patient receives preoperative (neoadjuvant) systemic therapy (chemotherapy, hormone therapy, immunotherapy) or radiation therapy, **code the farthest extension identified prior to treatment (clinically).**

Example: Patient has rectal mass firmly fixed to pelvic wall (clinically T4, extension code 610). Patient undergoes preoperative radiation therapy. The pathology report from the low anterior resection shows residual tumor outside the rectum in perimuscular tissue (pathologically T3, extension code 400). *Code extension as 610, because the preoperative treatment apparently "shrank" the tumor away from the pelvic wall.*

c. **Partial or no response to neoadjuvant treatment.** In the infrequent event that the tumor does not respond to neoadjuvant treatment and is, in fact, more extensive after preoperative treatment as determined by the operative or pathology report, code the farthest extension and code CS Tumor Size/Ext Eval as 6, based on pathology/operative report after treatment. If response to treatment is unknown, code the farthest clinical extension and code CS Tumor Size/Ext Eval as 5.

Example: Patient found to have an obstructing central lung tumor very close to the main stem bronchus (clinically T2, extension code 200). Patient undergoes six weeks of intensive chemotherapy. At resection,

tumor was observed directly extending into trachea (pathologically T4, extension code 700). *Code extension as 700, because the tumor was noted to be more extensive after the preoperative treatment.*

Example: Patient has a 5.5 cm hard, moveable mass in the right breast (clinically T3, extension code 100) and receives preoperative chemotherapy. The pathology report from the modified radical mastectomy shows residual 2.8 cm mass with infiltration of the deep subcutaneous tissues over the mass (pathologically T2, extension code 200). *Code extension as 200, because although the chemotherapy "shrank" the tumor, the residual tumor was found to be more extensive than the clinical presentation. (Code Tumor Size as 055 because the derived T3 pre-neoadjuvant treatment is greater than the post-treatment T2. Code TS/Ext Eval as 5 {clinical information prior to neoadjuvant treatment} because the tumor size determines the T classification for Extension codes 100, 200, and 300 for breast.)*

- If clinical extension is unknown but a pathologic extension is given after treatment and clinician states there was a response to neoadjuvant, code CS Extension as 999 and TS/Ext Eval as 5.

- If clinical extension is unknown but a pathologic extension is given and clinician states no response to treatment, code CS Extension from path report and TS/Ext Eval as 6.

d. **Priority of imaging/radiographic techniques.** Information on extent of disease from imaging/radiographic techniques can be used to code extension when there is no more specific extension information from a pathology or operative report, but it should be taken as low priority, just above a physical exam.

e. **Involved organ not listed in schema.** If an involved organ or tissue is not mentioned in the schema, approximate the location and code it with listed organs or tissues in the same anatomic area.

f. **Contiguous (direct) extension only.** With the exception of mucinous carcinoma of the appendix, corpus uteri, ovary, fallopian tube and female peritoneum, all codes represent contiguous (direct) extension of tumor from the site of origin to the organ/structure/tissue represented in the code.

Example: Carcinoma of the prostate with extension to pubic bone is coded 600.
Carcinoma of the prostate with metastases to thoracic spine is coded in CS Extension to the appropriate code for tumor extension and the metastases to the thoracic spine are coded in the CS Mets at Dx field.

3. **Timing rule.** Refer to general guidelines for Collaborative Stage for timing rules for data collection.

4. **Ambiguous terminology.** Refer to the ambiguous terminology section for terms that constitute tumor involvement or extension.

5. **Code the highest applicable specific number.** Codes for Unknown, Not Applicable, and NOS categories such as Localized, NOS or "Stated as T1, NOS" do not take priority over more specific codes with lower numbers.

Example: The patient has a T1 colon carcinoma confined to the submucosa. Possible code choices are 160 Invades submucosa; 170 Stated as T1, NOS; and 300 Localized, NOS. All three of these codes map to T1, but the one that provides the most specific information about depth of invasion is code 160.

6. **Inferring extension code from stated T category or site-specific staging:** If the information in the medical record is ambiguous or incomplete regarding the extent to which the tumor has spread, the extent of disease may be inferred from the T category or alternative staging system stated by the physician.

a. If the only indication of extension in the record is the physician's statement of a T category from the TNM staging system or a stage from a site-specific staging system, such as Dukes C, code the appropriate "Stated as T_, NOS" category or record the numerically lowest equivalent extension code for the site-specific staging system.

7. **Use of NOS categories:** Some schemas include designations such as T1, NOS; T2, NOS; Localized, NOS; and other non-specific categories. The NOS is added when there is further breakdown of the category into subsets (such as T1a, T1b, T1c), but the correct subset cannot be determined. The NOS designation, which can appear in both the descriptions of codes and the mapping, is not official AJCC descriptive terminology. The NOS should be disregarded in reports and analyses when it is not a useful distinction. The data collector should only code to a category such as "Stated as T1 NOS" when the appropriate subset (e.g., T1a or T1b) cannot be determined.

8. **Discontinuous or distant metastases:** Distant metastases must be coded in the CS Mets at Dx field. The only exceptions are mucinous carcinoma of the appendix, corpus uteri, ovary, fallopian tube and female peritoneum, where discontinuous metastases in the pelvis or abdomen are coded in the CS Extension field.

9. **In situ pathology with nodal or metastatic tumor:** Do not code CS Extension as in situ if there is any evidence of nodal or metastatic involvement; use the code for Localized, NOS, if there is no better information.

Example: Excisional biopsy of breast tumor shows extensive DCIS. Sentinel node biopsy reveals one positive axillary node. *Code CS Extension as 100, localized, NOS, because an in situ tumor theoretically cannot metastasize and apparently an area of invasion was missed by the pathologist*

10. **Microscopic residual or positive tumor margins:** The presence of microscopic residual disease or positive tumor margins does not increase the extension code.

11. **Document choice of codes in text:** It is strongly recommended that the choice of extension codes be documented in a related text field on the abstract.

Table H.47 CS Extension Standard Table

CODE	DESCRIPTION	TNM 7 MAP	TNM 6 MAP	SS77 MAP	SS2000 MAP
000	In situ; non-invasive	Tis	Tis	IS	IS
SITE/HISTOLOGY-SPECIFIC CODES					
800	Further contiguous extension				
950	No evidence of primary tumor	T0	T0	U	U
999	Unknown extension; primary tumor cannot be assessed; not stated in patient record	TX	TX	U	U

Note: Remember to check individual schemas for site-specific codes.

CS TUMOR SIZE/EXT EVAL:

Instructions for Coding:

1. **Document the staging basis for the farthest extension and/or greatest tumor size:** The underlying purpose of this field is to capture the staging basis for the highest T category assigned to the case. In most circumstances, this will be the staging basis for the highest Tumor Size code or Extension code as appropriate to the site. See also instructions 2, 3, and 4.

a. Select the CS Tumor Size/Ext Eval code that documents the report or procedure from which the information about the farthest extension or largest size of the primary tumor (where applicable) was obtained; this may not be the numerically highest Eval code.

Example 1: Fine needle aspiration biopsy (Eval code 1) confirms adenocarcinoma of prostate. CT scan of pelvis (Eval code 0) shows tumor extension through the prostatic capsule into adjacent connective tissues. *Code CS Tumor Size/Ext Eval as 0 because the CT scan showed more extensive tumor than the biopsy.*

Example 2: Patient has elevated PSA, negative digital rectal exam, and clinically inapparent prostate tumor. Needle biopsy identifies adenocarcinoma in right lobe only. *Code CS Tumor Size/Ext Eval as 1 because the needle biopsy, not the clinical examination, established the extent of disease.*

Example 3: Patient has bronchoscopic biopsy (Eval code 1) confirming squamous cell carcinoma of the right upper lobe bronchus. CT scan of chest (Eval code 0) shows that RUL mass extends into mediastinum (Lung Extension code 700). *Code CS Tumor Size/Ext Eval as 0 because the CT scan showed the farthest extension of tumor.*

Example 4: Imaging shows 3.0 cm mass in right upper lobe of lung. Fine needle aspiration biopsy shows adenocarcinoma. *Code CS Tumor Size/Ext Eval as 0 because the imaging documents what is known about the tumor and drives the classification of T, and the FNA simply confirms that the mass is cancer.*

Example 5: Patient has 6 cm mass in left breast with overlying erythema and edema. Core needle biopsy confirms duct carcinoma and the patient receives neoadjuvant chemotherapy followed by a modified radical mastectomy. The pathology report from the surgery shows a 2.5 cm residual carcinoma. *Code the Tumor Size/Ext Eval as 5 (surgical resection after neoadjuvant therapy – size/extension based on clinical information prior to treatment), which maps to clinical staging. (Tumor size would be coded 060.)*

b. In the infrequent situation where there is both clinical and pathologic documentation of the same T category, **pathologic information takes priority.**

Example: Lung cancer patient has biopsy-proven extension to adjacent trachea (Extension code 700) and radiographic evidence of extension to neural foramina (Extension code 750). *Code CS Extension as 750 and TS/Ext Eval as 3. When both codes map to T4, pathologic staging basis takes priority.*

c. **Mapping of T subcategories:** Select the CS TS/Ext Eval code that describes how the most advanced subcategory of the derived T was determined.

- If a specific subcategory of T will be derived (such as T2a, etc.), determine if there was any pathological evidence for the specific subcategory. If so, select a CS Tumor Size/Ext Eval code that will derive a "p" staging basis.

- If there was only clinical evidence of the subcategory disease, select a CS Tumor Size/Ext Eval code that will derive a "c" staging basis. In the latter case there may have been pathological evidence of a lower T subcategory, but this is not considered in assigning the Eval code.

Example: Cervical carcinoma with bullous edema of bladder (CS Extension code 605, maps to T3a) demonstrated on cystoscopy (CS Tumor Size/Eval code 1). KUB radiography (CS Tumor Size/Eval code 0) shows non-functioning kidney (CS Extension code 635, maps to T3b). *Code CS Tumor Size/Ext Eval as 0 because the imaging documented a higher subcategory of T3 than the cystoscopy.*

d. **When the only procedure is a Polypectomy:** In some situations, an endoscopic procedure may remove the entire tumor, and the TS/Ext Eval must be coded to reflect the correct staging basis for tumor extension.

- If there is no tumor at the margin of resection after the polypectomy, code TS/Ext Eval as 3(pathologic).

- If there is tumor at the margin of resection after the polypectomy, code TS/Ext Eval as 1 (endoscopic/diagnostic biopsy).

When the patient has further surgery:

- If there is no primary tumor in resection, use extension information from polypectomy and code TS/Ext Eval as 3 (pathologic).

- If more tumor is found at resection, code farthest extension from polypectomy or resection and code Eval as 3 (pathologic).

2. **When tumor size is the primary factor.** For primary sites where tumor size is the primary factor in determining the T category in TNM, code CS Tumor Size/Ext Eval on the basis of how the tumor size was determined.

Note: In the CS Extension field, an asterisk (*) in the TNM 6 Map column or a caret (^) in the TNM 7 Map column usually indicates that tumor size is the determining factor in the mapping.

a. If the tumor size is taken from physical exam or imaging and there was also a needle biopsy or incisional biopsy, code CS Tumor Size/Ext Eval according to which gave the better information about tumor size.

Example: On physical examination, patient has a 1.5 cm (T1) lesion in the floor of mouth with mucosal extension onto the gingiva. A biopsy confirms the malignancy and the patient is treated with radiation therapy. *Code the CS Tumor Size/Ext Eval as 0 since the tumor size was determined on physical exam and the biopsy simply confirmed the malignant diagnosis. (Mucosal extension to another structure does not alter the T classification).*

Example: Bronchoscopy (Eval code 1) shows blockage in right middle bronchus with no parenchymal extension (Extension code 100). CT scan (Eval code 0) shows tumor size as 2.5 cm (maps to T1b). *Code CS Tumor Size/Ext Eval as 0 because the tumor size determines the difference between T1a, T1b and T2.*

3. **When tumor size is not a factor.** For primary sites/histologies where tumor size is not a factor in determining the T category in TNM, code CS Tumor Size/Ext Eval on the basis of the CS extension field only.

Note: For most primary sites, if the tumor is classified as T4 or sometimes even T3, tumor size is no longer a factor.

