2025 Cancer Reporting Guide

Rules and Guidelines for Cancer Reporting in Texas

Texas Cancer Registry

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TEXAS Health and Human Services

Texas Department of State Health Services

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INTRODUCTION TO CANCER REPORTING

Texas Cancer Registry

About the Texas Cancer Registry

The Texas Cancer Registry (TCR) is a statewide, population-based registry that serves as the foundation for measuring the cancer burden in Texas, comprehensive cancer control efforts, health disparities, progress in prevention, diagnosis, treatment, and survivorship, and supports a wide variety of cancer-related research. These priorities cannot be adequately addressed in public health, academic institutions, or the private sector without timely, complete, and accurate cancer data.

TCR is one of the largest cancer registries in the United States. It is one of twelve state registries funded by both the National Cancer Institute (NCI)'s Surveillance, Epidemiology, and End Results (SEER) Program and Centers for Disease Control and Prevention (CDC)'s National Program of Cancer Registries (NPCR). In addition to Texas, the other state registries supported by both programs as well as state funds are Kentucky, Greater California, Utah, Louisiana, Georgia, Iowa, New York, Massachusetts, Idaho, Illinois, and New Jersey.

TCR currently meets the NPCR high quality data standards and is Gold Certified by the North American Association of Central Cancer Registries (NAACCR). TCR joined the SEER program in May 2021.

The purpose and ultimate goal of TCR is to collect, maintain, and disseminate the highest quality cancer data that will contribute towards cancer prevention and control, improving diagnoses, treatment, survival, and quality of life for all cancer patients.

Cancer reporting to TCR is mandated by the *Texas Cancer Incidence Reporting Act, Health and Safety Code, Chapter 82*. All cases of cancer diagnosed or treated in a health care facility, clinical laboratory, or by a health care practitioner as defined in Section 82.002, must be reported to the TCR according to Section 82.008. This includes all hospitals, cancer treatment centers, ambulatory surgical centers, clinical pathology laboratories, and in certain circumstances, physicians and dentists. Cancer incidence data should be reported to TCR as specified by *Rules in Texas Administrative Code, Title 25, Part 1, Chapter 91, Subchapter A.*

Click this link to access the cancer reporting law and rules found on the TCR website.

Texas Cancer Registry Funding

TCR is funded by the Cancer Prevention and Research Institute of Texas (CPRIT) and the Texas Department of State Health Services (DSHS). TCR also acknowledges funding from the following federal agencies.

- The CDC provides financial support under Cooperative Agreement #1NU58DP007140. The contents of the TCR website are solely the responsibility of the authors and do not necessarily represent the official views of the CDC or Texas Department of Health and Human Services.
- The SEER Program provides financial support under Contract #75N91021D00011.

The Texas Cancer Registry ***2025 Cancer Reporting Guide*** serves as a supplement to the *2025 SEER Program Coding and Staging Manual* for the consistent collection and coding of relevant cancer case information. **This edition should be used for reportable cases diagnosed January 1, 2025, and forward**. The contents of this manual are based on the guidelines and standards for cancer reporting established by NPCR at the CDC, SEER at the NCI, NAACCR, and the American College of Surgeons (ACS).

The ***2025 Cancer Reporting Guide*** can be opened on the Cancer Reporting Guides page on the TCR website.

For any problems, contact TCR. Remember to check the TCR Education and Training webpage for training opportunities and more information. Please see contact information on next page.

Regional Map and Contact Information

Texas is divided into Public Health Regions (PHR), as shown in the map below.

Physical Address Texas Cancer Registry (Tower 706) Texas Department of State Health Services 1100 West 49th Street Austin, TX 78756-3199 **Phone Numbers** TCR Main Line: 512-776-3080 TCR Toll Free: 1-800-252-8059 TCR Fax: 512-776-7681 **Media Inquires** PressOfficer@dshs.texas.gov	**Mailing Address** Texas Cancer Registry (Mail Code 1928) Texas Department of State Health Services PO Box 149347 Austin, TX 78714-9347 **Email** CancerData@dshs.texas.gov CancerReporting@dshs.texas.gov

Visit the TCR Contact Information Page to view the most current regional contact list.

