



# Texas Cancer Registry Data Dictionary

*For Cancers Diagnosed 1995 – 2013*

January 2016



The Texas Cancer Registry (TCR) Data Dictionary contains descriptions of data items that are available for analysis and research. As of November 2015, all data items have been submitted by TCR to the North American Association of Central Cancer Registries (NAACCR) and the National Program of Cancer Registries (NPCR) in the Call for Data cancer incidence submission, ensuring that any data released has met the highest quality standards. The data is at least 95% complete for neoplasms diagnosed in 1995 through 2013. More recent data are available on a limited basis for certain types of studies. Individual-level data that is not available for release includes cases reported by a Department of Veteran's Affairs facility or by another state's central cancer registry that does not participate in the NAACCR National Interstate Data Exchange Agreement.

NAACCR develops uniform cancer data reporting standards for consistency among all cancer registries in North America. For additional information on data fields reported by TCR to NAACCR, see the Version 16 Standards for Cancer Registries, Vol II: Data Standards and Data Dictionary at: <http://www.naacr.org/Applications/ContentReader/Default.aspx?c=10>

For additional information on NPCR, visit <http://www.cdc.gov/cancer/npcr/>

TCR's cancer incidence files contain 1,837,657 Texas resident malignant and in-situ cancers (excluding malignant non-genital basal and squamous cancers of the skin, and in situ cervix cases) diagnosed from 1995–2013. Benign and borderline brain and central nervous system cases are included for 2004–2011 only. Files containing confidential variables<sup>1</sup> will be sent by secure file transfer protocol, TCR's WebPlus server. A TCR-created tumor identification number (MedRefID) will be included in all datasets.

TCR requests that any person or organization reporting results or analyses using TCR data include the following acknowledgement statement: "Cancer incidence data have been provided by the Texas Cancer Registry, Cancer Epidemiology and Surveillance Branch, Texas Department of State Health Services, 1100 W 49th Street, Austin, TX 78756, <http://www.dshs.state.tx.us/tcr/default.shtm>"

Texas Cancer Registry acknowledges the National Program of Cancer Registries (NPCR), Centers for Disease Control and Prevention (CDC) for the funds that helped support the availability of these data.

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<sup>1</sup> Confidential variables are noted with an asterisk and are only available for release with prior Texas Department of State Health Services (DSHS) Institutional Review Board (IRB) approval. Instructions for applying for confidential TCR data are available at <http://www.dshs.state.tx.us/tcr/irb.shtm>.

For more information please see <http://www.naacr.org/Applications/ContentReader/Default.aspx?c=10>

Variable	Description	NAACCR Item Number	Variable Name	Coding scheme	In SAS incidence file	In Limited Use SEER*Stat incidence file
Patient ID Number	Sequential identification number assigned to each new patient with a record in the TCR database. Unique for each patient, not for each tumor, because patients may have more than one tumor in the database. In combination with Sequence Number - Central [380], it can be used to identify multiple tumors in same patient.	20	PatientID	Sequentially assigned number; unique per person.	X	X
Address at Diagnosis- City	City where patient lived at time of diagnosis	70	DxCity	Text field	X Confidential	
Address at diagnosis- State	Patient's state of residence at date of diagnosis	80	DxState	2 letter USPS standard abbreviations. US= Resident of the US, state unknown; CD= Resident of Canada, province unknown; XX= Resident of a country other than the US or Canada & the country is known; YY= Resident of a country besides US or Canada and country is not known; ZZ=No information is available	X	X
Address at Diagnosis- County	Identifies patient's county at diagnosis. This is updated annually with FIPS code of county of geocoded address.	90	DxCounty	3 digit code for TX county (001-507) issued by FIPS. In multiple tumor cases, FIPS code may be different for each tumor. Non-US residents= CD or XX; An out of state resident who's address is known but county is not= 998; unknown county=999	X	X
Address at Diagnosis- Postal Code	Patient's ZIP Code of residence at date of diagnosis.	100	DxPostalZip	9 digit zip code, 99999999=Resident of US and code is unknown; 99999= Resident of Canada and postal code unknown; 88888888=Resident of country other than US or Canada and the postal code is unknown.	X Confidential	
Census Tract 1970/80/90	Code for the census tract or BNA of the patient's residence at the time of diagnosis. SEER used this field for tumors reported before 1998.	110	CenTract708090	Census Tract Codes=000100-949999; BNA Codes= 950100-998999; 000000= area not census-tracted; 999999=area census-tracted but census tract not available; blank= Census Tract 1970/80/90 not coded.	X Confidential	
Census Tract 2000	Census tract of patient's residence at date of diagnosis based on the 2000 Census designations. Data have been geocoded using specialized software by DSHS Center for Health Statistics. Calculated 1995-present.	130	CenTract2000	Census Tract Codes=000100-999998; 000000=Area not census tracted; 999999=Area census-tracted, but census tract is not available; Blank=Census Tract 2000 not coded	X Confidential	
Census Tract 2010	Census tract of patient's residence at date of diagnosis based on the 2010 Census designations. Data have been geocoded using specialized software by DSHS Center for Health Statistics. Calculated 1995-present.	135	CenTract2010	Census Tract Codes=000100-999998; 000000=Area not census tracted; 999999=Area census-tracted, but census tract is not available; Blank=Census Tract 2000 not coded	X Confidential	
Census Tract Poverty Indicator	Assigns a code for neighborhood poverty level based on the census tract of diagnosis address. Cases diagnosed between 1995 and 2004 are assigned a code based on the 2000 U.S. Census, the last decennial census for which poverty level was collected. Cases diagnosed since 2005 are assigned a code based on the American Community Survey.	145	PovertyInd	1=0-5%; 2=5-9.9%; 3=10-19.9%; 4=20-100%; 5=Unknown or N/A	X	X
Marital Status at Diagnosis	Code for patient's marital status at time of diagnosis for the reportable tumor. If patient has multiple tumors, marital status may be different for each tumor.	150	Marital	1=Single (never married), 2=Married (including common law); 3=Separated; 4=Divorced; 5=Widowed; 6=Unmarried or domestic partner (same sex or opposite sex, registered or unregistered, other than common law marriage); 9=Unknown	X	

Variable	Description	NAACCR Item Number	Variable Name	Coding scheme	In SAS incidence file	In Limited Use SEER*Stat incidence file
Race 1	Primary race of the patient	160	Race1	01=White; 02=Black; 03=American Indian, Aleutian, or Eskimo (includes all indigenous populations of the Western hemisphere); 04=Chinese; 05=Japanese; 06=Filipino; 07=Hawaiian; 08=Korean; 10=Vietnamese; 11=Laotian; 12=Hmong; 13=Kampuchean (Cambodian); 14=Thai; 15=Asian Indian or Pakistani, NOS (code 09 prior to Version 12); 16=Asian Indian 17=Pakistani; 20=Micronesian, NOS; 21=Chamorro/Chamoru; 22=Guamanian, NOS; 25=Polynesian, NOS; 26=Tahitian; 27=Samoa; 28=Tongan; 30=Melanesian, NOS; 31=Fiji Islander; 32=New Guinean; 96=Other Asian, including Asian, NOS and Oriental, NOS; 97=Pacific Islander, NOS; 98=Other; 99=Unknown	X	X
Race 2	Identifies the patient's additional races.	161	Race2	01=White; 02=Black; 03=American Indian, Aleutian, or Eskimo (includes all indigenous populations of the Western hemisphere); 04=Chinese; 05=Japanese; 06=Filipino; 07=Hawaiian; 08=Korean; 10=Vietnamese; 11=Laotian; 12=Hmong; 13=Kampuchean (Cambodian); 14=Thai; 15=Asian Indian or Pakistani, NOS (code 09 prior to Version 12); 16=Asian Indian 17=Pakistani; 20=Micronesian, NOS; 21=Chamorro/Chamoru; 22=Guamanian, NOS; 25=Polynesian, NOS; 26=Tahitian; 27=Samoa; 28=Tongan; 30=Melanesian, NOS; 31=Fiji Islander; 32=New Guinean; 88=No other race documented; 96=Other Asian, including Asian, NOS and Oriental, NOS; 97=Pacific Islander, NOS; 98=Other; 99=Unknown	X	X
Spanish/Hispanic Origin	Identifies persons of Spanish or Hispanic origin based on Spanish/Hispanic names. Not dependent on race.	190	Hispanic	0=Non-Spanish/non-Hispanic including Portuguese and Brazilian; 1=Mexican; 2=Puerto Rican; 3=Cuban; 4=South or Central American (except Brazil); 5=Other specified Spanish/Hispanic (includes European); 6=Spanish, NOS/Hispanic, NOS/Latino; NOS; 7=Spanish surname only; 8=Dominican Republic (date of diagnosis on or after 2005); 9=unknown.	X	X
NHIA Derived Hispanic Origin	Classifies Hispanic ethnicity based on a NAACCR algorithm, using birthplace or another specific identifier. Only available for records obtained from a complete research file. Available for all diagnosis years. The algorithm uses the following standard variables: Spanish/Hispanic Origin [190], Name--Last [2230], Name--Maiden [2390], Birthplace [250], Race 1 [160], IHS Link [192], Sex [220].	191	NHIA	0=Non-Hispanic; 1=Mexican; 2=Puerto Rican.; 3=Cuban; 4=South or Central American (except Brazil); 5=Other specified Spanish/Hispanic origin (includes European; excludes Dominican Republic); 6=Spanish, NOS; Hispanic, NOS; Latino, NOS; 7=NHIA surname match only; 8= Dominican Republic; Blank=Algorithm has not been run	X	X
Indian Health Service Link	Results of the linkage of the registry database with the Indian Health Service patient registration database. Available for all diagnosis years.	192	IHSLink	0=No IHS match; 1=IHS match; Blank=link not attempted or results pending	X	X
Race--NAPIIA (derived API)	NAPIIA is an acronym for NAACCR Asian and Pacific Islander Identification Algorithm. The algorithm recodes some single-race cases with a Race 1 [160] code of 96 to a more specific Asian race category, based on birthplace and name fields (first, last, and maiden names).	193	RaceNAPIIA	Birthplace can be used to indirectly assign a specific race to one of eight Asian race groups (Chinese, Japanese, Vietnamese, Korean, Asian Indian, Filipino, Thai, and Cambodian), and names can be used to indirectly assign a specific race to one of seven Asian groups (Chinese, Japanese, Vietnamese, Korean, Asian Indian, Filipino, and Hmong).	X	X
Sex	Patient's sex	220	Sex	1=Male; 2=Female; 3=Other (Hermaphrodite/Intersexed); 4=Transsexual/Transgender; 9=Not Stated/Unknown.	X	X
Age at Diagnosis	Age of patient at DX in complete years.	230	AgeDX	000=Less than 1 year old, diagnosed in utero; 001=1 year old but less than 2 years; 002=2 years old, etc.; 999=Unknown age.	X	X
Date of Birth	Patient's date of birth. Month and year of birth can be released in the Limited Use dataset. Day of birth requires IRB approval.	240	BirthDate	YYYYMMDD= When complete date is known and valid; YYYYMM= When year and month are known and valid, and day is unknown; YYYY= When year is known and valid, and month and day are unknown; 999 or 9999=Unknown.	X Confidential	X (as month and year)
Date of Birth Flag	Explains why there is no appropriate value in this field.	241	BirthDateFlag	12=Birth date is unknown; Blank=A valid date is provided in Date of Birth [240], or date was not expected to have been transmitted.	X	
Birthplace- State	USPS abbreviation for the state in which patient was born, or CanadaPost abbreviation for the Canadian province in which the patient was born.	252	BPState	2 letter postal code abbreviation for the state. ZZ=unknown; US= US resident but state is unknown; CD=resident of Canada; XX= country other than US and country is known; YY=country other than US and country is not known.	X	X