Example: CT scan of head and neck (Eval code 0) shows tumor confined to supraglottic larynx (Extension code 100). Panendoscopy (Eval code 1) demonstrates that there is impaired vocal cord mobility (Extension code 250). *Code CS Tumor Size/Ext Eval as 1 because the endoscopy documented a higher Extension code than the CT scan.*

Example: Sigmoidoscopy and biopsy (Eval code 1) show a 4 cm adenocarcinoma in the upper rectum. Ultrasound (Eval code 0) shows that the carcinoma invades into the perirectal fat. Patient opts for radiation therapy. *Code the CS Tumor Size/Ext Eval field as 0 because the ultrasound showed the depth of invasion, which is the primary factor in classifying the T category for colorectal cancers.*

Note: For colon, rectosigmoid and rectum carcinomas, always assign the Tumor Size/Ext Eval code based on extension (depth of invasion). Tumor size is not a factor in classifying colorectal cancers.

4. **When both tumor size and extension determine T category.** For primary sites where both tumor size and extension determine the T category in TNM, select the code that best explains how the information in the CS Tumor Size and CS Extension fields were determined.

a. If there is a difference between the derived category for the tumor size and the CS extension, select the evaluation code that reflects how the worse or higher category was determined.

Example: Tumor size for a breast cancer biopsy is 020 (maps to T1). On physical exam, there is ulceration of the skin (extension code 512, maps to T4). *Code CS Tumor Size/Ext Eval field as 0, physical examination, because the ulceration information from thephysical examination results in a higher T category.*

Note: For breast, unless there is skin or chest wall involvement, always assign the Tumor Size/Ext Eval code based on size. If there is skin or chest wall involvement or a statement of inflammatory carcinoma (T4 disease), assign Eval code based on extension.

Example: Panendoscopy and biopsy (Eval code 1) confirm a 3.5 cm lesion on the lateral border of the anterior tongue involving the intrinsic musculature (Extension code 200 with tumor size 035, equivalent to a T2). CT scan of the head and neck (Eval code 0) indicates that the lesion actually involves the extrinsic or deep muscles of the tongue (Extension code 750, equivalent to T4a). *Code CS Tumor Size/Ext Eval as 0 because the CT scan documented a higher stage than the tumor size.*

b. If the patient had no surgery, use code 0, 1, or 9.

Example: Patient has a chest x-ray showing an isolated 4 cm tumor in the right upper lobe. Patient opts for radiation therapy. *Code this field as 0. Staging algorithm will identify information as clinical (c).*

Example: Colon cancer with colonoscopy and biopsy confirming adenocarcinoma in the submucosa. *Code this field as 1. Staging algorithm will identify information as clinical (c). The biopsy does not meet the criteria for pathologic staging.*

Example: Information obtained from endoscopies for cervix or bladder showing size or extent of the tumor is coded as 1 in this field and the staging algorithm will identify the information as clinical (c).

Exception: Lung cancer with mediastinoscopy showing direct extension into mediastinum. *Code this field as 1. The staging algorithm will identify information as pathologic (p) in the sixth edition mapping and clinical (c) in the seventh edition mapping.*

c. If the patient had surgery followed by other treatment(s), use code 3.

d. If the size or extension of the tumor determined prior to treatment was the basis for neoadjuvant therapy, use code 5. Cases coded to Tumor Size/Ext Eval code 5 can be analyzed or compared with other cases with a clinical staging basis.

e. If the size or extension of the tumor was greater after presurgical treatment than before treatment, use code 6. This code is likely to be used infrequently and maps to the "y" intercurrent treatment staging basis. Cases coded to Tumor Size/Ext Eval code 6 cannot be analyzed with or compared to any other cases that did not receive neoadjuvant treatment and surgery.

f. If the patient had an autopsy and the autopsy information meets the timing rules for determining extension, use code 2 if the diagnosis was known or suspected prior to death. Use code 8 if the malignancy was not known or suspected prior to death.

5. **When there is no TNM mapping:** For sites and histologies for which no TNM schema has been defined, such as brain or Kaposi sarcoma, this field is always coded 9, Not Applicable (See Appendix 3). For any sites and histologies not listed in Table 6, code to the value that best reflects the diagnostic methods used, whether or not a stage is actually calculated for an individual case. In other words, do not use code 9 when a case has a histology that is excluded from staging but the site does have a TNM schema defined, for example, a sarcoma of the breast. In those cases, use code 9 only when the nature of the diagnostic methods is actually unknown.

6. **Examples of imaging studies included in Code 0:** Code 0 includes imaging studies such as standard radiography, special radiographic projections, tomography, computerized tomography (CT), ultrasonography (US), angiography, scintigraphy (nuclear scans), magnetic resonance imaging (MRI), positron emission tomography (PET) scans, spiral scanning (CT or MRI) and other non-invasive methods of examining tissues.

7. **Explanation of Code 1:** Codes 0 – 3 are oriented to the AJCC staging basis. In general, Code 1 includes microscopic analysis of tissue that does not meet the requirements for pathologic staging in the TNM system. Code 1 also includes observations at surgery, such as an exploratory laparotomy in which

unresectable pancreatic cancer is identified and further tumor extension is not biopsied. However, pathologic staging requirements vary by site; for some site schemas, code 1 may be classified as pathologic. For specific classification rules, refer to the *AJCC Cancer Staging Manual, seventh edition*.

Example: A total cystectomy is required to pathologically stage a bladder cancer. Any tissue removed during another procedure, such as a transurethral resection of a bladder tumor, does not meet the requirements for pathologic staging and should be coded to 1 in this field. This also applies to transurethral resection of the prostate.

a. If there is a choice between Eval code 0 (physical exam and imaging) and Eval code 1 (needle biopsy), use the Eval code that provides the best information about the tumor size and/or extent of disease. In most situations, the needle biopsy simply confirms the malignancy and the physical exam or imaging provides more information about tumor extension.

Example: Colposcopic examination and biopsy (Eval code 1) of the cervix shows extensive involvement of the endocervix. Bimanual examination of the pelvis (Eval code 0) indicates that the tumor is fixed to the pelvic sidewall ("frozen pelvis"). *Code CS Tumor Size/Ext Eval as 0 (clinical) because the bimanual examination indicates farther extension than the endoscopy.*

Example: Patient has nonspecific abdominal symptoms. An Upper GI exam (Eval code 0) shows localized thickening of the stomach wall. Esophagogastroscopy and biopsy (Eval code 1) confirm diffuse involvement of the upper part of the stomach with extension into the lower esophagus. *Code CS Tumor Size/Ext Eval as 1 because the endoscopy documents more involvement than the imaging.*

8. **Explanation of Code 3:** For most schemas, Code 3 meets the criteria for pathologic staging. For most schemas, use code 3 for a biopsy of tumor extension that meets the requirements for pathologic staging basis. In CSv2, the definition of code 3 has been reworded to include not only surgical resection but also a positive biopsy that confirms the highest T classification. In other words, according to TNM rules, if the highest T category can be confirmed microscopically (positive cytology or tissue), this meets the requirements for pathologic staging basis and the CS Tumor Size/Ext Eval field should be coded to 3.

Example: Patient visits doctor complaining of urinary frequency and pain. Pelvic examination shows extensive cervical carcinoma (Eval code 0). Cystoscopic biopsy of bladder shows squamous carcinoma compatible with cervical origin (cervix extension code 700, equivalent to T4). *Code CS Tumor Size/Ext Eval as 3 (pathologic) because biopsy documents highest T category.*

9. **Neoadjuvant therapy and 2nd primaries:** When an incidental 2nd primary is discovered at the time of surgery following neoadjuvant therapy (systemic/radiation therapy followed by surgery), this 2nd primary should be coded to Eval code 3, and NOT be coded to eval codes 5 or 6. This would also be true for a 2nd (or higher number) primary diagnosed and treated with a surgical resection as the first course of therapy, when the previous primary was treated with systemic or radiation therapy at any time (adjuvant or neoadjuvant or for a recurrence). To include these cases with those purposefully treated with neoadjuvant therapy would skew the data. The effect of the prior treatment for the previous primary on the new primary is unknown.

10. **Different code structure for prostate:** The CS Tumor Size/Ext Eval field for prostate is unique. An extra category was inserted between codes 1 and 2 in the common (standard table used for other sites) Tumor Size/Ext Eval table to provide a code for situations where no prostatectomy was performed, but

there was a positive biopsy of extraprostatic tissue. This allows assignment of codes in the T3-T4 range (Extension 410-700). Common table code 2 (autopsy of suspected/known cancer) becomes code 3 for prostate, and common table code 3 (pathologic) becomes code 4.

Example: A prostate cancer patient has a biopsy of the rectum that shows microscopic involvement of the rectal wall (Extension code 500, equivalent to T4). Code Tumor Size/Ext Eval as 2 (positive biopsy of extraprostatic tissue, which maps to pathologic) because according to the *AJCC Cancer Staging Manual, seventh edition,* the case meets the requirements for pathologic staging in the T category.

Example: Patient presents with urinary symptoms and undergoes transurethral resection to improve urinary flow. Adenocarcinoma is found in the chips of tissue removed from the prostate. *Code Tumor Size/Ext Eval as 1 because there was no clinical evidence of cancer and the transurethral resection is an endoscopic procedure that does not meet the criteria for pathologic staging of prostate.*

Example: Needle biopsies of the prostate confirm adenocarcinoma. The patient undergoes a radical prostatectomy that shows extensive involvement of the prostate. *Code Tumor Size/Ext Eval as 4 because the prostatectomy meets the criteria for pathologic staging.*

Note: Cryoprostatectomy does not meet pathologic staging criteria because there is no tissue available for the pathologist to examine.

11. **Coding Eval field when tumor size or extension is unknown:** The Eval fields should be coded based on how the information was obtained, even if the information in the related field (Tumor Size, Regional Nodes, or CS Mets at Dx) is unknown. For example, even if it is not possible to determine the tumor size or extension and the Extension field is coded as 999, the registrar still knows what procedures were used to try to determine those fields. In other words, just because the tumor size or extension is coded 999, the Eval field does not have to be coded 9.

12. **Schemas always coded 9:**

AdnexaUterineOther
Brain
CNS Other
Digestive Other
Endocrine Other
Eye Other
Genital Female Other
Genital Male Other
HemeRetic
Ill Defined Other
Intracranial Gland
Kaposi Sarcoma
Melanoma Sinus Other
Middle Ear
Myeloma Plasma Cell Disorder
Pharynx Other
Respiratory Other
Sinus Other
Trachea
Urinary Other

Table H.48 CS Tumor Size/Extent Eval Standard Table

CODE	DESCRIPTION	STAGING BASIS
0	**Does not meet criteria for AJCC pathologic staging:** No surgical resection done. Evaluation based on physical examination, imaging examination, or other non-invasive clinical evidence. No autopsy evidence.	c
1	**Does not meet criteria for AJCC pathologic staging:** No surgical resection done. Evaluation based on endoscopic examination, diagnostic biopsy, including fine needle aspiration biopsy, or other invasive techniques, including surgical observation without biopsy. No autopsy evidence used. *See Notes 1 and 2 below*	c
2	**Meets criteria for AJCC pathologic staging:** No surgical resection done, but evidence derived from autopsy (tumor was suspected or diagnosed prior to autopsy). *See Note 3 below.*	p
3	**Either meets criteria for AJCC pathologic staging:** Surgical resection performed WITHOUT pre-surgical treatment or radiation OR surgical resection performed, unknown if pre-surgical systemic treatment or radiation performed **AND** Evaluation based on evidence acquired before treatment, supplemented or modified by the additional evidence acquired during and from surgery, particularly from pathologic examination of the resected specimen. No surgical resection done. Evaluation based on positive biopsy of highest T classification. *See Note 3 below.*	p
5	**Does not meet criteria for AJCC y-pathologic (yp) staging:** Surgical resection performed AFTER neoadjuvant therapy and tumor size/extension based on clinical evidence, unless the pathologic evidence at surgery (AFTER neoadjuvant) is more extensive (see code 6)	c
6	**Meets criteria for AJCC y-pathologic (yp) staging:** Surgical resection performed AFTER neoadjuvant therapy AND tumor size/extension based on pathologic evidence, because pathologic evidence at surgery is more extensive than clinical evidence before treatment. *See Note 4 below.*	yp
8	**Meets criteria for autopsy (a) staging:** Evidence from autopsy only (tumor was unsuspected or undiagnosed prior to autopsy)	a
9	Unknown if surgical resection done Not assessed; cannot be assessed Unknown if assessed Not documented in patient record *For sites with no TNM schema:* Not applicable	c

Note 1: Remember to check individual schemas for site-specific codes.