Cancer Coding Resources

- *SEER Program Coding and Staging Manual 2025,* Adamo M, Groves C. (September 2024). SEER Program Coding and Staging Manual 2025. National Cancer Institute, Bethesda, MD 20892. U.S. Department of Health and Human Services National Institutes of Health National Cancer Institute. seer.cancer.gov/tools/codingmanuals/
- *STandards for Oncology Registry Entry (STORE 2025):* Released 11/15/2024. Commission on Cancer, ACS store-manual-2025.pdf
- *Hematopoietic & Lymphoid Neoplasm Coding Manual*, Ruhl J, Adamo M, Dickie L., Negoita, S. (November 2024). *Hematopoietic and Lymphoid Neoplasm Coding Manual.* National Cancer Institute, Bethesda, MD, 2024. https://seer.cancer.gov/tools/heme/
- *Solid Tumor Rules* (2023) Dickie L., Johnson, CH., Adams, S., Negoita, S. (November 2024). Solid Tumor Rules. National Cancer Institute, Rockville, MD 20850.seer.cancer.gov/tools/solidtumor/
- *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary*, Record Layout Version 25. Thornton ML, (ed). Data Standards and Data Dictionary, Version 25, 26th ed. Springfield, Ill.: North American Association of Central Cancer Registries, June 2024. naaccr.org/data-standards-data-dictionary/
- *SEER Summary Stage 2018 V3.2*, Ruhl JL, Callaghan C, Schussler N (eds.) Summary Stage 2018: Codes and Coding Instructions, National Cancer Institute, Bethesda, MD, 2024.seer.cancer.gov/tools/ssm
- *Site-Specific Data Items (SSDI) /Grade,* Ruhl J, Hofferkamp J, et al. (October 2024). SSDI Manual. NAACCR, Springfield, IL 62704-4194. https://apps.naaccr.org/ssdi/list/
- *SEER*Rx Interactive Antineoplastic Drugs Database* (Web-based). Surveillance, Epidemiology, and End Results Program, National Cancer Institute, Bethesda, MD 20850-9765. seer.cancer.gov/seertools/seerrx/
- *SEER Inquiry System (SINQ).* Surveillance, Epidemiology, and End Results Program, National Cancer Institute, Bethesda, MD 20850-9765. https://seer.cancer.gov/seer-inquiry/
- *Texas Cancer Incidence Reporting Act* (Amended April 2015), Texas Health and Safety Code, Chapter 82; and Rules, Title 25 Texas Administrative Code, Chapter 91, Subchapter A. Cancer Registry (Effective April 2017). dshs.texas.gov/tcr/lawrules.aspx
- *Physician Data Query (PDQ).* National Cancer Institute, Bethesda, MD 20850-9765. cancer.gov/publications/pdq

Acknowledgments

We wish to acknowledge that some information presented in this handbook was taken verbatim from the following manuals in order to avoid any misinterpretation of the instruction and coding manuals:

SEER Program Coding and Staging Manual 2025, Adamo M, Groves C. (September 2024). SEER Program Coding and Staging Manual 2025. National Cancer Institute, Bethesda, MD 20892. U.S. Department of Health and Human Services National Institutes of Health National Cancer Institute. seer.cancer.gov/tools/codingmanuals/

STandards for Oncology Registry Entry (STORE 2025): Released 11/15/2024. Commission on Cancer, ACS store-manual-2025.pdf

HELPFUL WEBSITES

dshs.texas.gov/tcr/ Texas Cancer Registry website with information on cancer reporting, trainings, pathology reporting, cancer reporting resources.

seer.cancer.gov/registrars/ SEER website with information on cancer reporting, trainings, SEER SINQ, cancer reporting questions and answers, cancer reporting resources.

cancer.gov/ NCI website with information on cancer, cancer types, research, grants and training, news and events.

ncra-usa.org/ National Cancer Registrars Association website with information on career path for becoming a Oncology Data Specialist (ODS), continuing education hours to maintain credential, mentoring and other volunteer opportunities, annual educational conference information.

naaccr.org/ North American Association of Central Cancer Registries website with information on education opportunities, credentialing, national data standards, educational annual conference, Virtual Pooled Registry, Data and Statistics, Research tools, certification, and volunteer opportunities.