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Birthplace- Country	Country in which patient was born.	254	BPCountry	ZZN=North America NOS; ZZC=Central America NOS; ZZS= South America NOS; ZZP=Pacific NOS; ZZE=Europe NOS; ZZF=Africa NOS; ZZA=Asia NOS; ZZX=Non-US NOS; ZZU=Unknown.	X	X
Census Industry Code 1970-2000	Patient's usual industry, using U.S. Census Bureau codes according to coding procedures recommended for death certificates. This data item applies only to patients who are age 14 years or older at the time of diagnosis	280	IndCen	Software for automated coding of industry and occupation to 1990 Census classifications is available from the Division of Safety Research, National Institute for Occupational Safety and Health, CDC ( <a href="http://www.cdc.gov/niosh/SOIC/">http://www.cdc.gov/niosh/SOIC/</a> ).	X	
Occupation Source	Describes source of occupation information provided on this patient. Applied by central cancer registry.	290	OccSrc	0=Unknown occupation/no occupation available; 1=Reporting facility; 2=Death certificate; 3=Interview; 7=Other source; 8=N/A patient age < 14 at dx; 9=Unknown source; Blank=Not collected.	X	
Industry Source	Describes source of industry occupation information provided on this patient.	300	IndSrc	0=Unknown industry/not available; 1=Reporting facility records; 2=Death certificate; 3=Interview; 7=Other source; 8=N/A, patient age < 14 at dx; 9=Unknown source; Blank=not collected.	X	
Text- Usual Occupation	Patient's usual job or type of work.	310	TxUsualOcc	If the patient is currently a homemaker but has ever held a job outside the home, the last job outside the home is reported. Only collected for patients 14 years and older.	X Confidential	
Text- Usual Industry	Patient's longest held industry. If this is unknown, most recent occupation.	320	TxUsualInd	Text field	X Confidential	
Census Occupation/Industry System	Identifies coding system used for occupation and industry.	330	OccIndCodSys	1=1970 Census; 2=1980 Census; 3=1990 Census; 4=2000 Census; 5=2010 Census; 7=Other coding system; 9=Unknown coding system; Blank=Not collected.	X	
Census Tract Certainty 1970/80/90	Indicates basis of assignment of census tract for an individual record.	364	CenTractCer708090	1=Census tract based on complete and valid address; 2=Census tract based on ZIP+4; 3= Census based on residence ZIP+2; 4=Census tract based on ZIP only; 5=Census tract based on ZIP of PO box; 6=Census based on residence city/ZIP, city/ZIP has only one census tract; 9=Not assigned, geocoding attempted; blank=Not assigned, geocoding not attempted.	X	
Census Tract Certainty 2000	Indicates basis of assignment of census tract for an individual record.	365	CenTractCer2000	1=Census tract based on complete and valid address; 2=Census tract based on ZIP+4; 3= Census based on residence ZIP+2; 4=Census tract based on ZIP only; 5=Census tract based on ZIP of PO box; 6=Census based on residence city/ZIP, city/ZIP has only one census tract; 9=Not assigned, geocoding attempted; blank=Not assigned, geocoding not attempted.	X	X
Census Tract Certainty 2010	Indicates basis of assignment of census tract for an individual record.	367	CenTractCer2010	1=Census tract based on complete and valid address; 2=Census tract based on ZIP+4; 3= Census based on residence ZIP+2; 4=Census tract based on ZIP only; 5=Census tract based on ZIP of PO box; 6=Census based on residence city/ZIP, city/ZIP has only one census tract; 9=Not assigned, geocoding attempted; blank=Not assigned, geocoding not attempted.	X	X
Sequence Number--Central	Sequence of all reportable neoplasms over the lifetime of the person. In combination with TCR Patient ID [20], can be used to identify multiple tumors in same patient.	380	SeqNumCentr	00=One primary only; 01=First of two or more primaries; 02=Second of two or more primaries; etc. through 59; 60=one nonmalignant tumor; 61 first of 2 or more nonmalignant tumors, etc. through 87; 88=Unspecified nonmalignant; 99=Unspecified.	X	X
Date of Diagnosis	Earliest date the primary cancer was diagnosed clinically or microscopically, confirmed by a recognized medical practitioner, regardless of whether the diagnosis was made at the reporting facility or elsewhere. Month and year of diagnosis can be released in the Limited Use dataset. Day of diagnosis requires IRB approval.	390	DxDate	YYYYMMDD Format. YYYYMM when day is unknown. By NAACCR/CDC standards, for cases where information is derived solely from a death certificate, the date of diagnosis is the date of death.	X Confidential	X (as month and year)
Date of Diagnosis Flag	Explains why there is no appropriate value in this field.	391	DxDateFlag	12=Date of diagnosis is unknown; Blank=a valid date is provided in Date of Diagnosis [390], or the date was not expected to have been transmitted.	X	
Primary Site	Code for the primary site of the tumor being reported using either ICD-O-2 or ICD-O-3.	400	PSite	For codes, please see: <a href="http://seer.cancer.gov/siterecode/icdo3_dwho/home/index.html">http://seer.cancer.gov/siterecode/icdo3_dwho/home/index.html</a>	X	X

Variable	Description	NAACCR Item Number	Variable Name	Coding scheme	In SAS incidence file	In Limited Use SEER*Stat incidence file
Laterality	The side of a paired organ, or the side of the body on which the reportable tumor originated. This applies to the primary site only.	410	Lateral	0=Not a paired site; 1=Right origin of primary; 2=Left origin of primary; 3=Only one side involved, left or right not specified; 4=Bilateral involvement at time of Dx, or lateral origin unknown, or both ovaries involved simultaneously, or single histology, or bilateral retinoblastomas, or bilateral Wilms' tumor; 5=Paired site midline tumor; 9=Paired site, but no information concerning laterality.	X	X
Grade	Code for the grade or degree of differentiation of the reportable tumor. For lymphomas and leukemia, field also is used to indicate T-, B-, Null-, or NK-cell origin.	440	Grade	1=Grade I; 2=Grade II; 3=Grade III; 4=Grade IV; 5=T-cell; 6=B-cell; 7= Null cell; 8=NK (natural killer) cell; 9=Grade/differentiation unknown, not stated, or not applicable.	X	X
Site Coding System--Current	Describes how the primary site currently is coded. If converted, this field shows the system to which it is converted.	450	SiteCodSysCur	1=ICD-8 and MOTNAC; 2=ICD-9; 3= ICD-O, First Edition; 4= ICD-O, Second Edition; 5=ICD-O, Third Edition; 6= ICD-10; 9= Other.	X	
Morph Coding System--Current	Describes how morphology is currently coded. If converted, this field shows the system it is converted to.	470	MorphCodSysCur	1=ICD-O First Edition; 2=ICD-O 1986; 3=ICD-O 1988; 4=ICD-O Second Edition; 5=ICD-O Second edition plus REAL lymphoma codes; 6=ICD-O second edition plus FAB codes; 7=ICD-O, Third Edition; 8=ICD-O, Third Edition, plus 2008 WHO hematopoietic/ lymphoid new terms used for conditions diagnosed 1/1/2010 and later; 9=Other.	X	
Diagnostic Confirmation	Best method of diagnostic confirmation of the cancer being reported at any time in the patient's history.	490	DxConf	1= Positive histology; 2= Positive cytology; 3= Positive histology plus positive immuno-phenotyping and/or positive genetic studies (only for hematopoietic & lymphoid neoplasms M-9590/3-9992/3); 4= Positive microscopic, NOS; 5=Positive laboratory test/marker study; 6=Direct visualization w/o microscopic confirmation; 7=Radiography and/or other imaging w/o microscopic confirmation; 8=Clinical diagnosis only (other than 5, 6, or 7); 9=Unknown whether or not microscopically confirmed, death certificate only.	X	X
Type of Reporting Source	Identifies what type of source documents were used to abstract the reported tumor. This data item is intended to indicate the completeness of information available to the abstractor. Reports from health plans. Death certificate only cases may be missing more information and are frequently excluded from analysis.	500	TypeRepSrc	1=Hospital inpatient; 2=Radiation Treatment Center or Medical Oncology Center; 3=Laboratory only; 4=Physician's Office/Private Medical Practitioner; 5=Nursing/Convalescent Home/Hospice; 6=Autopsy Only; 7=Death Certificate Only; 8=Other hospital outpatient unit/surgery center including but not limited to outpatient surgery and nuclear medicine services.	X	X
Histologic Type ICD-O-3	Codes for the histologic type of the tumor being reported using ICD-O-3.	522	HistTypeICDO3	Please see <a href="http://seer.cancer.gov/siterecode/icdo3_dwho/home/index.html">http://seer.cancer.gov/siterecode/icdo3_dwho/home/index.html</a> for more information	X	X
Behavior Code ICD-O-3	ICD-O-3 code for behavior of reported tumor. ICD-O-2 codes from 1995-2000 converted to ICD-O-3.	523	BehaviorICDO3	0=Benign (reportable only for intracranial and CNS sites) ; 1=Borderline malignant, low/uncertain malignant potential (reportable only for intracranial and CNS sites); 2=Carcinoma in situ, intraepithelial, non-infiltrating, noninvasive; 3=Malignant, primary, and/or metastatic (invasive). All ICD-O-2 behaviors for 1995-2000 were converted to ICD-O-3.  Behavior is the fifth digit of the morphology code [NAACCR item 522] after the slash.	X	X
Reporting Facility Number	Identifies the facility/institution reporting the case. In the case of multiple reports from multiple facilities, the first reporter, or all reporters, are available.	540	RepHosp	Enter the 3 digit facility number assigned by the TCR. It is a 10-digit numeric code starting with 7 leading zeros. Hierarchy of class of case codes, from best to worst: 12, 14, 11, 13, 10, 22, 20, 21, 00, 30-99. See NAACCR Data Standards for Cancer Registries for additional details and code definitions: <a href="http://www.naacr.org/Applications/ContentReader/Default.aspx?c=10">http://www.naacr.org/Applications/ContentReader/Default.aspx?c=10</a>	X Confidential	