Note 2: For lung, code 1 was pathologic staging basis in CS version 1 and clinical in CS version 2. For liver, code 1 was clinical in CS version 1 and pathologic in CS version 2.

Note 3: Where sixth and seventh editions differ, there will be separate Staging Basis columns for TNM6 and TNM7.

Note 4: The codes in this common table do not apply to prostate. See the Prostate Schema.

Note 5: This staging basis is displayed as "yp" but is stored in the record as "y" because the field is only one character in length.

Note 6: For primary sites with no TNM schema, code 9 is defined as not applicable and the staging basis is blank.

CS LYMPH NODES: Instructions for Coding

1. **Record the specific involved regional lymph node chain(s) farthest from the primary site:** The lymph nodes may be involved by tumor either clinically or pathologically. Regional lymph nodes are listed for each schema. In general, the regional lymph nodes in the chain(s) closest to the primary site have the lower codes. Nodes farther away from the primary or in farther lymph node chains have higher codes. If a lymph node chain is not listed, check an anatomy book or medical dictionary for a synonym. If the lymph node chain and its synonym are not listed in CS Lymph Nodes, code the involved node in CS Mets at DX. **Record the highest applicable code in the following order: pathology report, imaging, physical exam.**

Exception: The higher codes for "Regional lymph nodes, NOS;" "Lymph nodes, NOS;" "Stated as N1, no other information;" "Stated as N2a, no other information;" and so forth, should be used only when there is no available information regarding the specific regional nodes involved.

Example: Patient has a right upper lobe lung cancer, and right hilar lymph nodes are positive on fine needle aspiration biopsy. CT scan shows matted left paratracheal (contralateral mediastinal) nodes, but they are not biopsied. Patient chooses radiation therapy as primary treatment. *Use the code for contralateral mediastinal lymph node involvement as it is higher than the code for peribronchial lymph nodes.*

a. **If there is no neoadjuvant therapy:** Record involved regional lymph nodes **from the pathology report**, if it is available, when the patient receives no radiation or systemic treatment prior to surgery.

b. **Pathologic information takes precedence:** If there is a discrepancy between clinical information and pathologic information about the same lymph nodes, pathologic information takes precedence if no preoperative treatment was administered. It is not necessary to biopsy every lymph node in the suspicious area to disprove involvement.

Example: Axillary lymphadenopathy stated as "suspicious for involvement" noted on physical exam. After axillary dissection, all lymph nodes are negative. *Code CS Lymph Nodes as 000, no regional lymph node involvement.*

c. **Inaccessible lymph nodes rule for regional lymph nodes:** For inaccessible lymph nodes, record CS Lymph Nodes as Code 000 (None) rather than Code 999 (Unknown) when the following three conditions are met:

1. There is no mention of regional lymph node involvement in the physical examination, pretreatment diagnostic testing or surgical exploration.

2. The patient has clinically low stage (T1, T2, or localized) disease.

3. The patient receives what would be usual treatment to the primary site (treatment appropriate to the stage of disease as determined by the physician) or is offered usual treatment but refuses it, since this presumes that there are no involved regional lymph nodes that would otherwise alter the treatment approach.

Note: Code 999 can and should be used in situations where there is reasonable doubt that the tumor is no longer localized and there is no documentation of involved regional lymph nodes. Code 999 should also be used when there is no documentation in the medical record about the status of accessible regional lymph nodes.

Note: If the inaccessible nodes rule applies and the case is coded 000, use code 0 in CS Reg Nodes Eval, as this code documents that criteria were met for a clinical N0.

d. **Direct tumor extension into lymph node:** If there is direct extension of the primary tumor into a regional lymph node, code the involved node in this field.

Table H.49 Multiple Nodes Involved for Head and Neck Primary The code structure for CS Lymph Nodes for head and neck cancers varies by primary site, but in general, the following code ranges apply:

CODE	DESCRIPTION
000	None
100-190	Single positive ipsilateral node involved
200-290	Multiple positive ipsilateral nodes
300-320	Positive ipsilateral nodes, unknown if 1 or > 1
400-490	Bilateral or contralateral positive nodes
500-520	Regional nodes, NOS, unk. number and laterality
800	Lymph nodes, NOS

If even one involved node is in a higher category, use the appropriate code in the higher category.

Example: Patient with hypopharyngeal cancer has two positive ipsilateral level IV nodes and one positive ipsilateral level V node. Level IV nodes are listed in CS Lymph Nodes code 100; level V nodes are listed in CS Lymph Nodes code 120. Because more than one node is involved, the correct code range is 200-290. *Code as 220 because there are multiple lymph nodes involved and at least one of them is in code 120.*

Example: Patient with base of tongue cancer has regional lymph nodes involved on both sides of neck. “Regional nodes, NOS” is in code 100, but bilateral nodes are involved. *Code as 400, bilateral lymph nodes listed in 100.*

e. **Neoadjuvant treatment planned or administered:** If the patient receives preoperative (neoadjuvant) systemic therapy (chemotherapy, hormone therapy, and immunotherapy) or radiation therapy, code the farthest involved regional lymph nodes based on information prior to surgery.

Example: Patient has a hard matted mass in the axilla (code 510) and a needle biopsy of the breast that confirms ductal carcinoma. Patient receives three months of chemotherapy. The pathology report from the modified radical mastectomy shows only scar tissue in the axilla with no involvement of axillary lymph nodes (Negative, code 000). *Code CS Lymph Nodes as 510 because prior to treatment they appeared to be clinically involved and the chemotherapy apparently "sterilized" the lymph nodes.*

f. **Partial or no response to neoadjuvant treatment:** In the infrequent event that clinically involved regional lymph nodes do not respond to neoadjuvant treatment and are, in fact, more extensively involved after preoperative treatment as determined by the operative or pathology report, code the farthest extension and code CS Reg Nodes Eval as 6, based on pathology/operative report after treatment. If response to treatment is not documented, code the clinical status of the lymph nodes and code CS Reg Nodes Eval as 5.

Example: Patient has needle biopsy-proven prostate cancer with no mention of involved lymph nodes on CT scan (Negative, code 000). He receives Lupron while deciding whether to undergo a radical prostatectomy. At the time of surgery, a laparoscopic pelvic node biopsy is reported to show metastases (Regional nodes involved, code 100) to lymph nodes and the prostatectomy is canceled. *Code CS Lymph Nodes as 100 because the preoperative treatment (Lupron) had no effect on the lymph nodes.*

- If clinical involvement of regional lymph nodes is unknown but pathologic involvement is stated after treatment and clinician states there was a response to neoadjuvant, code CS Lymph Nodes as 999 and CS Reg Nodes Eval as 5.

- If clinical involvement of regional lymph nodes is unknown but pathologic involvement is stated and clinician states no response to treatment, code CS Lymph Nodes from path report and CS Reg Nodes Eval as 6.

g. **Use of Code 800:** The CS Lymph Nodes table for nearly every schema contains a code 800, defined as Lymph nodes, NOS. This code is to be used only when it is not possible to determine whether the involved lymph nodes are regional or distant. Each schema also includes a separate code for "Regional lymph nodes, NOS". In general, lymph nodes removed during a resection of the primary site are regional and should be coded as such. Occasionally a distant lymph node will be removed separately from the primary site. In the infrequent situation where the involved lymph node is not identified as either regional or distant, use code 800, which will map to N1 category using the TNM downstaging rule applied in the CS computer algorithm.

2. **When CS Extension is coded as in situ/noninvasive:** Use code 000 for lymph node involvement when the CS Extension is coded in situ, even if no lymph nodes are removed, since "in situ" by definition means noninvasive. If there is evidence of nodal involvement associated with a tumor described as in situ, it would indicate that an area of invasion was missed and the primary tumor is not an in situ lesion, so involved lymph nodes can be coded as appropriate for the case. Code the CS Extension field and the behavior code to reflect that the tumor is invasive.

3. **Terms meaning lymph node involvement:** For solid tumors, the terms “fixed” or “matted” and “mass in the hilum, mediastinum, retroperitoneum, and/or mesentery” (with no specific information as to tissue involved) are considered involvement of lymph nodes.

a. Any other terms, such as “palpable,” “enlarged,” “visible swelling,” “shotty,” or “lymphadenopathy” should be ignored, unless there is a statement of involvement by the clinician.

Exception: The terms *adenopathy*, *enlargement*, and *mass in the hilum or mediastinum* should be coded as involvement for lung primaries only.

Example: Peribronchial lymph nodes are positive on fine needle aspiration biopsy. Contralateral mediastinal mass noted on CT scan but not biopsied. Patient chooses radiation therapy as primary treatment. *Use the code for contralateral mediastinal lymph node involvement as it is higher than the code for peribronchial lymph nodes.*

b. For lymphomas, any positive mention of lymph nodes indicates involvement of those lymph nodes. Keep in mind, however, that involved lymph nodes are coded in CS Extension for lymphomas.

c. Regional lymph nodes are not palpable for inaccessible lymph nodes sites such as bladder, colon, kidney, prostate, esophagus, stomach, lung, liver, corpus uteri and ovary. The best description concerning regional lymph nodes will be on imaging studies or in the surgeon's evaluation at the time of exploratory surgery or definitive surgery. If regional lymph nodes for these sites are not mentioned on imaging or exploratory surgery, they are presumed to be clinically negative (code 000) based on the inaccessible lymph nodes rule.

d. The terms “homolateral”, “ipsilateral” and “same side” are used interchangeably.

e. Any unidentified nodes included with the resected primary site specimen are to be coded as regional lymph nodes, NOS.

4. **Coding size of lymph node:** When size of involved regional lymph nodes is required, code from pathology report, if available.

a. Code the size of the metastasis, not the entire node, unless otherwise stated in the site-specific schema. The size of the metastasis within the lymph node can be inferred if the size for the entire node falls within one of the codes; for example, a single involved node 1.5 cm in size can be coded to “single lymph node < 2 cm” because the metastasis cannot be larger than 1.5 cm.

Example: Patient has radical nephroureterectomy for urothelial carcinoma of the renal pelvis. Synoptic pathology list shows three involved nodes, the largest of which is 2 cm in greatest diameter. *Code CS Lymph Nodes as 200 because multiple lymph nodes are involved and no single lymph node or its metastasis is larger than 5 cm in size.*

b. If the size of the metastasis in the node is unknown, code the size of the involved node(s) if given.

c. Code the clinical size of the involved node(s) in the absence of a pathologic size.

d. If the size given is described as a mass, code the size of the mass.

Example: Patient presents with 6 cm hard upper jugular (Level II) neck mass. Needle biopsy of mass shows metastatic squamous carcinoma. Panendoscopy finds lesion on soft palate. *Code CS Lymph Nodes as 300 (regional lymph nodes listed in 100 {regional lymph node, NOS}, not stated if single or multiple). Code Lymph Nodes Eval as 0 (physical exam). Code Site-specific Factor 1 (size of lymph node) as 060.Code Site-specific Factor 2 as 988 (not applicable in CSv2). Code Site-specific Factor 3 as 010 (level II node involved).Code Site-specific Factors 4-6 as 000 (no nodes involved). Code Site-specific Factor 7 as 010 (upper level nodes involved).Code Site-specific Factor 8 as 010 (nodes involved clinically, no extracapsular extension clinically).Code Site-specific Factor 9 as 050 (lymph nodes involved pathologically, unknown if extracapsular extension).The computer algorithm will combine the codes from CS Lymph Nodes, SSF1, and Lymph Nodes Eval and derive a cN2a.*

e. Information about location, number and size of lymph nodes may be split among the CS Lymph Nodes field and one or more site-specific factors. Code the fields as completely as possible and the computer algorithm will derive the correct N category. Refer to the discussion of head and neck lymph nodes and breast lymph nodes in Section 2 of this manual for further information.