iacr.com.fr/index.php International Association of Cancer Registries (IARC) website with information on support for central registries, publications, and annual meetings.

cancerbulletin.facs.org/forums/help CAnswer Forum ACS website with cancer reporting and coding questions and answers.

facs.org/quality-programs/cancer/ncdb/call-for-data ACS Call for Data website with information on submission requirements to the National Cancer Database.

https://www.facs.org/quality-programs/cancer-programs/american-joint-committee-on-cancer/ ACS with information on becoming a certified ACS registry, improve hospital outcomes, standards and staging, ACS portals for improving quality, surgeon specific registry, research programs.

tools.usps.com/go/ZipLookupAction_input United States Postal Service address lookup website.

zip-codes.com/zip-code/78734/zip-code-78734.asp Zip code look up website.

melissa.com/lookups/addressverify.asp Address look up website.

bls.gov/soc/ United States Bureau of Occupational Statistics website to look up occupations and industry.

nccn.org/ National Comprehensive Cancer Network (NCCN) website with information on guidelines for treatment by cancer type, prevention, detection and risk reduction, supportive care, education and research, patient resources.

breastcancer.org/ Breast Cancer helpful information website.

nlm.nih.gov/ National Library of Medicine website with information on clinical trials, resources, grants, and research.

anatomyatlases.org/ Anatomy Atlases website with an anatomy digital library.

oralcancerfoundation.org/ The National Oral Cancer Foundation website with information on support, advocacy, screening, research.

pathologyoutlines.com/ Pathology Outlines website with information on the Curing Cancer Network, sharing innovative cancer ideas.

Medical Eponyms Website for medical eponyms.

docfinder.docboard.org/tx/df/txsearch.htm Physician lookup website.

https://www.thima.org/ Texas Health Information Management Association website with information on membership, events, resources, and educational webinars.

TCR Coding and Staging Requirement Summary

CDC NPCR & NCI SEER

Beginning with cases diagnosed January 1, 2025 and forward, CDC NPCR and NCI SEER will adopt the new record format and data collection requirements as published in the NAACCR Data Standards and Data Dictionary, Version 25.

Share these requirements with your software vendors and key stakeholders. For more information, see Chapter VIII: Required Status Table.

Coding Cancer Cases

SEER Coding and Staging Manual Contents

The *2025 SEER Program Coding and Staging Manual* includes data item descriptions, codes, and coding instructions for cases diagnosed January 1, 2025 and forward as reported by SEER registries. For all cases diagnosed on or after January 1, 2025, the instructions and codes in the SEER manual take precedence over all previous instructions and codes. Updates to the SEER manual identified after publication will be found in the SEER Inquiry System (SINQ). SINQ can be found under the category of 'Updates to Current Manual', found under the "Other Category" category until a subsequent revision of this manual is issued.

- Updates to Current Manual

- Cancer Pathology Coding Histology And Registration Terminology (Cancer PathCHART (PathCHART)
- Extent of Disease (EOD)
- Hematopoietic & Lymphoid Neoplasm Database and Manual
- Primary Site
- SEER Program Coding and Staging Manual
- SEER Rx
- Solid Tumor Rules
- Summary Stage

TCR's ***2025 Cancer Reporting Guide*** serves as a supplement to the *2025 SEER Program Coding and Staging Manual* for the consistent collection and coding of relevant cancer case information.

Note: See the for questions about American Joint Commission on Cancer (**AJCC) Tumor-Nodes-Metastases (TNM) staging, Grade**, the **Site-Specific Data Items**, and **data items not required by SEER**. SEER required data items are listed in the Required Status Table NAACCR Data Dictionary.

ACS Commission on Cancer CAnswer Forum

- CoC Standards
- AJCC
    - Version 9
    - 8th Edition
    - 7th Edition
- STORE
- Rapid Cancer Reporting System
- SSDI/Grade
- Ask the Pathologist

ICD-O

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 and month 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 TCR.

Effective for cases diagnosed January 1, 2025, forward, ICD-O-3.2 Coding Table Excel is the preferred reference for morphology codes.