Variable	Description	NAACCR Item Number	Variable Name	Coding scheme	In SAS incidence file	In Limited Use SEER*Stat incidence file
Class of Case	Identifies the role of the reporting facility in the patient's diagnosis and treatment. Divides case records into analytic and non-analytic categories. Determines which cases will be included in the analysis of the facility's cancer experience.	610	ClassCase	Analytical cases= Codes 00-22. Non analytical cases (classes 30-49 and 99) are usually excluded from the facility's routine treatment or survival statistics. Analytical cases are diagnosed at the reporting facility or staff physician's office, and/or received any of the first course of treatment at a reporting facility. Non-analytical cases are diagnosed and received all of the course 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.	X Confidential	
Primary Payer at Diagnosis	Primary payer/insurance carrier at time of initial diagnosis and/or treatment.	630	PriPayerDx	01=Not insured; 02=Not insured, self-pay; 10=Insurance, NOS; 20-21: types of private insurance; 31, 35=Types of Medicaid; 60-64=Types of Medicare; 65=TRICARE; 66=Military; 67=Veterans affairs; 68=Indian/Public Health Service; 99=Insurance status unknown.	X	X
SEER Summary Stage 2000	Summary stage at the initial diagnosis or treatment of the reportable tumor.	759	SEERSumStg2000	Coded only for 2001-2004 cases. 0=In situ; 1=Localized; 2=Regional by direct extension only; 3=Regional to regional lymph nodes only; 4=Regional (direct extension and regional lymph nodes); 5=Regional, NOS; 7=Distant metastasis or systemic disease (leukemia, multiple myeloma); 8=Not applicable; 9=Unstaged.	X	X
SEER Summary Stage 1977	Summary stage at the initial diagnosis or treatment of the reportable tumor.	760	SEERSumStg1977	0=In situ; 1=Localized; 2=Regional by direct extension only; 3=Regional by regional lymph nodes only; 4=Regional (direct extension and lymph nodes); 5=Regional, NOS; 7=Distant metastasis or systemic disease (leukemia, multiple myeloma); 8=Not applicable; 9=Unstaged.	X	X
EOD--Tumor Size	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.	780	EODTumSize	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.	X	
Regional Nodes Positive	Records the exact number of regional nodes examined by the pathologist and found to contain metastases.	820	RegNodPos	00= All nodes examined are negative; 01-89= nodes are positive (exact number of positive nodes); 90= 90 or more nodes are positive; 95= Positive aspiration of lymph node(s) was performed; 97= Positive nodes are documented, but the number is unspecified; 98=No nodes were examined; 99=Unknown whether nodes are positive; not applicable; not stated in patient record.	X	X
Regional Nodes Examined	Records the total number of regional lymph nodes that were removed and examined by the pathologist.	830	RegNodExam	00= All nodes examined ; 01-89= nodes examined (exact number of nodes examined); 90= 90 or more nodes are examined; 95= No regional nodes were removed, but aspiration of regional nodes was performed; 96= Regional lymph node removal was documented as a sampling, and the number of nodes is unknown/not stated; 97= Regional lymph node removal was documented as a dissection, and the number of nodes is unknown/not stated; 98= Regional lymph nodes were surgically removed, but the number of lymph nodes is unknown/not stated and not documented as a sampling or dissection; nodes were examined, but the number is unknown; 99=It is unknown whether nodes were examined; not applicable or negative; not stated in patient record	X	X
TNM Path Stage Group	Detailed site-specific codes for the pathologic stage group as defined by AJCC and recorded by the physician. CoC requires that AJCC TNM staging be used in its approved cancer programs. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.	910	AJCCPathGrp	88=Not applicable, no code assigned for this case in the current AJCC Staging Manual; 99=Unknown, unstaged Note: See the AJCC Cancer Staging Manual, current edition for site-specific categories for the TNM elements and stage groups. See the FORDS manual for specifications for codes and data entry rules.		

Variable	Description	NAACCR Item Number	Variable Name	Coding scheme	In SAS incidence file	In Limited Use SEER*Stat incidence file
TNM Clinical Stage Group	Detailed site-specific codes for the clinical stage group as defined by AJCC and recorded by the physician. CoC requires that AJCC TNM staging be used in its approved cancer programs. This staging is used by physicians to estimate prognosis, to plan treatment, to evaluate new types of therapy, to analyze outcome, to design follow-up strategies, and to assess early detection results.	970	AJCCclinGrp	88=Not applicable, no code assigned for this case in the current AJCC Staging Manual; 99=Unknown, unstaged Note: See the AJCC Cancer Staging Manual, current edition for site-specific categories for the TNM elements and stage groups. See the FORDS manual for specifications for codes and data entry rules.		
Treatment Initiation Date	Date of initiation of first course of therapy.	1260	FirstRxDateSEER	YYYYMMDD Format; 99999999=Unknown if any treatment; 00000000=No therapy. In SEER*Stat this is stored as Year of Initial Rx--SEER; and a second variable Month of Initial Rx--SEER.	X	X (as month and year)
Treatment Initiation Date Flag	This flag explains why no appropriate value is in this field.	1261	FirstRxDateSEERFlag	10=No information whatsoever can be inferred from this exceptional value; 11=No proper value is applicable in this context; 12=A proper value is applicable but not known; Blank=A valid date value is provided, or date was not expected to have been transmitted.	X	
Surgery Type- Primary Site	Site-specific codes for the type of surgery to the primary site performed as part of the first course of treatment.	1290	RxSumSurgPSite	00=None; 10-19=Site-specific code (tumor destruction); 20-80=Site-specific codes (resection); 90=Surgery, NOS; 98=Site-specific codes (special); 99=Unknown.	X	X
Lymph Nodes Removed	Scope of regional lymph node surgery.	1292	RxSumScopeRegLN	0=None; 1=Biopsy or aspiration of regional lymph node, NOS; 2=Sentinel lymph node biopsy; 3=number of regional lymph nodes removed unknown, not stated, regional lymph nodes removed, NOS; 4=1 to 3 regional lymph nodes removed; 5=4 or more regional lymph nodes removed; 6=sentinel node biopsy and code 3, 4, or 5 at same time or timing not noted; 7=Sentinel node biopsy and code 3, 4, or 5 at different times; 9=Unknown or not applicable.	X	X
Surgical removal of distal lymph nodes or other tissue	Records the surgical removal of distant lymph nodes or other tissue(s)/organ(s) beyond the primary site.	1294	RxSumSurgOthReg	0=None, diagnosed at autopsy; 1=non-primary surgical procedure; 2=non-primary surgical procedure to other regional sites; 3=non-primary surgical procedure to distant lymph node(s); 4=non-primary surgical procedure to distant site; 5=any combination of codes 2, 3 or 4; 9=unknown; death certificate only	X	X
Reason for No Surgery	This data item provides information related to the quality of care and describes why primary site surgery was not performed.	1340	ReasonNoSurg	0=Surgery of the primary site was performed; 1=Surgery of the primary site was not performed because it was not part of the planned first-course treatment; 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 therapy. No reason was noted in the patient's record; 7=Surgery of the primary site was not performed; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in the patient record; 8=Surgery of the primary site was recommended, but it is unknown if it was performed. Further follow-up is recommended; 9=It is unknown if surgery of the primary site was recommended or performed. Death certificate-only cases and autopsy-only cases.	X	X
Type of Radiation Treatment	Codes for the type of radiation therapy performed as part of first course of treatment.	1360	RxSumRad	0=None; 1=Beam radiation; 2=Radioactive implants; 3=Radioisotopes; 4=Combination of 1 with 2 or 3; 5=Radiation, NOS; 6=Only for historical cases; 7=Patient or their guardian refused; 8=Radiation recommended, unknown if administered; 9=Unknown if radiation administered.	X	X