5. **Inferring lymph node involvement from stated N category or site-specific staging:** If the only indication of lymph node involvement in the record is the physician's statement of an N category from the TNM staging system or a stage from a site-specific staging system, such as Dukes C, code the appropriate "Stated as N_, NOS" category or record the numerically lowest equivalent CS Lymph Nodes code for the site-specific staging system. CS Version 2 includes many code choices to accommodate physician statements of N1, N2 NOS, N2a, and so forth.

a. If there is a discrepancy between documentation in the medical record and the physician's assignment of TNM, the documentation takes precedence. Cases of this type should be discussed with the physician who assigned the TNM.

b. If the information in the medical record is ambiguous or incomplete regarding the extent to which the tumor has spread, lymph node involvement may be inferred from the N category stated by the physician.

6. **Isolated Tumor Cells (ITCs) in lymph nodes:** Several chapters in the TNM seventh edition refer to isolated tumor cells or ITCs. ITCs are single cells or small clusters of epithelial cells in regional lymph nodes whose metastatic potential is unknown. ITCs are coded according to site-specific guidelines.

a. For breast, ITCs are coded as negative lymph nodes (CS Lymph Nodes code 000 or 050, which maps to pN0(i+) or pN0(mol+).

b. For cutaneous melanoma, ITCs are coded as positive lymph nodes.

c. For Merkel cell carcinoma, ITCs are coded as positive lymph nodes.

7. **Use of NOS categories:** Some schemas include designations such as N1, NOS; N2, NOS, and other non-specific categories. The NOS is added when there is further breakdown of the category into subsets (such as N1a, N1b, N1c), but the correct subset cannot be determined. The NOS designation, which can

appear in both the descriptions of codes and the mapping, is not official AJCC descriptive terminology. The NOS should be disregarded in reports and analyses when it is not a useful distinction. The data collector should only code to a category such as "Stated as N1 NOS" when the appropriate subset (e.g., N1a or N1b) cannot be determined.

8. **Discontinuous (satellite) tumor deposits (peritumoral nodules) for colon, appendix, rectosigmoid and rectum:** Tumor nodules in pericolic or perirectal fat without evidence of residual lymph node structures can be one of several aspects of the primary cancer: discontinuous spread, venous invasion with extravascular spread, or a totally replaced lymph node. These various aspects are handled in different ways in CS. Furthermore, there are different definitions in the sixth and seventh editions of the *AJCC Cancer Staging Manual* for discontinuous tumor nodules found near the primary site.

a. In the seventh edition and CSv2, if the primary tumor is localized or maps to T1 or T2, code CS Lymph Nodes as 050 if the only information available is the presence of tumor nodules in pericolic fat. In addition, code the total number of tumor deposits in the appropriate Site-specific Factor for Tumor Deposits. If there are tumor deposits and involved regional lymph nodes, code the information on regional lymph nodes in CS Lymph Nodes, the number of positive nodes in Lymph Nodes Positive, and the number of tumor deposits in the appropriate Site-specific Factor for Tumor Deposits.

b. In the sixth edition of TNM and CS Version 1, tumor nodule(s) present in pericolic or perirectal fat should be coded using the following guidelines:
   - Code as regional lymph node involvement if the nodule has a smooth contour.
   - Code as tumor extension if the nodule has an irregular contour.

9. **Sentinel lymph nodes**. Involved nodes found during sentinel lymph node procedures are classified as positive nodes and coded in CS Lymph Nodes. However, whether the involved sentinel lymph nodes are clinical or pathologic will depend on whether the primary tumor meets the criteria for clinical or pathologic staging. In other words, involved sentinel nodes may be classified as clinical if there is no resection of the primary tumor. For further information, see the coding guidelines for CS Reg Nodes Eval.

10. For the following primary sites, CS Lymph Nodes is always coded 988, Not applicable:
Placenta
Brain and Cerebral Meninges
Other Parts of Central Nervous System
Intracranial Gland
Hodgkin and Non-Hodgkin Lymphoma
Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms
Other and Ill-Defined Primary Sites
Unknown Primary Site

11. **Document choice of code in text:** It is strongly recommended that the choice of regional lymph node codes be documented in a related text field on the abstract.

Table H.50 CS Lymph Nodes Standard Table

CODE	DESCRIPTION	TNM 7 MAP	TNM 6 MAP	SS77 MAP	SS2000 MAP
000	None; no regional lymph node involvement	N0	N0	None	None
SITE/HISTOLOGY-SPECIFIC CODES					
999	Unknown; regional lymph nodes cannot be assessed; not stated in patient record	NX	NX	U	U

Note: Remember to check individual schemas for site-specific codes.

Table H.51 For schemas that do not use the CS Lymph Nodes field:

CODE	DESCRIPTION
988	Not applicable; Information not collected for this schema

Seventh Edition TNM and CSv2 Changes in Eval Code Definitions

A major change reflecting current medical practice occurred in the rules for clinical and pathologic classification of regional lymph nodes effective with the seventh edition of the *AJCC Cancer Staging Manual*. In CSv2, CS Lymph Nodes Eval is coded as clinical or pathologic based on the intent of the procedure and matching the assessment of the T classification (coded in CS TS/Ext Eval). The intent can be either clinical/diagnostic or therapeutic.

When the lymph node procedure is part of the workup, the staging basis is clinical (CS Lymph Nodes Eval codes 0, 1, 5, 9). If the microscopic assessment (workup) of lymph nodes, such as a regional node biopsy or sentinel lymph node procedure, is intended to help choose the treatment plan, the information obtained is part of clinical staging. In these circumstances, the tumor size and/or extension (T-category) information is also clinical and any resection of the primary site does not meet the criteria for pathologic T classification.

When the intent of the lymph node procedure is therapeutic (treatment), the staging basis is pathologic (CS Reg Nodes Eval codes 2, 3, 6). In these circumstances, there is also a resection of the primary site that meets the criteria for pathologic T classification (also part of the treatment) or there is microscopic confirmation of the highest T category without a surgical resection of the primary site.

Example 1: Breast cancer patient diagnosed by mammography and core needle biopsy; axilla clinically negative. Patient opts for lumpectomy and sentinel node biopsy, which is negative for lymph node metastases. *Code CS Lymph Nodes Eval as 3 because the sentinel node biopsy was part of the treatment.*

Example 2: Large breast mass found to be cancerous on core needle biopsy. Fullness in axilla on physical examination. Sentinel node biopsy shows micrometastasis in one of three nodes.

Patient received neoadjuvant chemotherapy followed by modified radical mastectomy. On the mastectomy pathology report, no positive lymph nodes were found. *Code CS Lymph Nodes Eval as 5 because the sentinel node biopsy was performed as part of the workup and the patient received surgical treatment to primary site following neoadjuvant treatment.*

Example 3: Patient has hard lump in low neck and an endoscopic paratracheal node biopsy confirms metastatic lung cancer. Patient treated with chemoradiation. *Code CS Lymph Nodes Eval as1 because the endoscopic biopsy was part of the workup and patient did not have resection of the primary site.*

Example 4: Sigmoid colon cancer diagnosed by colonoscopy. At the time of resection, 3/15 pericolic lymph nodes were found to contain metastatic cancer. *Code CS Lymph Nodes Eval as 3because positive nodes were found as part of surgical resection of primary site.*

Example 5: Patient diagnosed with medullary thyroid carcinoma, and undergoes total thyroidectomy and anterior compartment node dissection. Node dissection finds 2 of 12 lymph nodes contain metastatic carcinoma. *Code CS Lymph Nodes Eval as 3 because the lymph nodes were part of the therapeutic resection of the primary site.*

Example 6: Patient has malignant melanoma on the forearm confirmed by shave biopsy. Patient has an FNA of an enlarged axillary lymph node that shows no involvement of the axillary lymph node by melanoma. Patient's treatment consists of wide excision of primary site. *Code CS Lymph Nodes Eval as 1 because the sentinel node biopsy was done to determine what type of treatment the patient should have.*

CS LYMPH NODES EVAL:

Instructions for Coding

1. **Document the farthest involved regional nodes:**

a. Select the CS Lymph Nodes Eval code that identifies the type of report or procedure from which the information about the farthest involved regional lymph nodes was obtained. This may not be the numerically highest eval code.

Example: Modified radical neck dissection for hypopharyngeal cancer shows one lower jugular node involved (CS LN code 100, Eval code 3). Physical exam shows hard, matted scalene (transverse cervical) node presumed to contain metastasis (CS LN code 320, Eval code 0). *Code CS Lymph Nodes Eval as 0 because the scalene node involvement was determined clinically rather than by examination of tissue.*

b. If there is a discrepancy between clinical and pathologic information about the same lymph node chain(s), **pathologic information takes priority**. It is not necessary to biopsy every node in the chain to prove that they are negative.

Example Lung cancer patient has a CT scan showing a mass of lymph nodes in the ipsilateral mediastinum. Biopsies at mediastinoscopy report that two ipsilateral mediastinal lymph nodes are negative for tumor. *Code CS Lymph Nodes as 000 and CS Lymph Nodes Eval as 1 because the mediastinoscopy disproved the clinically suspicious mediastinal nodes.*

c. **Mapping of N subcategories:** Select the CS Lymph Node Eval code that describes how the most advanced subcategory of the derived N was determined.

- If a specific subcategory of N will be derived (such as N2b), determine if there was any pathological evidence for the specific subcategory. If so, select a CS Lymph Node Eval code that will derive a "p" staging basis if the patient also has surgical resection of the primary site.

- If there was only clinical evidence of the subcategory disease, select a CS Lymph Node Eval code that will derive a "c" staging basis. In the latter case there may have been

pathological evidence of a lower N subcategory, but this is not considered in assigning the Eval code.

Example: Breast cancer patient with 10 of 14 axillary nodes positive at time of modified radical mastectomy (CS Lymph Nodes code 600, Site-specific Factor 3 code 010, maps to pN3a). Patient also has palpable hard supraclavicular node presumed to be involved by the clinician (CS Lymph Nodes code 800, maps to N3c). *Code CS Lymph Node Eval as 0 because the physical examination documented a higher N subcategory than the axillary dissection.*

2. **When there is no TNM mapping:** For sites and histologies for which no TNM schema has been defined, such as brain or Kaposi sarcoma, this field is always coded 9, Not Applicable. For any sites that have no TNM mapping, code to the value that best identifies the diagnostic methods used, whether or not a stage group is actually calculated for an individual case. In other words, do not use code 9 when a case has a histology that is excluded from staging but the site does have a TNM schema defined, for example, for a sarcoma of the breast. In those cases, use code 9 only when the nature of the diagnostic methods is actually unknown.

3. Select the code that best explains how the information in the CS Lymph Nodes field was determined.

a. **If no lymph nodes are removed:** If the patient had no removal of lymph node(s), use code 0, 1, or 9.

Example: Prostate cancer with laparoscopic lymph node biopsy showing microscopically involved nodes; radical prostatectomy canceled. *Code CS Lymph Node Eval as 3. Staging algorithm will identify information as pathologic (p). According to AJCC, a positive biopsy of one or more regional lymph nodes is sufficient to meet the pathologic staging basis for prostate cancer.*

Example: Lung cancer with CT scan or MRI showing involved contralateral mediastinal nodes. *Code CS Lymph Node Eval as 0. Staging algorithm will identify information as clinical (c).*

b. **Lymph nodes removed followed by other treatment(s):** If the patient had removal of lymph node(s) surgery together with removal of the primary site that meets the criteria for a pathologic T and these procedures are followed by other treatment(s), use code 3.

c. **When there is pre-operative treatment:** If the patient receives preoperative (neoadjuvant) systemic therapy (chemotherapy, hormone therapy, immunotherapy) or radiation therapy, the clinical status of lymph nodes takes precedence (code 5). If lymph node dissection is not performed after neoadjuvant therapy, use code 0 or 1.

d. **When there is more extensive lymph node involvement after preoperative treatment:** Use only code 5 or 6 if the node assessment is performed after neoadjuvant therapy. If the size, number or extension of regional lymph node involvement determined prior to treatment was the basis for neoadjuvant therapy, use code 5. However, if more extensive tumor is found during lymph node examination after neoadjuvant therapy, use code 6.

e. **Use of autopsy codes 2 and 8:** If the patient had an autopsy and the autopsy information meets the timing rules for determining regional lymph node involvement, use code 2 if the diagnosis

was known or suspected prior to death. Use code 8 if the malignancy was not known or suspected prior to death.