Solid Tumor Rules

Use the Solid Tumor Rules to determine the number of primaries to abstract and the histology to code for cases diagnosed 1/1/2018 and forward. The Solid Tumor Rules and the General Instructions replace the *2007 Multiple Primary & Histology (MP/H) Rules* for the following:

- Breast
- Colon (includes rectosigmoid and rectum for cases diagnosed 1/1/2018 forward)
- Head & Neck
- Kidney
- Lung
- Malignant central nervous system (CNS) and Peripheral Nerves
- Non-malignant CNS
- Urinary Sites
- Cutaneous Melanoma (for cases diagnosed 1/1/2021 and forward)
- Other Sites (for cases diagnosed 1/1/2023 and forward)

Hematopoietic & Lymphoid Neoplasm Database and Manual

The *Hematopoietic & Lymphoid Neoplasm Database* and the *Hematopoietic & Lymphoid Neoplasm Manual* consist of rules, guidelines and an interactive desktop Heme DB reference to assist registrars in determining case reportability, the number of primaries, as well as instructions for coding primary site, histology, grade, diagnostic confirmation and other therapy for a hematopoietic and/or lymphoid neoplasms (9590/3-9993/3). *Hematopoietic & Lymphoid Neoplasm Database* is a tool to assist in screening for reportable cases and determining reportability requirements. It contains abstracting and coding information such as definitions, synonyms, definitive diagnosis methods, and abstractor notes. The *Hematopoietic & Lymphoid Neoplasm Manual* has the rules and instructions for determining the number of primaries, the primary site and histology, and the cell lineage or phenotype.

Staging Cancer Cases

Below are the resources available for the stage-related data required to be collected by TCR for the following data items for cases diagnosed 2022 and forward. Summary Stage 2018 (SS2018), EOD, Site-Specific Data Items, and the Grade data items.

Summary Stage 2018

Directly coded SEER Summary Stage 2018 is required from all facilities for reporting year 2018 and forward. Summary Stage 2018 systems will continue to be used for cases diagnosed on or after January 1, 2025. A change log is available for the SS2018 revisions between versions under Revision History.

Summary Stage is the most basic way of categorizing how far a cancer has spread from its point of origin. Historically, Summary Stage has also been called General Stage, California Stage, historic stage, and SEER Stage.

The 2018 version of Summary Stage applies to every site and/or histology combination, including lymphomas and leukemias. Summary Stage is a combination of the most precise clinical and pathological documentation of the EOD. Many central registries report their data by Summary Stage since the staging categories are broad enough to measure the success of cancer control efforts and other epidemiologic efforts.

See the SEER Summary Stage 2018 Manual for detailed coding instructions.

TCR Required Site-Specific Data Items

Collaborative Stage Site-Specific Factors have been discontinued and SSDIs are used for collection of site-specific information for cases diagnosed on or after January 1, 2018. See the SEER Program Coding and Staging Manual 2025 to determine which staging data items are required to be collected for cases diagnosed on or after January 1, 2025.

Before using the Site-Specific Data Item Manual as an information resource for specific data items, it is important to review the introductory materials and general instructions carefully. Although the majority of data items that are currently collected as SSDIs were previously collected as SSFs, the format of the data items and allowable values have changed substantially, particularly for laboratory values.

Grade Manual

The *Grade Coding Instructions and Tables* Grade Manual is the primary resource for documentation and coding instructions for Grade for cases diagnosed on or after January 1, 2018. Before using the Grade Manual as a coding reference, it is important to review the introductory materials and general instructions of the manual carefully. These reflect several important changes in the collection of Grade data items, including use of AJCC-recommended grade tables where applicable and the introduction of Grade Clinical, Grade Pathological, and Grade Post Therapy Clin (yc) and Grade Post Therapy Path (yp) data items.

Extent of Disease 2018

TCR began collecting EOD 2018 for cases diagnosed January 1, 2022 and forward. The three main data items are EOD Primary Tumor, EOD Regional Nodes, and EOD Mets. Using these three data items, an EOD T, EOD N, and EOD M will be derived, along with an EOD Stage Group. SEER developed a staging database referred to as the SEER*RSA that provides information about each cancer (primary site/histology/other factors defined).