Variable	Description	NAACCR Item Number	Variable Name	Coding scheme	In SAS incidence file	In Limited Use SEER*Stat incidence file
Sequence of Radiation and Surgery	Codes for the sequencing of radiation and surgery given as part of the first course of treatment.	1380	RxSumSurgRadSeq	0=No radiation and/or no surgery, or unknown if given; 2=Radiation before surgery; 3=Radiation after surgery; 4=Radiation both before and after surgery; 5=Intraoperative radiation; 6=Intraoperative radiation with other radiation given before and/or after the surgery; 7=Surgery both before and after radiation; 9=Sequence unknown, but both surgery and radiation given.	X	X
Chemotherapy at First Course of Treatment	Codes for chemotherapy given as part of first course of treatment or reason chemotherapy was not given.	1390	RxSumChemo	Codes 00-03, 82, 85-88, 99. See NAACCR Data Standards for Cancer Registries for code definitions <a href="http://www.naaccr.org/Applications/ContentReader/Default.aspx?c=10">http://www.naaccr.org/Applications/ContentReader/Default.aspx?c=10</a>	X	X
Hormone at first course of treatment	Records whether systemic hormonal agents were administered as first-course treatment at any facility, or the reason they were not given.	1400	RxSumHorm	Codes 00-01, 82, 85-88, 99. See NAACCR Data Standards for Cancer Registries for code definitions: <a href="http://www.naaccr.org/Applications/ContentReader/Default.aspx?c=10">http://www.naaccr.org/Applications/ContentReader/Default.aspx?c=10</a>	X	X
Immunotherapy (Biological Response Modifier) at First Course of Treatment	Records whether immunotherapeutic (biologic response modifiers) agents were administered as first-course treatment at all facilities or the reason they were not given.	1410	RxSumBRM	Codes 00-01, 82, 85-88, 99. See NAACCR Data Standards for Cancer Registries, for code definitions <a href="http://www.naaccr.org/Applications/ContentReader/Default.aspx?c=10">http://www.naaccr.org/Applications/ContentReader/Default.aspx?c=10</a>	X	X
Other Treatment (not surgery, radiation, or systemic therapy)	Identifies other treatment given at all facilities that cannot be defined as surgery, radiation, or systemic therapy.	1420	RxSumOth	0=None; 1=Other; 2=Other experimental; 3=Other - double-blind; 4=Other - unproven; 7=Refusal; 8=Recommended; 9=Unknown; unknown if administered.	X	X
Reason for No Radiation	The reason the patient did not receive radiation treatment as part of first course of therapy.	1430	ReasonNoRad	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 administered because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, etc.); 5= Radiation therapy was not administered because the patient died prior to planned or recommended treatment; 6= Radiation therapy 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 noted in the patient's record; 7= Radiation therapy was not administered; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in the patient record; 8= Radiation therapy was recommended, but it is unknown if it was administered; 9= It is unknown if radiation therapy was recommended or administered. Death-certificate-only.	X	
Dominant Modality of Radiation	Records the dominant modality of radiation therapy used to deliver the clinically most significant regional dose to the primary volume of interest during the first course of treatment.	1570	RadRegModal	See NAACCR Data Standards for Cancer Registries, for code definitions <a href="http://www.naaccr.org/Applications/ContentReader/Default.aspx?c=10">http://www.naaccr.org/Applications/ContentReader/Default.aspx?c=10</a>	X	X
Systemic/Surgery Sequence	Records the sequencing of systemic therapy (RX Summ-Chemo [1390], RX Summ-Hormone [1400], RX Summ-BRM [1410], and RX Summ-Transplant/Endocr [3250]) and surgical procedures given as part of the first course of treatment. See also RX Summ--Surg Prim Site [1290], RX Summ--Scope LN Surg [1292], and RX Summ--Surg Oth Reg/Dis [1294].	1639	RxSumSysSurSeq	0=No systemic therapy and/or surgical procedures; unknown if surgery and/or systemic therapy given; 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 and/or after surgery; 7=Surgery both before and after systemic therapy; 8=Sequence unknown, but both surgery and systemic therapy given.	X	X
Date of Last Contact	Date of last contact with the patient, or date of death if the patient has died. The specific day of last contact is confidential.	1750	DateLastContact	YYYYMMDD= When complete date is known and valid; YYYYMM= When year and month are known and valid, and day is unknown; YYYY= When year is known and valid, and month and day are unknown; Blank= When no known date applies.	X Confidential	X (as month and year)
Date of Last Contact Flag	Explains why there is no appropriate value in this field.	1751	DateLastContFlag	12=Date of last contact is unknown; Blank= A valid date value is provided in Date of Last Contact [1750], or the date was not expected to have been transmitted.	X	X
Vital Status	Vital status at last date of last contact (1750).	1760	VitalStatus	0=Dead; 1=Alive; 4=Dead (SEER). Should be the same for all tumors.	X	X

Variable	Description	NAACCR Item Number	Variable Name	Coding scheme	In SAS incidence file	In Limited Use SEER*Stat incidence file
Follow-Up Source Central	Records the source of Vital Status/Date of Death information.	1791	FupSourceCentral	00=Follow-up not performed for this patient ; (01-29)=File Linkages; 01=Medicare/Medicaid File; 02=Center for Medicare and Medicaid Services (CMS, formerly HCFA); 03=Department of Motor Vehicle Registration; 04=National Death Index (NDI); 05=State Death Tape/Death Certificate File; 06=County/Municipality Death Tape/ Death Certificate File; 07= Social Security Administration Death Master File; 08=Hospital Discharge Data; 09=Health Maintenance Organization (HMO) file; 10=Social Security Epidemiological Vital Status Data; 11=Voter Registration File; 12=Research/Study Related Linkage; 29=Linkages, NOS; (30-39)=Hospitals and Treatment Facilities; 30=Hospital in-patient/outpatient; 31=Casefinding; 32=Hospital cancer registry; 33=Radiation treatment center; 34=Oncology clinic; 35=Ambulatory surgical center; 39=Clinic/facility, NOS; (40-49)=Physicians; 40=Attending physician; 41=Medical oncologist ; 42=Radiation oncologist; 43=Surgeon; 48=Other specialist; 49=Physician, NOS; (50-59) Patient; 50=Patient contact; 51= Relative contact; 59=Patient, NOS; (60-98)=Other; 60=Central or Regional cancer registry; 61=Internet sources ; 62= Hospice; 63=Nursing homes; 64=Obituary; 65=Other research/study related sources; 98=Other, NOS; 99=Unknown source	X	X
Current Address- Postal Code	Patient's current postal code.	1830	CurrPostalZip	999999999=Resident of US and postal code is unknown; 99999= Resident of Canada and postal code unknown; 888888888=Resident of country other than US or Canada and the postal code is unknown.	X Confidential	
Current Address- Country	Country code for address of patient's current usual residence.	1832	CurrCountry	ISO Country Three Character Codes. ZZN=North America NOS; ZZU=Unknown. Please see NAACCR data dictionary for more information.	X Confidential	
Current Address- County	County of patient's current residence	1840	CurrCounty	3 digit code for county issued by FIPS. In multiple tumor cases, FIPS code may be different for each tumor. 998=Canadian residence or unknown, or known town/city/state/or country but county code is not known and resident outside of the state of reporting institution; 999=county unknown.	X Confidential	
Unusual Follow-Up Method	User-defined numeric codes used to flag cases that need unusual follow-up methods. Note: This data item is no longer supported by CoC (as of January 1, 2003).	1850	FupUnusual	00=Record was not reported to TCR solely by a VA or other state, and person has not opted out of being contacted for research studies; 01=Record was reported only by another state's central cancer registry (OOS); 02=Patient opted out of being contacted by researchers (HIPAA); 04=Record was reported only by a Veterans Administration facility (VA).	X Confidential	
Cause of death	Official cause of death as coded from the death certificate in valid ICD-7, ICD-8, ICD-9, and ICD-10 Codes	1910	DthCause	0000=Patient alive at last contact; 7777=State death certificate or listing not available; 7797= State death certificate or listing available, but underlying cause of death not coded.	X	X
ICD Revision Number	Indicator for the coding scheme used to code the cause of death.	1920	ICDRevNum	0=Patient alive at last follow-up; 1=ICD-10; 7=ICD-7; 8=ICDA-8; 9=ICD-9	X	X
Place of Death	State or country where the patient died and where certificate of death is filed	1940	DthPlace	997= Not applicable, patient alive; 999= Place of death unknown. Note: See Appendix B of the NAACCR data dictionary for geocodes.	X	
Over-Ride Age/Site/Morphology	Indicate that data in a record (or records) have been reviewed and, while unusual, are correct.	1990	OvrdAgeSiteMorph	1=Reviewed & confirmed age/ site/ histology combo correct as reported; 2=Reviewed & confirmed case diagnosed in utero; 3=Reviewed & confirmed that conditions 1 & 2 apply; Blank=not reviewed or reviewed and corrected.	X	X
Over-Ride Sequence Number/Diagnosis Confirmation	Flag indicating that the record has been reviewed and, while, unusual, is correct	2000	OvrdSqDxCnf	Blank=Not reviewed or reviewed and corrected; 1=Reviewed and confirmed as reported	X	X
Over-Ride Site/Lat/SeqNo	Flag indicating that the record has been reviewed and, while, unusual, is correct	2010	OvrdSitLatSq	Blank=Not reviewed or reviewed and corrected; 1=Reviewed and confirmed as reported	X	X
Over-Ride Surgery/ Diagnosis Confirmation	Flag indicating that the record has been reviewed and, while, unusual, is correct	2020	OvrdSurgDxCf	Blank=Not reviewed or reviewed and corrected; 1=Reviewed and confirmed as reported	X	X
Over-Ride Site/Type	Flag indicating that the record has been reviewed and, while, unusual, is correct	2030	OvrdSiteType	Blank=Not reviewed or reviewed and corrected; 1=Reviewed and confirmed as reported	X	X