4. **Definition of code 0**: Code 0 is the lowest common denominator for evaluation methods and includes physical examination, imaging examination, and/or other non-invasive clinical evidence. If CS Lymph Nodes is coded 000 based on the clinician's impression that there are no involved regional nodes (inaccessible nodes rule), use code 0 to document that met the criteria for a clinical M0.

Examples of imaging studies included in Code 0: Code 0 includes imaging studies such as standard radiography, special radiographic projections, tomography, computerized tomography (CT), ultrasonography (US), lymphography, angiography, scintigraphy (nuclear scans), magnetic resonance imaging (MRI), positron emission tomography (PET) scans, spiral scanning (CT or MRI) and other non-invasive methods of examining tissues. According to the *AJCC Cancer Staging Manual* seventh edition, extensive imaging is not necessary to assign a clinical staging basis.

5. **Use of code 1:** Codes 0-3 are oriented to the AJCC staging basis. Code 1 includes microscopic analysis of tissue insufficient to meet the requirements for pathologic staging in the TNM system.

For example, a needle biopsy of an axillary lymph node will document that a lymph node contains metastases from a breast cancer, but does not meet the requirement for removal of a sufficient number of lymph nodes so that the highest N stage can be assessed. For specific classification rules, refer to the *AJCC Cancer Staging Manual, seventh edition*. Code 1 also includes observations at surgery, such as abdominal exploration at the time of a colon resection, where regional lymph nodes are not biopsied. Code 1 is used when the lymph node procedure is part of the patient's workup to determine the course of treatment and the patient does not undergo resection of the primary site sufficient to meet the criteria for a pathologic T category.

6. **Use of code 3:** Code 3 maps to pathologic staging across all sites. Use code 3 when the lymph node procedure meets the requirements for pathologic staging basis of regional lymph nodes. The requirements vary among sites as to the location and number of lymph nodes involved, the size of the involved nodes, and other characteristics. For example, for prostate cancer, a positive fine needle aspiration biopsy of a single lymph node is sufficient to code CS Lymph Nodes Eval as code 3, because only one positive node is needed to classify the case as pN1 and there is only one positive N category (N1). In contrast, a fine needle aspiration of a hilar mass (N1) associated with a lung cancer should be coded in CS Lymph Nodes Eval as 1 because by itself it is not sufficient to document the highest N since there are three positive N categories. However, microscopic assessment of the highest N category, for example a supraclavicular node containing metastatic lung cancer, is always pathologic (code 3).

7. **Sentinel nodes:** The coding guidelines for positive sentinel lymph nodes in CS Lymph Nodes Eval are site-specific. In general, however, whether the involved sentinel lymph nodes are clinical or pathologic will depend on whether the primary tumor meets the criteria for clinical or pathologic staging. In other words, involved sentinel nodes may be classified as clinical if there is no resection of the primary tumor or if the resection of the primary tumor is not adequate for pathologic T.

a. When the tumor size and/or extension of the primary tumor meets the criteria for pathologic staging and lymph nodes are biopsied or removed for examination, information on lymph nodes is considered pathologic and it is not necessary to document the highest N category.

Example: Patient has a lumpectomy and sentinel lymph node procedure for breast cancer. The margins around the primary tumor are clear, and there is one of three sentinel nodes positive for metastatic duct carcinoma. *Code CS Lymph Nodes Eval as 3 because when the primary tumor procedure meets the criteria for pathologic T and sentinel nodes meet the criteria for pathologic N.*

b. When the tumor size and/or extension of the primary tumor does not meet the criteria for pathologic staging, examination of a single lymph node or sentinel nodes is considered clinical.

Example: Patient presents with large ulcerated mass in the breast and clinically positive axillary nodes. Core needle biopsies of the breast mass and the axillary node confirm carcinoma. Patient undergoes pre-operative chemotherapy followed by a modified radical mastectomy. *Code CS Lymph Nodes Eval as 5 because when the primary tumor procedure does not meet the criteria for pathologic T, and a core needle biopsy of level I lymph nodes performed prior to neoadjuvant treatment is clinical.*

c. If there is a positive biopsy of a lymph node in the highest N category, CS Lymph Nodes Eval should be coded as 3 regardless of whether the primary tumor is clinical or pathologic.

Example: Patient presents with a hard supraclavicular mass, which is excised and shows metastatic squamous carcinoma. Further diagnostic workup shows a mass in the left upper lobe of the lung with several satellite nodules. *Code CS Lymph Nodes Eval as 3 because supraclavicular nodes are in the highest N category (N3).*

8. **Neoadjuvant therapy and 2nd primaries:** When an incidental 2nd primary is discovered at the time of surgery following neoadjuvant therapy (systemic/radiation therapy followed by surgery), this 2nd primary should be coded to Eval code 3, and NOT be coded to eval codes 5 or 6. This would also be true for a 2nd (or higher number) primary diagnosed and treated with a surgical resection as the first course of therapy, when the previous primary was treated with systemic or radiation therapy at any time (adjuvant or neoadjuvant or for a recurrence). To include these cases with those purposefully treated with neoadjuvant therapy would skew the data. The effect of the prior treatment for the previous primary on the new primary is unknown.

9. **Coding CS Lymph Nodes Eval when lymph node status is unknown:** The Eval fields should be coded based on how the information was obtained, even if the information in the related field (Tumor Size, Regional Nodes, or Mets at Dx) is unknown. For example, even if it is not possible to determine lymph node involvement and the CS Lymph Nodes field is coded as 999, the registrar still knows what procedures were used to try to determine that field. In other words, just because the lymph nodes are coded 999, the Eval field does not have to be coded 9.

10. **The following schemas are always coded 9 Not Applicable or Does Not Apply:**

AdnexaUterineOther
Brain
CNSOther
DigestiveOther
EndocrineOther
EyeOther
GenitalFemaleOther
GenitalMaleOther
HemeRetic
IllDefinedOther
IntracranialGland
KaposiSarcoma
Lymphoma
MelanomaSinusOther
MiddleEar
MyelomaPlasmaCellDisorder
PharynxOther
Placenta
RespiratoryOther
SinusOther
Trachea
UrinaryOther

Table H.52 CS Lymph Nodes Eval Standard Table

CODE	DESCRIPTION	STAGING BASIS
0	**Does not meet criteria for AJCC pathologic staging:** No regional lymph nodes removed for examination. Evaluation based on physical examination, imaging examination, or other non-invasive clinical evidence. No autopsy evidence used	c
1	**Does not meet criteria for AJCC pathologic staging based on at least one of the following criteria** No regional lymph nodes removed for examination. Evaluation based on endoscopic examination or other invasive techniques, including surgical observation without biopsy. No autopsy evidence used. **OR** Fine needle aspiration, incisional or core needle biopsy, or excisional biopsy of regional lymph nodes or sentinel nodes as part of the diagnostic workup WITHOUT removal of the primary site adequate for pathologic T classification (treatment).	c
2	**Meets criteria for AJCC pathologic staging:** No regional lymph nodes removed for examination, but evidence derived from autopsy (tumor was suspected or diagnosed prior to autopsy).	p
3	**Meets criteria for AJCC pathologic staging based on at least one of the following criteria:** Any microscopic assessment of regional nodes (including FNA, incisional or core needle biopsy, excisional biopsy, sentinel node biopsy or node resection) WITH removal of the primary site adequate for pathologic T classification (treatment) or biopsy assessment of the highest T category. **OR** Any microscopic assessment of a regional node in the highest N category, regardless of the T category information.	P p

CODE	DESCRIPTION	STAGING BASIS
5	**Does not meet criteria for AJCC y-pathologic (yp) staging:** Regional lymph nodes removed for examination AFTER neoadjuvant therapy and lymph node evaluation based on clinical evidence, unless the pathologic evidence at surgery (AFTER neoadjuvant treatment) is more extensive (see code 6).	c
6	**Meets criteria for AJCC y-pathologic (yp) staging:** Regional lymph nodes removed for examination AFTER neoadjuvant therapy AND lymph node evaluation based on pathologic evidence, because of the pathologic evidence at surgery is more extensive than clinical evidence before treatment. *See Note 1.*	yp
8	**Meets criteria for AJCC autopsy (a) staging:** Evidence from autopsy: tumor was unsuspected or undiagnosed prior to autopsy.	a
9	Unknown if lymph nodes removed for examination Not assessed; cannot be assessed Unknown if assessed Not documented in patient record ***For sites that have no TNM staging:*** Not applicable; staging basis is displayed as a blank.	c

Note 1: Remember to check individual schemas for site-specific codes

Note 2: This staging basis is displayed as "yp" but is stored in the record as "y" because the field is only one character in length.

REGIONAL NODES POSITIVE:

Instructions for Coding

1. **Regional lymph nodes only:** Record information about only regional lymph nodes in this field. Involved distant lymph nodes should be coded in the "CS Mets at Dx" field.

   a. Although all lymph node involvement (regional and distant) is coded in CS Lymph Nodes for Kaposi sarcoma, retinoblastoma and lymphoma ocular adnexa, only count positive regional lymph nodes in this field. Do not include distant nodes coded in CS Lymph Nodes. If CS Lymph Nodes is coded 800, assume these are regional and count in this field.

2. This field is **based on pathologic information only**. This field is to be recorded regardless of whether the patient received preoperative treatment.

3. True in situ cases cannot have positive lymph nodes, so the only allowable codes are 00 (negative) or 98 (not examined). Codes 01-97 and 99 are not allowed.

4. **Cumulative nodes positive:** Record the total number of regional lymph nodes removed and found to be positive by pathologic examination.

a. The number of regional lymph nodes positive is cumulative from all procedures that remove lymph nodes through the completion of surgeries in the first course of treatment.

b. Do not count a positive aspiration or core biopsy of a lymph node in the same lymph node chain removed at surgery as an additional node in Regional Nodes Positive when there are positive nodes in the resection. In other words, if there are positive regional lymph nodes in a lymph node dissection, do not count the core needle biopsy or the fine needle aspiration if it is in the same chain. See also Definition of Code 95 below.

Example: Lung cancer patient has a mediastinoscopy and positive core biopsy of a hilar lymph node. Patient then undergoes right upper lobectomy that yields 3 hilar and 2 mediastinal nodes positive out of 11 nodes dissected. *Code Regional Nodes Positive as 05 and Regional Nodes Examined as 11 because the core biopsy was of a lymph node in the same chain as the nodes dissected.*

Example: Positive right cervical lymph node aspiration followed by right cervical lymph node dissection showing 1 of 6 nodes positive. *Code Regional Nodes Positive as 01 and Regional Nodes Examined as 06.*

c. If the positive aspiration or core biopsy is from a node in a different node region, include the node in the count of Regional Nodes Positive.

Example: Breast cancer patient has a positive core biopsy of a supraclavicular node and an axillary dissection showing 3 of 8 nodes positive. *Code Regional Nodes Positive as 04 and Regional Nodes Examined as 09 because the supraclavicular lymph node is in a different, but still regional, lymph node chain.*

d. If the location of the lymph node that is core-biopsied or aspirated is not known, assume it is part of the lymph node chain surgically removed, and do not include it in the count of Regional Nodes Positive.

Example: Patient record states that core biopsy was performed at another facility and 7/14 regional lymph nodes were positive at the time of resection. *Code Regional Nodes Positive as 07 and Regional Nodes Examined as 14.*

5. **Priority of lymph node counts:** If there is a discrepancy regarding the number of positive lymph nodes, use information in the following priority: final diagnosis, synoptic report (also known as CAP protocol or pathology report checklist), microscopic, gross.

6. **Use of code 95:** Use code 95 when the only procedure for regional lymph nodes is a needle aspiration (cytology) or core biopsy (tissue).

a. Use code 95 when a positive lymph node is aspirated and there are no surgically resected lymph nodes.