AJCC TNM

AJCC TNM data items are required only from facilities accredited by the ACS and only for analytical cases. For hospitals and cancer centers that are not ACS-accredited, these data items are required for analytical cases only as available (class of case 00-22).

Note: See the ACS Commission on Cancer CAnswer Forum for questions about **AJCC TNM staging**, the **Site-Specific Data Items**, and **data items not required by SEER**. SEER required data items are listed in the NAACCR Required Status Table.

- CoC Standards
- AJCC
  - Version 9
  - 8th Edition
  - 7th Edition
- Standards for Oncology Registry Entry (STORE)
- Rapid Cancer Reporting System
- SSDI/Grade
- Ask the Pathologist

*Registrar Staging Assistant (SEER*RSA)*

The Registrar Staging Assistant (SEER*RSA) website is available for use by cancer registrars to help code the Summary Stage 2018 (SS2018), Extent of Disease (EOD), Site-Specific Data Items, and Grade for cases diagnosed 2018 and forward.

TCR Coding and Staging Manuals By Diagnosis Year

Coding and Staging Schema	Diagnosis Year	Manual Version To Use
SEER Program Coding and Staging Manual	2022 - forward	Diagnosis Year
International Classification of Diseases for Oncology, 3rd Edition (ICD-O-3)	2001 - 2017	Manual with errata
ICD-O-3	2018 - 2020	Manual with ICD-O-3 tables
ICD-O-3	2021 - forward	Primary Site only
ICD-O-3.2 Coding Table and Update Tables	2021-forward	Diagnosis Year (Histology only)

Coding and Staging Schema	Diagnosis Year	Manual Version To Use
Multiple Primary and Histology Rules	2007 - 2017	Diagnosis Year
Solid Tumor Rules	2018 - forward	Diagnosis Year
Hematopoietic & Lymphoid Neoplasm Manual and Database	2010 - forward	Diagnosis Year
SEER April 1977 Summary Staging Guide	Prior to 2001	Diagnosis Year
SEER Summary Staging Manual 2000	2001 - 2003 2015 - 2017	Diagnosis Year
SEER Summary Stage 2018	2018 - forward	Current Version
SSDIs Manual and Grade Manual	2018 - forward	Current Version
EOD 2018	2022 - forward	Current Version
Collaborative Stage Data Collection System Coding Instructions, vs. 02.05	2004 - 2015	Diagnosis Year
AJCC Cancer Staging Manual, Seventh Edition	2015 - 2017	Diagnosis Year
AJCC Cancer Staging Manual, Eighth Edition	2018 - forward	Diagnosis Year
AJCC Cancer Staging System, Version 9	2021 - forward	Diagnosis Year

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

Note:

- Specific Collaborative Stage Site-Specific Factors are required for 2017 diagnosis cases.
- SSDI's replaced Collaborative Stage Site-Specific Factors for 2018 and forward diagnosis cases.

Per SEER, the new coding and staging instructions/guidelines replaces the old for their respective time periods.

2 REPORTING LAW AND RULES

Cancer reporting to TCR is mandated by the Texas Cancer Incidence Reporting Act, Health and Safety Code, Chapter 82. All cases of cancer diagnosed or treated in a health care facility, clinical laboratory, or by a health care practitioner as defined in Section 82.002, must be reported to TCR according to Section 82.008. This includes all hospitals, cancer treatment centers, ambulatory surgical centers, clinical pathology laboratories, and in certain circumstances, physicians, and dentists. Cancer incidence data should be reported to TCR as specified by Rules in Texas Administrative Code, Title 25, Part 1, Chapter 91, Subchapter A.

Confidentiality

According to Health and Safety Code, Section 82.009, reports, records, and information obtained by TCR are confidential and are not subject to disclosure under Chapter 552, Texas Government Code (Public Information), are not subject to subpoena, and may not otherwise be released or made public except under certain situations. Those situations include: 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 to ensure confidentiality as required by state and federal laws. Research requests for release of personal cancer data require approval by the Texas DSHS Institutional Review Board (IRB) in accordance with requirements in Texas Administrative Code, Chapter 91, Subchapter A, Rule §91.12.