Variable	Description	NAACCR Item Number	Variable Name	Coding scheme	In SAS incidence file	In Limited Use SEER*Stat incidence file
Over-Ride Histology	Flag indicating that the record has been reviewed and, while, unusual, is correct. This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software: Diagnostic Confirmation, Behavior ICDO2 (SEER IF31) Diagnostic Confirmation, Behavior ICDO3 (SEER IF31) Morph (1973-91) ICD-O-1 (SEER MORPH) Morphology--Type/Behavior ICDO2 (SEER MORPH) Morphology--Type/Behavior ICDO3 (SEER MORPH)	2040	OvrdHist	1=Reviewed & confirmed pathologist states primary to be in situ or malignant although behavior code is benign or uncertain; 2=Reviewed & confirmed behavior code is in situ but case not microscopically confirmed; 3=Reviewed & confirmed conditions 1 & 2 both apply; Blank=not reviewed or reviewed and corrected.	X	X
Over-Ride Report Source	Flag indicating that the record has been reviewed and, while, unusual, is correct	2050	OvrdRepSrc	Blank=Not reviewed or reviewed and corrected; 1=Reviewed and confirmed as reported	X	X
Over-Ride Ill-Define Site	Flag indicating that the record has been reviewed and, while, unusual, is correct. This over-ride is used with the following edits in the NAACCR Metafile of the EDITS software: Seq Num--Central, Prim Site, Morph ICDO2 (SEER IF22) Seq Num--Central, Prim Site, Morph ICDO3 (SEER IF22)	2060	OvrdIldfSite	1=Reviewed & confirmed as reported; a second or subsequent primary reported with ill-defined primary site has been reviewed & is an independent primary; Blank=not reviewed or reviewed and corrected. Code 1 can be used if a second or subsequent primary reporting with an ill-defined primary site has been reviewed and is indeed an independent primary. Leave blank and correct any errors for the case if an item is discovered to be incorrect.	X	X
Over-Ride Leukemia, Lymphoma	Flag indicating that the record has been reviewed and, while, unusual, is correct	2070	OvrdLeukLym	Blank=Not reviewed or reviewed and corrected; 1=Reviewed and confirmed as reported	X	X
Over-Ride Site/Behavior	Flag indicating that the record has been reviewed and, while, unusual, is correct	2071	OvrdSiteBeh	Blank=Not reviewed or reviewed and corrected; 1=Reviewed and confirmed as reported	X	X
Over-Ride Site/Lat/Morph	Flag indicating that the record has been reviewed and, while, unusual, is correct	2074	OvrdSiteLatMorph	Blank=Not reviewed or reviewed and corrected; 1=Reviewed and confirmed as reported	X	X
Date Tumor Record Available	Date the demographic and tumor identification information on a primary/reportable neoplasm, compiled from one or more source records, from one or more facilities, is available in the central cancer registry database to be counted as an incident tumor. Cancer identification information includes, at a minimum, site, histology, laterality, behavior, and date of diagnosis. Note: Always used to determine cut-off date.	2113	DfTumorRecAvail	YYYYMMDD= When complete date is known and valid; YYYYMM= When year and month are known and valid, and day is unknown; YYYY= When year is known and valid, and month and day are unknown; Blank= When no known date applies	X Confidential	
ICD-O-3 Conversion Flag	Specifies how the conversion of ICD-O-2 to ICD-O-3 was accomplished	2116	ICDO3ConvFlag	0=Morphology originally coded ICD-O-3; 1=Morphology converted without review; 2=Morphology converted with review; Blank=Not converted	X	
SEER Type of Follow-Up	Codes for the type of follow-up expected for a SEER case.	2180	SEERTypeFup	1=Autopsy-Only or Death-Certificate-Only case; 2=Active follow-up case; 3=in situ cancer of the cervix uteri only. Note- In SEER*Stat files, always coded as '2'		X
Last Name	Patient's last name	2230	LastName		X Confidential	
First Name	Patient's first name	2240	FirstName		X Confidential	
Middle Name	Patient's middle name	2250	MiddleName		X Confidential	
Name--Suffix	Title that follows a patient's last name, such as a generation order or credential status	2270	NameSuffix	Note: This data item is no longer supported by CoC (as of January 1, 2003).	X Confidential	
Name- Alias	Records an alternate name or "Also Known As" used by the patient.	2280	Alias	Record alias last name followed by a blank space and then alias first name.	X Confidential	
Social Security Number	Patient's Social Security Number. NOTE: used internally-only for linkage purposes	2320	SocSec	Nine-digit number, no dashes or slashes. 999999999=Unknown.	X Confidential	
Address at Diagnosis- Number and Street	Patient's number and street at the time of diagnosis.	2330	DxNumAndSt	In the case of multiple tumors, the address at diagnosis may be different for each. NO ADDRESS or UNKNOWN, city=Unknown, state=ZZ, zip=99999, FIPS=999.	X Confidential	

Variable	Description	NAACCR Item Number	Variable Name	Coding scheme	In SAS incidence file	In Limited Use SEER*Stat incidence file
Address- Current Number and Street	Number and street address or the rural mailing address of the patient's current usual residence. If available, usually obtained from linkage with external sources.	2350	CurrNumAndSt	US addresses should conform to the USPS Postal Addressing Standards	X Confidential	
Latitude	Latitude of the patient's residence.	2352	Latitude	Latitude is a 10- digit numeric field, right justified, with up to six decimal places and an explicit decimal point.	X Confidential	
Longitude	Longitude of the patient's residence.	2354	Longitude	Longitude is a 11- digit numeric field, right justified, with up to six decimal places and an explicit decimal point.	X Confidential	
Death Certificate Identification Number	Death certificate identification number as assigned by the vital statistics office.	2380	DCStateFileNum	Numerical field	X	
Name-Maiden	Maiden name of female patients who are or have been married. Note: This data item is no longer supported by CoC (as of January 1, 2003).	2390	MaidName	Text field	X Confidential	
Physician--Managing	Texas Medical Board license number of the managing physician who is responsible for overall management of patient during diagnosis and/or treatment for this cancer.	2460	PhysManaging	99999=unknown. License numbers available at <a href="http://www.tmb.state.tx.us/page/look-up-a-license">http://www.tmb.state.tx.us/page/look-up-a-license</a>	X Confidential	
Physician- Follow Up	Texas Medical Board license number of the follow-up physician who is currently responsible for the patient's medical care.	2470	PhysFup	Text field	X Confidential	
Collaborative Stage- Tumor Size	Records the largest dimension of the reported tumor in millimeters.	2800	CSTumorSize	See the most current version of the "Collaborative Stage Data Collection System" ( <a href="http://cancerstaging.org">http://cancerstaging.org</a> ) for rules and site-specific codes and coding structures.	X	X
Collaborative Stage- Extension	Identifies contiguous growth (extension) of the primary tumor within the organ of origin or extension into neighboring organs.	2810	CSExt	See the most current version of the "Collaborative Stage Data Collection System" ( <a href="http://cancerstaging.org">http://cancerstaging.org</a> ) for rules and site-specific codes and coding structures.	X	X
Collaborative Stage- Tumor Size/Extension Evaluation	Records how the codes for the two items CS Tumor Size [2800] and CS Extension [2810] were determined, based on the diagnostic methods employed.	2820	CSSizeExtEval	See the most current version of the "Collaborative Stage Data Collection System" ( <a href="http://cancerstaging.org">http://cancerstaging.org</a> ) for rules and site-specific codes and coding structures.	X	X
Collaborative Stage- Lymph Nodes	Identifies regional lymph nodes involved with cancer at the time of diagnosis.	2830	CSLymphNodes	See the most current version of the "Collaborative Stage Data Collection System" ( <a href="http://cancerstaging.org">http://cancerstaging.org</a> ) for rules and site-specific codes and coding structures.	X	X
Collaborative Stage- Lymph Nodes Evaluation	Records how the code for CS Lymph Nodes [2830] was determined, based on the diagnostic methods employed.	2840	CSNodesEval	See the most current version of the "Collaborative Stage Data Collection System" ( <a href="http://cancerstaging.org">http://cancerstaging.org</a> ) for rules and site-specific codes and coding structures.	X	X
Collaborative Stage- Metastasis at Diagnosis	Identifies the distant site(s) of metastatic involvement at diagnosis.	2850	CSMetsDX	See the most current version of the "Collaborative Stage Data Collection System" ( <a href="http://cancerstaging.org">http://cancerstaging.org</a> ) for rules and site-specific codes and coding structures.	X	X
Collaborative Stage- Metastasis Evaluation	Records how the code for how CS Metastases at Diagnosis was determined based on the diagnostic methods employed.	2860	CSMetsEval	See the most current version of the "Collaborative Stage Data Collection System" ( <a href="http://cancerstaging.org">http://cancerstaging.org</a> ) for rules and site-specific codes and coding structures.	X	X
Collaborative Stage- Site Specific Factor 15	Identifies additional information needed to generate stage or prognostic factors that have an effect on stage or survival.	2869	CSSSF15	The information recorded differs for each anatomic site. See the most current version of the "Collaborative Stage Data Collection System" ( <a href="http://cancerstaging.org">http://cancerstaging.org</a> ) for rules and site-specific codes and coding structures.	X	X
Collaborative Stage- Site Specific Factor 25	Identifies additional information needed to generate stage or prognostic factors that have an effect on stage or survival.	2879	CSSSF25	The information recorded differs for each anatomic site. See the most current version of the "Collaborative Stage Data Collection System" ( <a href="http://cancerstaging.org">http://cancerstaging.org</a> ) for rules and site-specific codes and coding structures.	X	X
Collaborative Stage- Site Specific Factor 1	Identifies additional information needed to generate stage or prognostic factors that have an effect on stage or survival.	2880	CSSSF1	Used for: C50 (breast); C70.0-C70.9, C71.0-C71.9, C72.0-C72.9, C75.1-C75.3 (brain, CNS); C34 (lung); C384 (pleura); C692 with 9510/3, 9511/3, 9512/3, 9513/3 (retinoblastoma). The information recorded differs for each anatomic site. See the most current version of the "Collaborative Stage Data Collection System" ( <a href="http://cancerstaging.org">http://cancerstaging.org</a> ) for rules and site-specific codes and coding structures.	X	X