Example: Patient with esophageal cancer. Enlarged mid-esophageal node found on CT scan, which is aspirated and found to be positive. Patient undergoes radiation therapy and no surgery. *Code Regional Nodes Positive as 95 and Regional Nodes Examined as 95.*

b. Use code 95 when a positive lymph node is aspirated and surgically resected lymph nodes are negative.

Example: Lung cancer patient has aspiration of suspicious hilar mass, which shows metastatic squamous carcinoma in lymph node tissue. Patient undergoes preoperative radiation therapy followed by lobectomy showing 6 negative hilar lymph nodes. *Code Regional Nodes Positive as 95 and Regional Nodes Examined as the 06 nodes surgically resected. (Code Reg Nodes Eval as 5.)*

7. **Definition of code 97:** Use code 97 for any combination of positive aspirated, biopsied, sampled or dissected lymph nodes if the number of involved nodes cannot be determined on the basis of cytology or histology. Code 97 includes positive lymph nodes diagnosed by either cytology or histology.

Example: Patient with carcinoma of the pyriform sinus has a mass in the mid neck. Fine needle aspiration (FNA) of one node is positive. The patient has neoadjuvant chemotherapy, then resection of the primary tumor and a radical neck dissection. In the radical neck dissection "several" of 10 nodes are positive; the remainder of the nodes show chemotherapy effect. *Code Regional Nodes Positive as 97 because the total number of positive nodes biopsied and removed is unknown, and code Regional Nodes Examined as 10.*

Note: For primary sites where the number of involved nodes must be known in order to map to N1, N2, etc., code 97 maps to N1and therefore should be avoided.

Note: If the aspirated node is the only one that is microscopically positive, use code 95.

Note: Avoid using Regional Nodes Positive code 97 if possible, even if this means slightly undercounting the number of nodes positive.

8. **Use of code 98:** Code 98 may be used in several situations.

a. When the assessment of lymph nodes is clinical only.

b. When no lymph nodes are removed and examined.

c. When a "dissection" of a lymph node drainage area is found to contain no lymph nodes at the time of pathologic examination.

d. If Regional Nodes Positive is coded as 98, Regional Nodes Examined is usually coded 00.

9. **Isolated tumor cells (ITCs) in lymph nodes:** For all primary sites except cutaneous melanoma and Merkel cell carcinoma of skin, count only lymph nodes that contain micrometastases or larger (metastases greater than 0.2 millimeters in size). Do not include in the count of lymph nodes positive any nodes that are identified as containing isolated tumor cells (ITCs). If the path report indicates that nodes are positive but the size of metastasis is not stated, assume the metastases are larger than 0.2 mm and count the lymph node(s) as positive.

a. **For cutaneous melanoma and Merkel cell carcinoma**, count nodes with ITCs as positive lymph nodes.

10. **Use of code 99:** Use code 99 if it is unknown whether regional lymph nodes are positive.

11. **Primary sites always coded 99:** For the following primary sites and histologies, the Regional Nodes
Positive field is always coded as 99.
Placenta
Brain and Cerebral Meninges
Other Parts of Central Nervous System
Intracranial Gland
Hodgkin and non-Hodgkin Lymphoma
Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms
Myeloma and PlasmaCell Disorders
Other and Ill-Defined Primary Sites
Unknown Primary Site

Table H.53 Regional Lymph Nodes Positive Standard Table

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

Note: Remember to check individual schemas for site-specific codes

REGIONAL NODES EXAMINED:

Instructions for Coding

1. **Regional lymph nodes only:** Record information about only regional lymph nodes in this field. Distant lymph node information should be coded in the "CS Mets at Dx" field.

a. Although all lymph node involvement (regional and distant) is coded in CS Lymph Nodes for Kaposi sarcoma, retinoblastoma and lymphoma ocular adnexa, only count regional lymph nodes in this field. Do not include distant nodes coded in CS Lymph Nodes. If CS Lymph Nodes is coded 800, assume these are regional and count in this field.

2. This field is **based on pathologic information only**. This field is to be recorded regardless of whether the patient received preoperative treatment.

3. **Use of code 0:** Code 00 may be used in several situations.

- When the assessment of lymph nodes is clinical.
- When no lymph nodes are removed and examined.
- When a "dissection" of a lymph node drainage area is found to contain no lymph nodes at the time of pathologic examination.
- If Regional Nodes Examined is coded 00, Regional Nodes Positive is coded as 98.

4. **Cumulative nodes removed and examined:** Record the total number of regional lymph nodes removed and examined by the pathologist.

a. The number of regional lymph nodes examined is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment with the exception of aspiration or core biopsies coded to 95.

b. Do not count a positive aspiration or core biopsy of a lymph node in the same lymph node chain removed at surgery as an additional node in Regional Nodes Examined.

Example Lung cancer patient has a mediastinoscopy and positive core biopsy of a hilar lymph node. Patient then undergoes right upper lobectomy that yields 3 hilar and 2 mediastinal nodes positive out of 11 nodes dissected. *Code Regional Nodes Positive as 05 and Regional Nodes Examined as 11 because the core biopsy was of a lymph node in the same chain as the nodes dissected.*

c. If the positive aspiration or core biopsy is from a node in a different node region, include the node in the count of Regional Nodes Examined.

Example Breast cancer patient has a positive core biopsy of a supraclavicular node and an axillary dissection showing 3 of 8 nodes positive. *Code Regional Nodes Positive as 04 and Regional Nodes Examined as 09 because the supraclavicular lymph node is in a different, but still regional, lymph node chain.*

d. If the location of the lymph node that is aspirated or core-biopsied is not known, assume it is part of the lymph node chain surgically removed, and do not include it in the count of Regional Nodes Examined.

Example: Patient record states that core biopsy was performed at another facility and 7/14 regional lymph nodes were positive at the time of resection. *Code Regional Nodes Positive as 07 and Regional Nodes Examined as 14.*

e. When neither the type of lymph node removal procedure nor the number of lymph nodes examined is known, use code 98.

5. **Priority of lymph node counts:** If there is a discrepancy regarding the number of lymph nodes examined, use information in the following priority: final diagnosis, synoptic report (also known as CAP protocol or pathology report checklist), microscopic, gross.

6. **Use of code 95:** Use code 95 when the only procedure for regional lymph nodes is a needle aspiration (cytology) or core biopsy (tissue).

Example: Patient with esophageal cancer. Enlarged mid-esophageal node found on CT scan, which is aspirated and found to be positive. Patient undergoes radiation therapy and no surgery. *Code Regional Nodes Positive as 95 and Regional Nodes Examined as 95.*

7. **Lymph node biopsy:** If a lymph node biopsy was performed, code the number of nodes removed, if known. If the number of nodes removed by biopsy is not known, use code 96.

8. **Definition of "sampling" (code 96):** A lymph node "sampling" is removal of a limited number of lymph nodes. Other terms for removal of a limited number of nodes include lymph node biopsy, berry picking, sentinel lymph node procedure, sentinel node biopsy, selective dissection. Use code 96 when a limited number of nodes are removed but the number is unknown.

9. **Definition of "dissection" (code 97):** A lymph node "dissection" is removal of most or all of the nodes in the lymph node chain(s) that drain the area around the primary tumor. Other terms include lymphadenectomy, radical node dissection, lymph node stripping. Use code 97 when more than a limited number of lymph nodes are removed and the number is unknown.

10. **Multiple lymph node procedures:** If both a lymph node sampling and a lymph node dissection are performed and the total number of lymph nodes examined is unknown, use code 97.

11. **Use of code 99.** If it is unknown whether nodes were removed or examined, code as 99.

12. **Primary sites always coded 99:**
For the following schemas, the Regional Nodes Examined field is always coded as 99.
Placenta
Brain and Cerebral Meninges
Other Parts of Central Nervous System
Intracranial Gland
Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms
Hodgkin and non-Hodgkin Lymphoma
Myeloma and Plasma Cell Disorders
Other and Ill-Defined Primary Sites
Unknown Primary Site

Table H.54 Regional Nodes Examined Standard Table

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

Note: Remember to check individual schemas for site-specific codes.

CS METS AT DX: Instructions for Coding

1. **Discontinuous or hematogenous metastases:** This field represents distant metastases (the TNM M component or distant stage in Summary Staging) that are known at the time of diagnosis. In other words, when the patient was diagnosed, tumor had already spread indirectly (through vascular or lymph channels) to lymph nodes beyond those defined as regional or to a site remote from the primary tumor.

Note: The structure of the CS Mets at Dx field is based on the M category of TNM. In some schemas, there may be additional items in CS Extension or CS Lymph Nodes that map to distant stage in Summary Staging (1977 and/or 2000) and there may be some items in CS Mets at Dx that map to regional stage in Summary Staging. Regardless of where such items are recorded, the staging algorithms will properly account for the information.

Note: For a few schemas such as breast, lung, and kidney, some codes in CS Mets at Dx are distant direct (contiguous) extension either in the summary staging system or in TNM. If the structure involved by direct extension is not listed in CS Extension, look for a code in CS Mets at Dx. Code the involved structure wherever it is listed—the CS computer algorithm will derive the correct stage in both TNM and summary stage. If the specific structure is not listed in either CS Extension or CS Mets at Dx, code as CS Extension 800, further contiguous extension.

2. **Use highest applicable code:** Assign the highest applicable code for metastasis at diagnosis, whether the determination was clinical or pathological and whether or not the patient had any preoperative systemic therapy. Code 40 includes statements of metastases to specific named structures or "carcinomatosis." Code 60 is nonspecific distant metastases or a statement of M1 with no further information about metastases; code 60 does not take priority over lower codes.

3. **Progression of disease:** Metastasis known to have developed after the extent of disease was established (also referred to as progression of disease) should not be recorded in the CS Mets at Dx field.

4. **Coding 00 versus 99**

a. Record CS Mets at Dx as Code 00 (None) if there is no clinical or pathologic evidence of distant metastases and the patient is not treated as if metastases are present or suspected. This presumes that there are no distant metastasis that would otherwise alter the treatment approach.

b. Code 99 may be used in situations where there is reasonable doubt that the tumor is no longer localized and there is no documentation of distant metastases. Note that code 99 maps to MX in sixth edition and cM0 in seventh edition.

c. Based on the *AJCC Cancer Staging Manual*, seventh edition, determination of the clinical M classification (CS Mets at Dx code 00) only requires history and physical examination. Imaging of distant organ sites is not required to assign cM0 or CS Mets at Dx code 00. In other words, the data collector can infer that there are no distant metastases and code CS Mets at Dx as 00 (cM0) unless distant metastases are identified and classified as cM1 or pM1 (or its equivalents in CS Mets at Dx). Use code 0 in CS Mets Eval as this documents minimal physical examination to support the inference of clinical M0.

5. **No MX classification for AJCC seventh edition:** The category MX has been eliminated from the seventh edition of the TNM staging system. As noted above, if there are no symptoms or other indication of distant metastases, the mapping algorithm takes CS Mets at Dx codes 00 and 99 and maps both to cM0.

6. **Inferring distant metastases from stated M category or site-specific staging:** If the only indication of distant metastases in the record is the physician's statement of an M category from the TNM staging system or a stage from a site-specific staging system, such as Dukes D, code the appropriate "Stated as M_, NOS" category or record the numerically lowest equivalent CS Mets at Dx code for the site-specific staging system. In most cases, this will be 60, Distant metastasis, NOS.

a. If the information in the medical record is ambiguous or incomplete regarding the extent to which the tumor has spread, the extent of disease may be inferred from the M category stated by the physician.

7. **Use of NOS categories:** Some schemas include a designation of M1, NOS. The NOS is added when there is further breakdown of the category into subsets (such as M1a, M1b, M1c), but the correct subset cannot be determined. The NOS designation, which can appear in both the descriptions of codes and the mapping, is not official AJCC descriptive terminology. The NOS should be disregarded in reports and analyses when it is not a useful distinction. The data collector should only code to a category such as "Stated as M1 NOS" when the appropriate subset (such as M1a or M1b) cannot be determined.