The Health Insurance Portability and Accountability Act (HIPAA) allows for the reporting of identifiable cancer data to public health entities. Because TCR falls under the definition of a public health entity, HIPAA allows your facility or practice to report data to us in compliance with state law. Written informed consent from each cancer patient reported to public health entities is not required under HIPAA; rather health care providers must simply document that reporting has occurred.

TCR adheres to all state and federal laws, rules, and guidelines regarding protected health information and follows strict security policies and procedures to assure patient and institutional confidentiality.

Disclosure of Data

All data reported to 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. The TCR Data Visualization Tool, linked off of the TCR Cancer Statistics webpage, can generate customized maps and tables of Texas cancer incidence and mortality rates. Public access to aggregate data is available through published reports, or through TCR, if in accordance with its data release policies and procedures.

TCR may exchange patient-specific data with the respective 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 TCR's confidentiality policies. However, no facility-specific patient

information can be released unless authorized under law. TCR will not release information from one facility to a different facility under any circumstances. TCR can contact the facility where the patient was seen and obtain consent to release information other than that authorized by law under special circumstances.

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

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 DSHS IRB.

Quality Assurance

TCR implements an extensive series of quality assurance procedures that are based on NCI's 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

TCR uses Web Plus, part of CDC's Registry Plus Software Suite, to submit data and export submitted data. Data is then uploaded from Web Plus to the SEER Data Management System (SEER*DMS) which collects cancer incidence and related information from population-based cancer registries.

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

Missed Cancer Casefinding (MCF) Quarters 1 and 2 & Death Clearance Missed Cancer Casefinding (DCCF) Quarters 3 and 4

TCR conducts data linkages twice a year with the DSHS Death Certificate File and Texas Inpatient and Outpatient Discharge Data to identify potentially missed cancer cases that have not been reported to TCR. Once the linkage is complete, each facility will be provided with a listing of potentially missed cases for review, abstraction, and submission. This may include multiple primaries. This process combines the Death Clearance Only (DCO) Audit performed in previous years as well as Casefinding Data Quality Audits. This process will help reporters and TCR staff identify possible missed resources to identify reportable cases (pathology, cytology, ambiguous terminology etc.).

All follow-back cases will be available for facilities in a single report and will contain the casefinding source, for example: DCO or inpatient/outpatient. Performed annually, this will eliminate multiple listing requests for facilities.

Your facility's assistance in reviewing, and if needed, reporting these potentially missed cases is critical for TCR to meet the CDC's NPCR and NCI's SEER cooperative agreement requirements and high-quality data standards, as well as maintain NAACCR gold certification.

Note: Small Casefinding and Data Collection (CFDC) facilities are not required to abstract missed cases. CFDC facilities must submit all medical records to TCR for review and abstraction.

Guidance

Refer to the email notification regarding the time sensitive completion dates for each project and submit the completed excel file via Web Plus.

Excel format contains 14 fields.

- Case Indicator

  I=inpatient

  I/O = inpatient and outpatient
- Last Name
- First Name
- Middle Initial
- Social Security Number (SSN)
- Date of birth (DOB)
- Medical Record #
- International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)
- Admission
- Discharge
- Cancer Codes (#)
- Visits (#)
- Reportable (Y/N)
- Reason Not Reportable

CANCER CODES (#) Column

If there are two or more codes, the probability of a reportable code is greater, please re-review reportable cancer codes.

REPORTABLE

(Y/N)

If case is reportable, enter the Accession Number & Web Plus release date/submission date in the "Reportable" column.

If case is Non-Reportable (NR), enter the Non-Reportable Code AND the reason in the "Reason Not Reportable" column.

Examples:

NR-02 Squamous cell carcinoma skin R temple.
NR-03 HX CA Ovary. FU scans WNL.
NR-03 Hx of. Review of 5 inpatient admission during the year, only 1 mentioned hx of mesothelioma.
NR-07 No cancer mentioned for Primary site.

NON-REPORTABLE 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, Cervical Intraepithelial Neoplasia (CIN) III

07 – No Cancer Mentioned in Record

08 – Diagnosed Prior to 1995

09 – Lab Only

10 – Other (Include Explanation)

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 Specialist. To request training submit your training needs using the online training request forms found on the Education and Training section of the TCR website. You can also contact the TCR Training Team at TCR.Training@dshs.texas.gov.