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Collaborative Stage- Site Specific Factor 2	Identifies additional information needed to generate stage or prognostic factors that have an effect on stage or survival.	2890	CSSSF2	For: C50 (breast); C54; C55 (corpus uteri). The information recorded differs for each anatomic site. See the most current version of the "Collaborative Stage Data Collection System" ( <a href="http://cancerstaging.org">http://cancerstaging.org</a> ) for rules and site-specific codes and coding structures.	X	X
Collaborative Stage- Site Specific Factor 3	Identifies additional information needed to generate stage or prognostic factors that have an effect on stage or survival.	2900	CSSSF3	For C619 (prostate). The information recorded differs for each anatomic site. See the most current version of the "Collaborative Stage Data Collection System" ( <a href="http://cancerstaging.org">http://cancerstaging.org</a> ) for rules and site-specific codes and coding structures. Collected 2004-present for prostate only.	X	X
Collaborative Stage-Version Input Original	Indicates the number of the version initially used to code Collaborative Staging (CS) fields. The CS version number is returned as part of the output of the CS algorithm. Because input codes and CS instructions may change over time, this identifies the correct interpretation of input CS items.	2935	CSVerInputOrig	6-digit code (e.g., 010100). First two digits represent the major version number; the 2nd two digits represent minor version changes; and, the last two digits represent even less significant changes that do not affect coding or derivation of results See the most current version of the "Collaborative Stage Data Collection System" ( <a href="http://cancerstaging.org">http://cancerstaging.org</a> ) for rules and site-specific codes and coding structures.	X	X
Collaborative Stage- Version Derived	Recorded the first time the CS output fields are derived and is updated each time CS Derived items are recomputed. The CS version number is returned as part of the output of the CS algorithm.	2936	CSVerDerived	6-digit code (e.g., 010100). First two digits represent the major version number, the 2nd two digits represent minor version changes, the last two digits represent even less significant changes that do not affect coding or derivation of results. See the most current version of the "Collaborative Stage Data Collection System" ( <a href="http://cancerstaging.org">http://cancerstaging.org</a> ) for rules and site-specific codes	X	X
Collaborative Stage- Version Input Current	Indicates the version of CS input fields after updating or recoding. Recorded the first time the CS input fields are entered and updated each time CS input fields are modified. Because input codes and CS instructions may change over time, this identifies the correct interpretation of input CS items.	2937	CSVerInputCurrent	6-digit code (e.g., 010100). First two digits represent the major version number, the 2nd two digits represent minor version changes, the last two digits represent even less significant changes that do not affect coding or derivation of results. See the most current version of the "Collaborative Stage Data Collection System" ( <a href="http://cancerstaging.org">http://cancerstaging.org</a> ) for rules and site-specific codes and coding structures.	X	X
Derived Seer Summary Stage 2000	The degree of advancement of a malignant tumor. For date of diagnosis 2004 and later.	3020	DerivedSS2000	0/IS=In situ; 1/L=Localized; 2/RE=Regional by direct extension; 3/RN=Regional to lymph nodes; 4/RE+RN=Regional (direct extension and lymph nodes); 5/RNOS=Regional, NOS; 7/D=Distant metastasis or systemic disease (leukemia, multiple myeloma); 8/NA=Not applicable; 9/U=Unstaged, unknown, unspecified	X	X
Derived Seer Summary Stage 2000-Flag	Flag to indicate whether the derived SEER Summary Stage 2000 was derived from CS or EOD codes.	3050	DerivedSS2000Flag	Blank=not derived; 1=SS2000 derived from Collaborative Stage; 2=SS2000 derived from EOD (prior to 2004)	X	X
Comorbid/Complication 1	Records the patient's preexisting medical conditions, factors influencing health status, and/or complications while in the hospital for cancer treatment. ICD-9-CM code for patient comorbidity or complication present at time of diagnosis; up to 10 collected.	3110	ComorbidComp1	ICD-9-CM classification, 5 characters No secondary diagnoses were made=00000 with the remaining comorbidities and complications left blank. See <a href="http://www.cdc.gov/nchs/icd/icd9cm.htm">http://www.cdc.gov/nchs/icd/icd9cm.htm</a> for more information	X	
Comorbid/Complication 2	Records the patient's preexisting medical conditions, factors influencing health status, and/or complications while in the hospital for cancer treatment. ICD-9-CM code for patient comorbidity or complication present at time of diagnosis; up to 10 collected.	3120	ComorbidComp2	ICD-9-CM classification, 5 characters No secondary diagnoses were made=00000, with the remaining comorbidities and complications left blank. See <a href="http://www.cdc.gov/nchs/icd/icd9cm.htm">http://www.cdc.gov/nchs/icd/icd9cm.htm</a> for more information	X	
Comorbid/Complication 3	Records the patient's preexisting medical conditions, factors influencing health status, and/or complications while in the hospital for cancer treatment. ICD-9-CM code for patient comorbidity or complication present at time of diagnosis; up to 10 collected.	3130	ComorbidComp3	ICD-9-CM classification, 5 characters No secondary diagnoses were made=00000, with the remaining comorbidities and complications left blank. See <a href="http://www.cdc.gov/nchs/icd/icd9cm.htm">http://www.cdc.gov/nchs/icd/icd9cm.htm</a> for more information	X	

Variable	Description	NAACCR Item Number	Variable Name	Coding scheme	In SAS incidence file	In Limited Use SEER*Stat incidence file
Comorbid/Complication 4	Records the patient's preexisting medical conditions, factors influencing health status, and/or complications while in the hospital for cancer treatment. ICD-9-CM code for patient comorbidity or complication present at time of diagnosis; up to 10 collected.	3140	ComorbidComp4	ICD-9-CM classification, 5 characters No secondary diagnoses were made=00000, with the remaining comorbidities and complications left blank. See <a href="http://www.cdc.gov/nchs/icd/icd9cm.htm">http://www.cdc.gov/nchs/icd/icd9cm.htm</a> for more information	X	
Comorbid/Complication 5	Records the patient's preexisting medical conditions, factors influencing health status, and/or complications while in the hospital for cancer treatment. ICD-9-CM code for patient comorbidity or complication present at time of diagnosis; up to 10 collected.	3150	ComorbidComp5	ICD-9-CM classification, 5 characters No secondary diagnoses were made=00000, with the remaining comorbidities and complications left blank. See <a href="http://www.cdc.gov/nchs/icd/icd9cm.htm">http://www.cdc.gov/nchs/icd/icd9cm.htm</a> for more information	X	
Comorbid/Complication 6	Records the patient's preexisting medical conditions, factors influencing health status, and/or complications while in the hospital for cancer treatment. ICD-9-CM code for patient comorbidity or complication present at time of diagnosis; up to 10 collected.	3160	ComorbidComp6	ICD-9-CM classification, 5 characters No secondary diagnoses were made=00000, with the remaining comorbidities and complications left blank. See <a href="http://www.cdc.gov/nchs/icd/icd9cm.htm">http://www.cdc.gov/nchs/icd/icd9cm.htm</a> for more information	X	
Comorbid/Complication 7	Records the patient's preexisting medical conditions, factors influencing health status, and/or complications while in the hospital for cancer treatment. ICD-9-CM code for patient comorbidity or complication present at time of diagnosis; up to 10 collected.	3161	ComorbidComp7	ICD-9-CM classification, 5 characters No secondary diagnoses were made=00000, with the remaining comorbidities and complications left blank. See <a href="http://www.cdc.gov/nchs/icd/icd9cm.htm">http://www.cdc.gov/nchs/icd/icd9cm.htm</a> for more information	X	
Comorbid/Complication 8	Records the patient's preexisting medical conditions, factors influencing health status, and/or complications while in the hospital for cancer treatment. ICD-9-CM code for patient comorbidity or complication present at time of diagnosis; up to 10 collected.	3162	ComorbidComp8	ICD-9-CM classification, 5 characters No secondary diagnoses were made=00000, with the remaining comorbidities and complications left blank. See <a href="http://www.cdc.gov/nchs/icd/icd9cm.htm">http://www.cdc.gov/nchs/icd/icd9cm.htm</a> for more information	X	
Comorbid/Complication 9	Records the patient's preexisting medical conditions, factors influencing health status, and/or complications while in the hospital for cancer treatment. ICD-9-CM code for patient comorbidity or complication present at time of diagnosis; up to 10 collected.	3163	ComorbidComp9	ICD-9-CM classification, 5 characters No secondary diagnoses were made=00000, with the remaining comorbidities and complications left blank. See <a href="http://www.cdc.gov/nchs/icd/icd9cm.htm">http://www.cdc.gov/nchs/icd/icd9cm.htm</a> for more information	X	
Comorbid/Complication 10	Records the patient's preexisting medical conditions, factors influencing health status, and/or complications while in the hospital for cancer treatment. ICD-9-CM code for patient comorbidity or complication present at time of diagnosis; up to 10 collected.	3164	ComorbidComp10	ICD-9-CM classification, 5 characters No secondary diagnoses were made=00000, with the remaining comorbidities and complications left blank. See <a href="http://www.cdc.gov/nchs/icd/icd9cm.htm">http://www.cdc.gov/nchs/icd/icd9cm.htm</a> for more information	X	
Rx Summ--Transplant/Endocr	Identifies systemic therapeutic procedures administered as part of the first course of treatment at this and all other facilities. If none of these procedures were administered then this item records the reason they were not performed. These include bone marrow transplants, stem cell harvests, surgical and/or radiation endocrine therapy.	3250	RxSumTransEndo	See NAACCR Data Standards for Cancer Registries for code definitions <a href="http://www.naacr.org/Applications/ContentReader/Default.aspx?c=10">http://www.naacr.org/Applications/ContentReader/Default.aspx?c=10</a>	X	X
Rural-Urban Continuum/Beale Code 1993	The RuralUrban Continuum (1993) codes (usually known as the Beale Codes) separate counties into four metropolitan and six non-metropolitan categories, based on the size their populations and form a classification scheme that distinguishes metropolitan counties by size and nonmetropolitan counties by degree of urbanization and proximity to metro areas.	3300	RuralUrbanCon1993	See NAACCR Data Standards for Cancer Registries for code definitions <a href="http://www.naacr.org/Applications/ContentReader/Default.aspx?c=10">http://www.naacr.org/Applications/ContentReader/Default.aspx?c=10</a>	X	X