8. **Circulating Tumor Cells (CTCs) and Disseminated Tumor Cells (DTCs) :** CTCs and DTCs are small clusters of tumor cells found in distant sites such as bone, circulating blood, or bone marrow having uncertain prognostic significance.

b. For breast, code CS Mets at Dx as 05 when a biopsy of a possible metastatic site shows isolated tumor cells or bone marrow micrometastases detected by IHC or molecular techniques. CS Mets at Dx code 05 maps to cM0 (i+).

c. For other sites, CTCs and DTCs are coded in CS Mets at Dx as 00 and map to cM0.

9. **Primary sites always coded 98.** For the following primary sites and histologies, CS Mets at Dx is always coded as 98.
Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms
Hodgkin and non-Hodgkin Lymphoma
Kaposi Sarcoma
Myeloma and Plasma Cell Disorders
Other and Ill-Defined Primary Sites
Unknown Primary Site

10. **Document choice of code in text.** It is strongly recommended that the positive and negative assessment of distant lymph nodes and/or distant metastasis codes be documented as well as the choice of code in a related text field on the abstract.

Table H.55 CS Mets at Dx Standard Table

CODE	DESCRIPTION	TNM7 MAP	TNM 6 MAP	SS77 MAP	SS2000 MAP
00	No; none	M0	M0	None	None
10	Distant lymph node(s)	M1	M1	D	D
SITE/HISTOLOGY-SPECIFIC CODES WHERE NEEDED					
40	Distant metastases except code 10 Carcinomatosis	M1	M1	D	D
50	40 + 10	M1	M1	D	D
60	Distant metastasis Stated M1, NOS	M1	M1	D	D
99	Unknown if distant metastasis Distant metastasis cannot be assessed Not documented in patient record	M0	MX	U	U

Note: Remember to check individual schemas for site-specific codes.

Table H.56 For Schemas that do not use the CS Mets at Dx field

CODE	DESCRIPTION
98	Not applicable for this site

CS METS EVAL: Instructions for Coding

1. **Document the highest code in CS Mets at Dx.** The primary use of the CS Mets Eval field is to assign a “c” or “p” to the M category derived from the CS Mets at Dx field. Since both clinical and pathologic evidence might be available for assessing distant metastasis, the coding of the Eval field can be confusing. The goal is to assign the Eval code that indicates the best evidence used to determine the M category. In other words, the concept of the Mets Eval field is slightly different from the other Eval fields in that results of the procedure are coded, rather than the type of procedure that provided the information about distant metastasis. Coding of the Eval field therefore requires that the abstractor take note of the M category that will be derived from the code in the CS Mets at Dx field and then use the following guidelines to determine the best Eval code to assign.

a. **Deriving M0.** If M0 will be derived (i.e., no distant metastasis are present), select an Eval code that will derive a “c” staging basis. There is no category of pM0, because it is impossible to

disprove all possible sites of metastasis pathologically. Therefore, do not assign CS Mets Eval code 2, 3, or 6 when CS Mets at DX is coded 00.

Example: Pancreatic carcinoma with negative chest X-ray and negative liver biopsy. Code CS Mets at Dx as 00 (None), which maps to M0. *Code CS Mets Eval as 1 to document the liver biopsy, which maps to the "c" staging basis.*

Example: Chest x-ray negative and surgical observation during hemicolectomy shows no liver metastasis. *Code CS Mets Eval as 1, because there was an invasive technique (surgery observation) that yielded a negative result.*

Example: CT scan indicates thickened stomach wall with normal liver, spleen, lung bases and impression states presumed gastric malignancy. Patient dies 2 days later from chronic renal failure. Autopsy confirms primary gastric adenocarcinoma with all other body systems normal. Code CS Mets Eval as 0 (imaging prior to death) as there is no category of pM0.

b. **Mapping of CS Mets at Dx code 99.** If the status of distant metastases is unknown (CS Mets at Dx code 99), choose an Eval code that will derive a "c" staging basis, because code 99 maps to M0 in TNM7, and this category can only be clinical. The appropriate code might be 9 (Unknown) in rare situations or might be another code if workup was done but the results were not definitively positive or negative.

Example: Cecum carcinoma abstracted from a pathology report of biopsy only, no clinical data or surgical observations available. *Code CS Mets at Dx as 99 (Unknown), which will map to M0 in the seventh edition. Code CS Mets Eval as 9 (Unknown), which maps to the "c" staging basis.*

Example: Lung cancer diagnosed by imaging. Patient has behavior changes, and brain imaging cannot rule out metastases. Patient is not a surgical candidate. *Code CS Mets at Dx as 99 (Unknown), which maps to M0 in the seventh edition. Code CS Mets Eval as 0(imaging), which maps to the "c" staging basis.*

c. **Pathologic M1 takes priority.** If M1 will be derived (i.e., there is metastatic disease present and coded in the CS Mets at Dx field) and there are no subcategories of M1, such as M1a and M1b, then determine if there was any pathological evidence for the M1 category.

- If there is microscopic confirmation of distant metastases, select an Eval code that will derive a "p" staging basis. In other words, any microscopic confirmation of a distant metastasis meets the criteria for pathologic M1.

Example: Patient with perforated stomach cancer. At surgery, peritoneal cytology is positive. CT scan shows multiple liver metastases. *Code CS Mets at Dx as 40for both the liver and peritoneal metastases, which maps to M1. (There are no subcategories of M1 for stomach). Code CS Mets Eval as 3 because any positive microscopic confirmation of distant metastases meets the criteria for pathologic staging of distant metastases.*

- If there was only clinical evidence of the M1 disease, select an Eval code that will derive a "c" staging basis.

Example: Patient diagnosed with kidney cancer and discharged to nursing home where she expired within two weeks of diagnosis. Discharge summary states bone metastases from kidney cancer as final diagnosis. There is no supporting documentation for the bone metastases in either the original hospital record or the nursing home record. *Code CS Mets Eval as 0 because the physicians' statement of bone metastases is part of "other non-invasive clinical evidence" in code 0 and maps to a clinical staging basis. Do not use code 9, because the presence of distant metastases was assessed by the clinician.*

d. **Mapping of M1 subcategories:** If a specific subcategory of M1 will be derived (such as M1a), determine if there was any pathological evidence for the specific subcategory. If so, select an Eval code that will derive a "p" staging basis. If there was only clinical evidence of the subcategory disease, select an Eval code that will derive a "c" staging basis. In the latter case there may have been pathological evidence of a lower M subcategory, but this is not considered in assigning the Eval code.

Table H.57 Mapping of M1 subcategories Example 1 Prostate carcinoma with one or more of the following:

INVOLVEMENT	CS METS AT DX CODE	TNM MAP
Positive biopsy of aortic lymph node (distant node)	Code 12	pM1a
Positive bone imaging	Code 30	cM1b
Positive brain imaging	Code 40	cM1c
All of the above	Code 55 (=codes 12+30+40)	cM1c

To code CS Mets at Dx, follow the general rule to code the highest applicable code, even though there is pathological evidence of metastases. *Code CS Mets at Dx as 55, which combines the codes for the lymph node, bone, and brain involvement. Code 55 maps to M1c. There is no pathologic evidence for the subcategory M1c (the only pathological evidence is for subcategory M1a). Code CS Mets Eval as 0 (imaging), which maps to the "c" staging basis.* The positive lymph node would map to M1a, a lower M subcategory. Do not base the Eval code on positive microscopic findings for a lower subcategory.

Example 2: Prostate carcinoma with positive biopsy of aortic lymph node (distant node), negative bone scan, and negative brain scan. *Code CS Mets at Dx as 12 (distant lymph node), which maps to M1a. Code CS Mets Eval as 3, which maps to the "p" staging basis.*

Example 3: Testicular carcinoma patient has a positive pelvic lymph nodes on FNA (CS Mets at Dx code 11, maps to M1a). Patient has CT of brain showing distant metastases (CS Mets at Dx code 40, maps to M1b). *Code CS Mets Eval as 0 because the higher M subcategory was established by imaging.*

Example 4: Cecum carcinoma with lung metastases on chest X-ray and positive liver biopsy. CS Mets at Dx is coded 36 (Metastases to more than one distant organ), which maps to M1b. *Code CS Mets Eval as 0, which maps to the "c" staging basis because only one organ/site was microscopically proven.*

Example 5: Sigmoid adenocarcinoma with liver metastases on ultrasound and positive peritoneal nodule biopsy. CS Mets at Dx is coded 36 (Metastasis to peritoneum). *Code CS Mets Eval as 3, which maps to the "p" staging basis because although only one organ/site is microscopically confirmed, that one organ/site is the peritoneum (M1b).*

2. **When there is no TNM mapping.** For sites and histologies for which no TNM schema has been defined, such as brain or Kaposi sarcoma, this field is always coded 9, Not Applicable. (See Rule 9.) For any sites and histologies not listed there, code to the value that best reflects the diagnostic methods used, whether or not a stage is actually calculated for an individual case. In other words, do not use code 9 when a case has a histology that is excluded from staging but the site does have a TNM schema defined, for example, a sarcoma of the breast. In those cases, use code 9 only when the nature of the diagnostic methods is actually unknown.

3. **When there is neoadjuvant treatment.** If the patient receives preoperative (neoadjuvant) systemic therapy (chemotherapy, hormone therapy, immunotherapy) or radiation therapy, the clinical status of metastases at diagnosis takes precedence (code 5), unless the pathologic evidence is more extensive (code 6).

4. **Definition of code 0**. Code 0 is the lowest common denominator for evaluation methods and includes physical examination, imaging examination, and/or other non-invasive clinical evidence. If CS Mets at Dx is coded 00 based on the clinician's impression that there are no distant metastases, use code 0 to document that met the criteria for a clinical M0.

Examples of imaging studies included in Code 0. Code 0 includes imaging studies such as standard radiography, special radiographic projections, tomography, computerized tomography (CT), ultrasonography (US), lymphography, angiography, scintigraphy (nuclear scans), magnetic resonance imaging (MRI), positron emission tomography (PET), spiral scanning (CT or MRI) and other non-invasive methods of examining tissues.

5. **Definition of Code 1.** Code 1 includes endoscopy and observations at surgery, such as abdominal exploration at the time of a colon resection, where distant metastasis is not biopsied as well as biopsies of distant sites that are negative.

6. **Definition of Code 3.** In general, any positive microscopic confirmation of a metastasis meets the criteria for pathologic staging. Therefore, a positive needle biopsy of a metastatic site is Eval Code 3.

Complete removal of a metastatic site is not required for pathologic staging.

7. **No pathologic M0.** AJCC does not recognize a pM0 category since it is not possible to microscopically rule out all possible metastatic sites. According to the *AJCC Cancer Staging Manual*, seventh edition, "A case where there are no symptoms or signs of metastases is classified as clinically M0. The only evaluation necessary to classify a case as clinically M0 is history and physical examination. It is not necessary to do extensive imaging studies to classify a case as clinically M0."

a. If there is no mention in the medical record of distant metastases, code CS Mets at Dx as 00 and CS Mets Eval as 0, which maps to cM0.

b. If there is evidence of metastases on physical examination, imaging, or exploratory surgery and there is no biopsy of the suspected metastatic site, code CS Mets at Dx appropriately (not 00 or 99) and CS Mets Eval with a code that maps to "c" staging basis. In general, such cases will map to cM1_.

c. If the patient has a biopsy or removal of a distant site and the pathology report is negative,generally use Eval code 1, because this does not meet the criteria for pathologic staging.

8. **Circulating Tumor Cells (CTCs) and Disseminated Tumor Cells (DTCs) in metastatic sites:** CTCs and DTCs, including bone marrow micrometastases, are clinical findings if detected by immunohistochemistry or molecular methods. The significance of these small clusters of tumor cells in distant sites is indeterminate. When identified, CTCs and DTCs are coded in CS Mets at Dx as 00 and CS Mets Eval should be assigned a code that maps to "c" staging basis. In general, such cases will map to cM0 or cM0 (i+).

9. **Neoadjuvant therapy and 2nd primaries.** When an incidental 2nd primary is discovered at the time of surgery following neoadjuvant therapy (systemic/radiation therapy followed by surgery), this 2nd primary should be coded to Eval code 3, and NOT be coded to eval codes 5 or 6. This would also be true for a 2nd (or higher number) primary diagnosed and treated with a surgical resection as the first course of therapy, when the previous primary was treated with systemic or radiation therapy at any time (adjuvant or neoadjuvant or for a recurrence). To include these cases with those purposefully treated with neoadjuvant therapy would skew the data. The effect of the prior treatment for the previous primary on the new primary is unknown.