3

CANCER REPORTING

Compliance

As the primary source of cancer case reporting to TCR, it is important that facilities submit their cancer cases in a timely manner. Due to reporting requirements of the CDC, SEER, and TCR, **all records must be submitted within six months of initial diagnosis or admission with active disease and/or treatment of cancer at the facility**.

Refer to the Cancer Reporting webpage for more information regarding Hospital, Pathology, and Physician Reporting, as well as Reporter Updates.

Timeliness of Data Submission

To ensure timely and complete cancer case reporting in Texas, TCR staff routinely monitor submissions of case reports from facilities. If submissions are not received in a complete and timely manner according to state law and rules, the facility registrar or reporter will be contacted by TCR staff regarding the delinquent reporting status.

This information is in *Section 91.5(a) (When to Report*) of the Cancer Registry Rules. Refer to TCR's Reporting Law and Rules webpage for more information regarding reporting timeliness.

If you have any questions, please contact your TCR Regional Operations staff for additional information.

Timely Reporting Calendar

The TCR Reporting Calendar is on the next page and can also be found on the TCR Reporting webpage.

TCR Timely Reporting Calendar Table

Cases admitted in:	Reported no later than:
January 2025	July 2025
February 2025	August 2025
March 2025	September 2025
April 2025	October 2025
May 2025	November 2025
June 2025	December 2025
July 2025	January 2026
August 2025	February 2026
September 2025	March 2026
October 2025	April 2026
November 2025	May 2026
December 2025	June 2026

Case Submission Requirements

Cancer reporting rules require monthly submissions from healthcare facilities with an annual caseload of greater than 400 and at least quarterly submissions for healthcare facilities with an annual caseload of 400 or fewer. **Weekly submissions from all facilities are strongly recommended.**

Case Submission Requirements Table

Caseload	Submission
>400	Monthly
≤400	≥ Quarterly

To ensure timely and complete cancer case reporting in Texas, TCR staff routinely monitor submissions of case reports from hospitals. If submissions are not received in a complete and timely manner according to state law and rules, the facility registrar or reporter will be contacted by TCR staff 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 submissions.

Small Cancer Caseload Facilities (125 or fewer)

TCR developed the "Small Facility Casefinding and Data Collection Program" as required by the *Texas Cancer Incidence Reporting Act (Chapter 82, Texas Health and Safety Code),* with the goal to increase and improve the reporting and data quality of cancer cases from Texas facilities with 125 or fewer expected cancer cases. TCR staff will conduct the casefinding and data collection activities for these facilities. Facilities will be contacted regarding their facility's compliance and eligibility for participation in this program. To participate in this program facilities must meet timelines as determined by TCR.

Ambulatory Surgery Centers Guidelines

Texas ambulatory surgery centers (ASC) that diagnose and/or treat cancer patients provide valuable treatment information that is otherwise not available to TCR.

If an ASC is affiliated with a health care system, cancer center, and/or hospital, that healthcare system, cancer center, and/or hospital is responsible for reporting cancer case(s) on the ASC's behalf.

If an ASC is a free-standing facility, TCR will conduct a linkage with the Texas Health Care Information Council Outpatient Data to identify reportable cases that are not otherwise reported to TCR, as well as missing surgical cancer treatment information. The linkage is done to minimize any additional reporting burden on the part of the ASC and TCR. The free-standing ASC is then required to provide the requested medical records to TCR for review and possible inclusion in the registry.

Pathology Laboratory Guidelines

Pathology Laboratories, both state and national, that diagnose cancer for Texas health care providers and residents provide valuable case-finding and diagnostic information that is not otherwise available to TCR. Receiving pathology reports from pathology laboratories is a critical source of information for comprehensive population-based cancer reporting.

The preferred electronic reporting formats are versions 2.3.1 or 2.5.1 Health Level Seven (HL7) standard protocols, in accordance with NAACCR, Pathology Laboratory Electronic Reporting, Volume 5 central registry standards.