Variable	Description	NAACCR Item Number	Variable Name	Coding scheme	In SAS incidence file	In Limited Use SEER*Stat incidence file
Rural-Urban Continuum/Beale Code 2003	The RuralUrban Continuum (2003) codes (usually known as the Beale Codes) separate counties into four metropolitan and six non-metropolitan categories, based on the size their populations and form a classification scheme that distinguishes metropolitan counties by size and nonmetropolitan counties by degree of urbanization and proximity to metro areas.	3310	RuralUrbanCon2003	See the NAACCR data dictionary for more information <a href="http://www.naacr.org/Applications/ContentReader/Default.aspx?c=10">http://www.naacr.org/Applications/ContentReader/Default.aspx?c=10</a>	X	X
Rural-Urban Continuum 2013	The Rural Urban Continuum (2013) codes separate counties into four metropolitan and six non-metropolitan categories, based on the size their populations and form a classification scheme that distinguishes metropolitan counties by size and non-metropolitan counties by degree of urbanization and proximity to metro areas.	3312	RuralUrbanCon2013	See the NAACCR data dictionary for more information <a href="http://www.naacr.org/Applications/ContentReader/Default.aspx?c=10">http://www.naacr.org/Applications/ContentReader/Default.aspx?c=10</a>		
Direct Summary Stage 2000 Flag	Flag indicates that data in a record (or records) have been reviewed and, while unusual, are correct.	3769	OvrdCS20	1=Directly coded SEER Summary Stage 2000 [759] used to report Summary Stage; Blank=Derived Summary Stage 2000 [3020] reported using Collaborative State Data Collection System or case diagnosed prior to 2012.	X	
Height	Patient height in inches on date of diagnosis.	9960	Height	2-digit number measured in inches. 98= 98 inches or greater; 99= unknown	X	
Weight	Patient weight in pounds on date of diagnosis.	9961	Weight	3-digit whole number measured in pounds (1 kg=2.2 pounds). 999= unknown	X	
Tobacco Use Cigarettes	Records the patient's past or current cigarette smoking.	9965	TobaccoUseCig	0=Never used/none; 1=Current user on date of dx; 2=Former user, quit within 1 year of date of dx; 3=Former user, quit >1 year prior to date of dx; 4=Former user; unknown quit date; 9=Unknown, not stated, no specifics provided, or "no".	X	
Tobacco Use Other Smoke	Records the patient's past or current use of smoking tobacco products other than cigarettes (pipes, cigars, etc.).	9966	TobaccoUseOther	0=Never used/none; 1=Current user on date of dx; 2=Former user, quit within 1 year of date of dx; 3=Former user, quit >1 year prior to date of dx; 4=Former user; unknown quit date; 9=Unknown, not stated, no specifics provided, or "no".	X	
Tobacco Use Smokeless	Records patient's past or present use of smokeless tobacco products (chewing tobacco, snuff, etc.).	9967	TobaccoUseSmokels	0=Never used/none; 1=Current user on date of dx; 2=Former user, quit within 1 year of date of dx; 3=Former user, quit >1 year prior to date of dx; 4=Former user; unknown quit date; 9=Unknown, not stated, no specifics provided, or "no".	X	
Tobacco Use NOS	Indicator of tobacco use, Not Otherwise Specified.	9968	TobaccoUseNOS	0=Never used/none; 1=Current user on date of dx; 2=Former user, quit within 1 year of date of dx; 3=Former user, quit >1 year prior to date of dx; 4=Former user; unknown quit date; 9=Unknown, not stated, no specifics provided, or "no".	X	
Source Comorbidity	Data source from which comorbidities/complications were collected.	9970	SourceComorbidity	0=No comorbid condition or complication identified/Not Applicable; 1=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 2 or more sources above; 6=Other source	X	
EDP MDE Link Variable	Indicates whether the tumor record linked to a tumor recorded in the DSHS Breast and Cervical Cancer Services (BCCS) program database (funded by federal NBCCEDP program)	9980	MDELink	0=Record sent for linkage, not match for this cancer with Texas BCCP data; 1=Record sent for linkage, match for this cancer with Texas BCCP; Blank=Record not sent for linkage or linkage result pending.	X	
EDP MDE Link Date	Date the tumor record was linked to a tumor record recorded in the DSHS Breast and Cervical Cancer Services (BCCS) program database (funded by federal NBCCEDP program)	9981	MDEDate	YYYYMMDD if record linked; blank if it did not link or linkage result pending.	X	
MedRefID	Sequential numeric identification number assigned to each tumor in the TCR database; unique to each tumor.	10015	MedRefID	Numerical field	X	X
Age Recode	Eighteen age groups that correspond to population data.	SEER*Stat recode		In categories of years: 00, 01-04, 05-09, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64, 65-69, 70-74, 75-79, 80-84, 85+		X
Age Recode with <1 year olds	Nineteen age groups that correspond to population data.	SEER*Stat recode		Years of age		X

Variable	Description	NAACCR Item Number	Variable Name	Coding scheme	In SAS incidence file	In Limited Use SEER*Stat incidence file
Age Recode with <1 year olds and 100+	Twenty-two age groups that correspond to population data.	SEER*Stat recode		In categories of years: 00, 01-04, 05-09, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64, 65-69, 70-74, 75-79, 80-84, 85-89, 90-94, 95-99, 100+		X
Age Recode with single ages and 85+	Derived field of single ages up to 85+	SEER*Stat recode		00 years, 01 years ... sequentially through 84 years; 85+		X
AYA site recode	This is a text variable with site names printed out. A site recode variable for cancers in adolescents and young adults (ages 15-39) that is derived from the variables Primary Site, Histologic type (ICD-O-3) and Behavior code (ICD-O-3).	SEER*Stat recode		See <a href="http://seer.cancer.gov/ayarecode/index.html">http://seer.cancer.gov/ayarecode/index.html</a> for SEER variable definition table.		X
AYA site recode/WHO 2008	These codes are updated for Hematopoietic codes based on WHO Classification of Tumors of Hematopoietic and Lymphoid Tissues (2008).	SEER*Stat recode		Uses SEER*stat coding scheme as shown: <a href="http://seer.cancer.gov/ayarecode/aya-who2008.html">http://seer.cancer.gov/ayarecode/aya-who2008.html</a>		X
Cause of death (ICD-10)	Official cause of death as coded from death certificate in valid ICD-10 codes. (Deaths in 1999+).	SEER*Stat recode		Text field		X
Cause of death (ICD-7, 8 or 9)	Official cause of death as coded from death certificate in valid ICD-9 codes. (Deaths in 1995-1998).	SEER*Stat recode		Text field		X
Cause of death recode	The cause of death recode variable records the cause of death including both cancer and non-cancer causes. This is the official cause of death based on ICD 8-10. Does not include separate categories for Kaposi sarcoma and mesothelioma.	SEER*Stat recode		Text variable with each cancer site cause of death, and non-cancer causes of death. See <a href="http://seer.cancer.gov/codrecode">http://seer.cancer.gov/codrecode</a>		X
Cause Of Death recode with Kaposi and mesothelioma	The cause of death recode variable records the cause of death including both cancer and non-cancer causes. This is the official cause of death based on ICD 8-10. This version includes the separate categories for Kaposi sarcoma and mesothelioma.	SEER*Stat recode		Text variable with each cancer site cause of death, and non-cancer causes of death. See <a href="http://seer.cancer.gov/codrecode/1969+_d09172004/">http://seer.cancer.gov/codrecode/1969+_d09172004/</a> for SEER cause of death recode.		X
Day of diagnosis	The day that the cancer diagnosis was made	SEER*Stat recode		Numerical field		
ICCC site recode extended ICD-O-3/WHO 2008	These codes are updated for Hematopoietic codes based on WHO Classification of Tumors of Hematopoietic and Lymphoid Tissues (2008).	SEER*Stat recode		See: <a href="http://seer.cancer.gov/iccc/iccc3_ext.html">http://seer.cancer.gov/iccc/iccc3_ext.html</a>		X
ICCC site recode extended ICD-O-3	The International Classification of Childhood Cancer has been defined based on primary site and ICD-O-3 morphology.	SEER*Stat recode		See <a href="http://seer.cancer.gov/ICCC/iccc3_ext.html">http://seer.cancer.gov/ICCC/iccc3_ext.html</a> for ICC3-3 main site recode definitions.		X
ICCC site recode ICD-O-3	The International Classification of Childhood Cancer has been defined based on primary site and ICD-O-3 morphology.	SEER*Stat recode		See <a href="http://seer.cancer.gov/iccc/iccc3.html">http://seer.cancer.gov/iccc/iccc3.html</a> for ICC3-3 main site recode definitions.		X
ICCC site recode ICD-O-3/WHO 2008	These codes are updated for Hematopoietic codes based on WHO Classification of Tumors of Hematopoietic and Lymphoid Tissues (2008). These codes are subject to change based on evolving ICD-O-3 coding rules.	SEER*Stat recode		Uses SEER*stat coding scheme: <a href="http://seer.cancer.gov/iccc/iccc-who2008.html">http://seer.cancer.gov/iccc/iccc-who2008.html</a>		X
ICD-O-3 Hist/behavior, labeled	This includes each ICD-O-3 Histology code including the behavior code, and the respective name of that histology and behavior.	SEER*Stat recode		This is a text variable with histology and behavior names printed out. Ordered by individual ICD-O-3-codes, with label. See the International Classification of Diseases for Oncology, Third edition (ICD-O-3) for histology and behavior codes.		X
ICD-O-3 Hist/behavior, malig, labeled	This includes each ICD-O-3 Histology code including the behavior code, and the respective name of that histology and behavior.	SEER*Stat recode		This is a text variable with histology and behavior names printed out. Ordered by individual ICD-O-3-codes and labels only for malignant neoplasms (behavior code=3). See the International Classification of Diseases for Oncology, Third edition (ICD-O-3) for histology and behavior codes.		X
Lymphoma subtype recode	This classification scheme was designed to facilitate epidemiologic studies of lymphoma subtypes.	SEER*Stat recode		See: <a href="http://seer.cancer.gov/lymphomarecode/">http://seer.cancer.gov/lymphomarecode/</a>		X
Lymphoma subtype recode/WHO 2008	These codes are updated for Hematopoietic codes based on WHO Classification of Tumors of Hematopoietic and Lymphoid Tissues (2008).	SEER*Stat recode		Uses SEER*stat coding scheme as shown: <a href="http://seer.cancer.gov/lymphomarecode/lymphoma-who2008.html">http://seer.cancer.gov/lymphomarecode/lymphoma-who2008.html</a>		X
Month of diagnosis	The month the cancer diagnosis was made.	SEER*Stat recode		Text field		X