10. **Schemas always coded 9 Not Applicable.**
AdnexaUterineOther
Brain
CNSOther
DigestiveOther
EndocrineOther
EyeOther
GenitalFemaleOther
GenitalMaleOther
HemeRetic
IllDefinedOther
IntracranialGland
KaposiSarcoma
Lymphoma
MelanomaSinusOther
MiddleEar
MyelomaPlasmaCellDisorder
PharynxOther
RespiratoryOther
SinusOther
Trachea
UrinaryOther

Table H.58 CS Mets Eval Table

CODE	DESCRIPTION	STAGING BASIS
0	**Does not meet criteria for AJCC pathologic staging of distant metastasis:** Evaluation of distant metastasis based on physical examination, imaging examination, and/or other non-invasive clinical evidence. No pathologic examination of metastasis performed or pathologic examination was negative.	c
1	**Does not meet criteria for AJCC pathologic staging of distant metastasis:** Evaluation of distant metastasis based on endoscopic examination or other invasive technique, including surgical observation without biopsy. No pathologic examination of metastasis performed or pathologic examination was negative.	**c**
2	**Meets criteria for AJCC pathologic staging of distant metastasis:** No pathologic examination of metastatic specimen done prior to death, but positive metastatic evidence derived from autopsy (tumor was suspected or diagnosed prior to autopsy).	p
3	**Meets criteria for AJCC pathologic staging of distant metastasis:** Specimen from metastatic site microscopically positive WITHOUT pre-surgical systemic treatment or radiation **OR** specimen from metastatic site microscopically positive, unknown if pre-surgical systemic treatment or radiation performed **OR** specimen from metastatic site microscopically positive prior to neoadjuvant treatment	p
5	**Does not meet criteria for AJCC y-pathologic (yp) staging of distant metastasis:** Specimen from metastatic site microscopically positive WITH pre-surgical systemic treatment or radiation, BUT metastasis based on clinical evidence.	c
6	**Meets criteria for AJCC y-pathologic (yp) staging of distant metastasis:** Specimen from metastatic site microscopically positive WITH pre-surgical systemic treatment or radiation, BUT metastasis based on pathologic evidence. ***See Note 2.***	yp
8	**Meets criteria for AJCC autopsy (a) staging of distant metastasis:** Evidence from autopsy based on examination of positive metastatic tissue AND tumor was unsuspected or undiagnosed prior to autopsy.	a
9	Not assessed; cannot be assessed Unknown if assessed Not documented in patient record **For sites with no TNM staging:** Not applicable	**c**

Note 1: Remember to check individual schemas for site-specific codes

Note 2: This staging basis is displayed as “yp” but is stored in the record as “y” because the field is only one character in length.

Table H.59 Purpose: **This table contains the data items currently or previously collected. The Texas Cancer Registry adheres to reporting requirements mandated by the National Program of Central Registries. Additional data items are required to meet requests from our data users.**

DATA ITEM	NAACCR ITEM NUMBER	COLLECTION DATES
Date of Admission/First Contact	580	1995 - present
Date of Admission/First Contact Flag	581	2010 - present
Registry Number	550	1995 - present
Reporting Facility	540	1995 - present
NPI Reporting Facility (Derived)	545	2009 - present
Reporting Source	500	1995 - present
Medical Record #	2300	1995 - present
Class of Case	610	1998 - present
Last Name	2230	1995 - present
First Name	2240	1995 - present
Middle Name	2250	1995 - present
Maiden Name	2390	1995 - present
Alias	2280	1995 - 2002 2006 - present

DATA ITEM	NAACCR ITEM NUMBER	COLLECTION DATES
Street Address	**2330**	**1995 - present**
Address at Dx Supplemental	**2335**	**2006 - present**
City	**70**	**1995 - present**
State	**80**	**1995 - present**
Zip Code	**100**	**1995 - present**
FIPS County Code at DX	**90**	**1995 - present**
Social Security Number	**2320**	**1995 - present**
Date of Birth	**240**	**1995 - present**
Date of Birth Flag	**241**	**2010 - present**
Place of Birth	**250**	**1998 - present**
Race 1	**160**	**1995 - present**
Race 2	**161**	**2001 - present**
Race 3	**162**	**2001 - present**
Race 4	**163**	**2001 - present**
Race 5	**164**	**2001 - present**
Spanish/Hispanic Origin	**190**	**1995 - present**

DATA ITEM	NAACCR ITEM NUMBER	COLLECTION DATES
Sex	**220**	**1995 - present**
Text Usual Occupation	**310**	**2010 - present**
Text Usual Industry	**320**	**2010 - present**
Other Pertinent Information	**2680**	**1995 - present**
Physician Managing	**2460**	**2006 - 2010**
Physician Follow Up	**2470**	**2006 - present**
Facility Referred From	**2410**	**2001 - 2010**
Facility Referred To	**2420**	**2001 - 2010**
Sequence Number Hospital	**560**	**1995 - present**
Sequence Number Central	**380**	**2011 - present**
Other Primary Tumors	**2200**	**1995 - present**
Primary Payer at DX	**630**	**2007 - present**
Comorbidity #1	**3110**	**2011 - present**
Comorbidity #2	**3120**	**2011 - present**
Comorbidity #3	**3130**	**2011 - present**
Comorbidity #4	**3140**	**2011 - present**

DATA ITEM	NAACCR ITEM NUMBER	COLLECTION DATES
Comorbidity #5	**3150**	**2011 - present**
Comorbidity #6	**3160**	**2011 - present**
Comorbidity #7	**3161**	**2011 - present**
Comorbidity #8	**3162**	**2011 - present**
Comorbidity #9	**3163**	**2011 - present**
Comorbidity #10	**3164**	**2011 - present**
Date of Initial Diagnosis	**390**	**1995 - present**
Date of Diagnosis Flag	**391**	**2010 - present**
ICD - O 2 Morph Prior to 2001	**420**	**1995 - 2001**
Behavior prior to 2001	**430**	**1995 - 2001**
ICDO 3 2001 and forward	**522**	**2001 - present**
Behavior 2001 and forward	**523**	**2001 - present**
Primary Site	**400**	**1995 - present**
Grade of Tumor	**440**	**1995 - present**
Grade Path Value	**441**	**2011 - present**
Grade Path System	**449**	**2011 - present**

DATA ITEM	NAACCR ITEM NUMBER	COLLECTION DATES
Laterality	**410**	**1995 - present**
Final DX Morph/Beh/Grade	**2590**	**1995 - present**
Final DX Primary Site and Laterality	**2580**	**1995 - present**
Lymph - Vascular Invasion	**1182**	**2011 - present**
Diagnostic Confirmation	**490**	**1995 - present**
Tumor Size Prior to 2004	**780**	**1998 - 2003**
Summary Stage 1977 for appropriate years	**760**	**1995 - 2000**
Summary Stage 2000 for appropriate years	**759**	**2001 - 2004**
CS Tumor Size 2004 and forward	**2800**	**2004 - present**
CS Extension	**2810**	**2004 - present**
CS Tumor Size/EXT Eval	**2820**	**2008 - present**
CS Lymph Nodes	**2830**	**2004 - present**
CS Lymph Nodes Eval	**2840**	**2011 - present**
Regional Nodes Positive	**820**	**1998 - present**
Regional Nodes Examined	**830**	**1998 - present**
Date of Initial RX Flag	**1261**	**2010 - present**

DATA ITEM	NAACCR ITEM NUMBER	COLLECTION DATES
CS Mets at DX	2850	2004 - present
CS Mets Eval	2860	2011 - present
CS Site Specific Factor 1 NPCR required only	2880	2004 - present
CS Site Specific Factor 2 NPCR required only	2890	2010 - present
CS Site Specific Factor 3 NPCR required only	2900	2004 - present
CS Site Specific Factor 4 NPCR required only	2910	2011 - present
CS Site Specific Factor 5 NPCR required only	2920	2011 - present
CS Site Specific Factor 6 NPCR required only	2930	2011 - present
CS Site Specific Factor 7 NPCR required only	2861	2011 - present
CS Site Specific Factor 8 NPCR required only	2862	2010 - present
CS Site Specific Factor 9 NPCR required only	2863	2010 - present
CS Site Specific Factor 10 NPCR required only	2864	2010 - present
CS Site Specific Factor 11 NPCR required only	2865	2010 - present
CS Site Specific Factor 12 NPCR required only	2866	2010 - present
CS Site Specific Factor 13 NPCR required only	2867	2010 - present
CS Site Specific Factor 14 NPCR required only	2868	2010 - present

DATA ITEM	NAACCR ITEM NUMBER	COLLECTION DATES
CS Site Specific Factor 15 NPCR required only	2869	2011 - present
CS Site Specific Factor 16 NPCR required only	2870	2011 - present
CS Site Specific Factor 17 NPCR required only	2871	2011 - present
CS Site Specific Factor 25 NPCR required only	2879	2010 - present
Summary Stage Documentation	2600	1995 - present
RX Summary - Reg LN Examined	1296	2001 - 2005
RX Summary - Scope of Reg LN Surgery	1292	2001 - present
Date of Initial Treatment	1260	2010 - present
Date of Initial Treatment Flag	1261	2010 - present
RX Date Surgery	1200	1995 - present
RX Date Surgery Flag	1201	2010 - present
Surgery RX Code	1290	1995 - present
Reason for No Surgery	1340	1998 - 2002 2006 - present
RX Summary - Surgery Other/Dist RX Code	1294	1998 - present
RX Text Surgery	2610	2004 - present
Date Radiation Started	1210	1995 - present

DATA ITEM	NAACCR ITEM NUMBER	COLLECTION DATES
RX Date Radiation Flag	**1211**	**2010 - present**
RX Summary - Radiation	**1360**	**1998 - 2003** **2012 - present**
Radiation Regional RX Modality Code	**1570**	**2003 - present**
Reason for no Radiation	**1430**	**1998 - 2002** **2011 - present**
RX Text - Radiation	**2620, 2630**	**2004 - present**
RX Summary - Surgery/Radiation Sequence	**1380**	**2004 - present**
RX Date - Systemic	**3230**	**2004 - 2010**
Date Chemotherapy Started	**1220**	**2010 - present**
RX Date Chemotherapy Flag	**1221**	**2010 - present**
Chemotherapy Code	**1390**	**1995 - present**
Reason for no Chemotherapy	**1440**	**1998 - 2002**
RX Text - Chemotherapy	**2640**	**2004 - present**
Date Hormone Therapy Started	**1230**	**2010 - present**
RX Date Hormone Flag	**1231**	**2010 - present**
Hormone Code	**1400**	**1995 - present**
Reason for no Hormone	**1450**	**1998 - 2002**

DATA ITEM	NAACCR ITEM NUMBER	COLLECTION DATES
RX Text - Hormone	2650	2004 - present
Date Immunotherapy Started	1240	2010 - present
RX Date Immunotherapy Flag	1241	2010 - present
Immunotherapy Code	1410	1995 - present
RX Summary Transplant/Endocrine	3250	2003 - present
RX Text - Immunotherapy	2660	2004 - present
RX Summary - Systemic/Surgery Sequence	1639	2006 - present
Date other Treatment Started	1250	1995 - present
RX Date Other Flag	1251	2010 - present
Other Treatment Code	1420	1995 - present
Chapter 3 RX Text - Other	2670	2004 - present
RX - Summary Treatment Status	1285	2010 - present
Date of Last Contact or Death	1750	1995 - present
Date of Last Contact Flag	1751	2010 - present
Vital Status	1760	1998 - present
Follow Up Source (Derived)	1790	2009 - present

DATA ITEM	NAACCR ITEM NUMBER	COLLECTION DATES
Date Abstracted	**2090**	**1995 - present**
Abstractor Initials	**570**	**1995 - present**
NAACCR Record Version	**50**	**2003 - present**
Height	**Non - NAACCR 9960**	**2011 - present**
Weight	**Non - NAACCR 9961**	**2011 - present**
Tobacco Use	**Non - NAACCR 9965 - 9968**	**2011 - present**