Variable	Description	NAACCR Item Number	Variable Name	Coding scheme	In SAS incidence file	In Limited Use SEER*Stat incidence file
Month of diagnosis recode	Derived field used internally by SEER*Stat for calculating survival time.	SEER*Stat recode		Text field		X
Month of last contact recode	Derived field used internally by SEER*Stat for calculating survival time	SEER*Stat recode		Text field		X
Origin recode SEER (Hispanic, Non-Hisp)	Derived race field	SEER*Stat recode		Spanish-Hispanic-Latino; Non-Spanish-Hispanic-Latino; Unknown		X
Primary Site - labeled	This is a text variable with site names listed.	SEER*Stat recode		Ordered by individual ICD-O-3 site codes to 1 decimal place, with site name listed.		X
Race recode (W, B, AI, API)	Derived race field	SEER*Stat recode		Allowable values: White; Black, American Indian/Alaska Native; Asian or Pacific Islander; Other unspecified; Unknown. For detailed information regarding major changes to this field, please see the following website: <a href="http://seer.cancer.gov/seerstat/variables/seer/race_ethnicity/">http://seer.cancer.gov/seerstat/variables/seer/race_ethnicity/</a>		X
Race Recode (White, Black, Other)	Derived race field	SEER*Stat recode		Text field		X
Race Recode (White, Non-White)	Derived race field	SEER*Stat recode		Text field		X
SEER cause-specific death classification	Using a program from SEER, the vital status of the case is classified for cause-specific survival analysis, by determining whether, based on the coded cause of death, this death would be considered to be caused by the cancer diagnosis.	SEER*Stat recode		Three values: Alive or dead of other cause; Dead; N/A not first tumor		X
Site recode with Kaposi and mesothelioma	This is a text variable with site names printed out. Site recode using ICD-O-3, including Kaposi sarcoma and mesothelioma.	SEER*Stat recode		See <a href="http://seer.cancer.gov/siterecode/icdo3_d01272003/">http://seer.cancer.gov/siterecode/icdo3_d01272003/</a> for SEER Site recode with Kaposi sarcoma and mesothelioma definitions.		X
Site recode	Derived field with site names listed.	SEER*Stat recode		See <a href="http://seer.cancer.gov/siterecode/icdo3_d01272003/">http://seer.cancer.gov/siterecode/icdo3_d01272003/</a> for SEER Site Recode definitions.		X
County at Diagnosis	Identifies patient's county at diagnosis.	SEER*Stat recode		3 digit code for county issued by FIPS. In multiple tumor cases, FIPS code may be different for each tumor. 998=Canadian residence or unknown, or known town/city/state/or country but county code is not known and resident outside of the state of reporting institution; 999=County unknown		X
Survival time recode (year)	Calculated using date of diagnosis and one of the following: date of death, date last known to be alive, or follow-up	SEER*Stat recode		Example: A person diagnosed in May 1976 who died in May 1980 has a survival time recode of 04 years and 00 months.		
Vital Status (Study Cutoff used)	Vital status of the patient	SEER*Stat recode		Text field		X
Year of birth	Patient's birth year	SEER*Stat recode		Numerical field		X
Year of last contact	Derived field used internally by SEER*Stat for calculating survival time.	SEER*Stat recode		Year of last contact is often used for the study cutoff years, for example if the true year of last contact is beyond the study cutoff year.		X
Year of last contact recode		SEER*Stat recode		Numerical field		X
CustomRaceTCR	Creates a merged variable which shows rates by race (with non-Hispanic and Hispanic designation for whites), and by Hispanic ethnicity (of any race), and includes persons of Other and Unknown race (it is not possible to generate a rate for persons of unknown race due to lack of denominator).	SEER*Stat User Defined Merged		White (White, Hispanic; White, Non-Hispanic); Black; Asian/Pacific Islander; American Indian/Alaska Native; Hispanic (of any race); Other & Unknown Race		X
Council of Government	Texas Council of Government geographic area where the patient lived at time of diagnosis.	TCR only		00-24, each representing a Texas geographic region. Coded as COG1-COG24 in SEER*Stat file. Please see <a href="http://www.txregionalcouncil.org/display.php?page=regions_map.php">http://www.txregionalcouncil.org/display.php?page=regions_map.php</a> for more information.	X	X
Health Service Region	HSR variable: Texas Health Services Region (HSR) where the patient lived at time of diagnosis. Defined by the counties included in each of the 11 Health Services Regions.	TCR only		01-11, each representing a Texas geographic region. Coded as Health Service Region 1 through Health Service Region 11 in SEER*Stat file. See <a href="http://www.dshs.state.tx.us/regions/state.shtm">http://www.dshs.state.tx.us/regions/state.shtm</a>	X	X
County Name	Name of the county in which the patient currently resides	N/A		Note: Many Texas county names have a variety of spellings.		X

Variable	Description	NAACCR Item Number	Variable Name	Coding scheme	In SAS incidence file	In Limited Use SEER*Stat incidence file
FIPS	Federal Information Processing Standard; a unique code that identifies counties and county equivalents in the United States.	N/A		Numerical field		
County Number	This code is a unique identifier that the Center for Health Statistics uses for counties in Texas.	N/A		The County Code = (FIPS+1)/2		
Public Health Region	Each county is assigned to one of 11 public health regions.	N/A		Text field	X	X
Health Service Area	For administrative purposes, there are 8 regional public health offices, some of which service multiple or partial public health regions. The 8 geographies served by the offices are called health service regions.	N/A		Text field		
Metropolitan Statistical Area	A Metropolitan Statistical Area (MSA) has a large population nucleus and adjacent communities that have a high degree of social and economic integration with the core.	N/A		MSAs are defined by the U.S. Office of Management and Budget (OMB). "--" Indicates that the county is not in an MSA.	X	
Metropolitan Divisions	In Texas, there are two metropolitan divisions subdividing the Dallas-Fort Worth-Arlington Metropolitan Statistical Area, the Dallas-Plano-Irving MD and the Fort Worth-Arlington MD.	N/A		"--" Indicates that the county is not in a Metropolitan Division		
Metro Area	Any county that is part of a Metropolitan Statistical Area is classified as a metro area regardless of its own size. A number of low population counties in Texas are considered metro areas because they are adjacent to larger population cores and share social and economic integration with the core.	N/A		Text field		X
NCHS Urban-Rural Classification	An urban-rural designation developed by the National Center for Health Statistics. The most recent classification scheme was developed in 2013.	N/A		Text field		
Border Region (32)	This region contains the 32 counties considered to be border counties according to the La Paz Agreement.	N/A		Text field	X	X
Border Region (15)	This region encompasses the 15 counties that share a physical border with Mexico.	N/A		Text field	X	X
Site recode ICD-O-3/WHO 2008	A 5 digit code which corresponds with specific primary sites and histologies. Useful for data validation.	TCR only		Codes listed at <a href="http://seer.cancer.gov/siterecode/icdo3_dwho/home/">http://seer.cancer.gov/siterecode/icdo3_dwho/home/</a>	X	X
Rural Commuting Area Codes	USDA RUCA-based indicator is a measure of the proximity to large urban centers and can be an indicator of access to oncology specialists and cancer treatment facilities.	TBD	TBD	1= 100% urban; 2=The percent of the population in an urban area < 100% and ≥ 50%; 3=The percent of the population in a rural area < 100% and > 50%; 4= 100% rural; 9= Unknown or not applicable – census tract not available or tract population was zero at the last decadal census		
Rural Urban Commuting Area 2010	USDA RUCA-based indicator is a measure of the proximity to large urban centers and can be an indicator of access to oncology specialists and cancer treatment facilities.	TBD	TBD	1= 100% urban; 2=The percent of the population in an urban area < 100% and ≥ 50%; 3=The percent of the population in a rural area < 100% and > 50%; 4= 100% rural; 9= unknown or not applicable – census tract not available or tract population was zero at the last decadal census		
Urban Rural Indicator Codes	URIC is a measure of the rural nature of the place of residence and can be an indicator of access to recreation, access to food stores, exposures to pollutants, crime levels, social cohesion, etc.	TBD	TBD	1= Urban commuting area – RUCA codes 1.0, 1.1, 2.0, 2.1, 3.0, 4.1, 5.1, 7.1, 8.1, and 10.1; 2=Not an urban commuting area – all other RUCA codes except 99; 9=Unknown or not applicable – census tract not available or RUCA code = 99		