In order to securely transmit pathology laboratory data to TCR, there are two strongly preferred options, either are acceptable:

1. The DSHS maintains the Public Health Information Network Messaging System (PHIN MS), a secure messaging platform provided by the CDC for receiving data from pathology laboratories. Information about the PHIN MS system can be found on CDC's PHIN webpage. Another secure

platform for electronic reporting is with the Association of Public Health Laboratories Informatics Messaging Services which can be found on Association of Public Health Laboratories webpage.

2. Pathology reporting, either in HL7 formats or as scanned pdf documents, may be securely uploaded to TCR using Web Plus, a web-based application also provided by the CDC. With this data submission method, you must obtain a Web Plus account by completing the Online Web Plus Account Registration and submitting the Web Plus Use and Confidentiality Statement by scanning and emailing to TCRTechSupport@dshs.texas.gov or via fax at 512-776-7681. More information on Web Plus can be found on our Web Plus webpage.

Required information in the pathology report includes not only information about the patient's cancer, but patient identifiers and demographics, such as name, date of birth, sex, patient address, and social security number. Other fields which are encouraged if available are race/ethnicity and primary payer. If these data items are not on the pathology report, they can be included on a separate Excel spreadsheet that can be uploaded using Web Plus. For your convenience, a template is available on the TCR Pathology Reporting webpage.

Sending paper pathology reports via mail/FedEx or fax are strongly discouraged. These reporting methods result in significantly more manual processing by TCR and are not as secure as electronically submitting reports using either PHIN MS or Web Plus.

The accountability for any HIPAA breach using mail/FedEx or fax to submit reports to TCR falls on the pathology laboratory deviating from TCR recommended method of reporting. Any laboratory sending paper records to TCR should follow HIPAA guidance for securely sending patient records through U.S. mail and needs to ensure the guidance is followed correctly.

Current guidance provided to TCR includes instructions to double envelope the pathology reports and write "CONFIDENTIAL" on the outside envelope prior to sending the paper records. Before choosing this method, consider one of the more secure electronic methods discussed previously.

Refer to the Contact Information webpage for the appropriate representative to call if you have additional questions.

Note: Hospital Reporting information regarding Timely Reporting Calendars and compliance, as well as Reporting Laws and Rules, can be found on the TCR website.

4

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 (case ascertainment) is a process used to identify all eligible cases to be reported to TCR through a review of source documents and case listings. Casefinding covers a range of cases that need to be assessed to determine whether or not they for reportability. **A casefinding list is not the same as a reportable list.**

Casefinding sources include disease indices, pathology and laboratory reports, patient logs, and similar resources specific to each facility.

Refer to the Casefinding Sources list below for a more detailed list. Every inpatient and/or outpatient with **active disease and/or receiving cancer-directed therapy** must be reported to TCR regardless of the patient's state. TCR does not require cases for patients with a history of cancer.

The requirements for reporting depend on the governing agencies of the registry. For example, hospitals participating in the Approvals Program of the CoC of the ACS follow the guidelines set forth by CoC; however, they must also adhere to TCR reporting criteria.

Remember that cases diagnosed prior to 1995 and foreign residents are no longer required to be reported.

Casefinding Methods

There are two types of casefinding methods—active and passive:

- Active casefinding—the personnel responsible for reporting obtain and review all sources for eligible cases. This method is more comprehensive and precise.
- 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 annually and amended as facility procedures or services change.

Casefinding Sources

1. Medical Records Department

- Disease Index
- Inpatient/Outpatient Admission and Discharge Reports

2. Pathology Department
    - Histology Reports
    - Cytology Reports
    - Hematology Reports
    - Autopsy Reports
    - Bone Marrow Reports
3. Surgery Department
4. Outpatient Department
5. Medical and Diagnostic Imaging
6. Radiation Oncology
7. Medical Oncology\Hematology
8. Emergency Room Reports
9. Lab Reports
10. Nuclear Medicine
11. Pain Clinic Log

Casefinding Lists

Use the casefinding lists to screen prospective cases and identify cancer cases for inclusion in the registry.

A casefinding list is **not** the same as a reportable list. Casefinding lists are intended for searching a variety of sources so as not to miss any reportable cases.

Pathology

The pathology department reports must be routinely checked. The best procedure is to have copies 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.

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. Examples include rural health clinics or surgery centers across town or off campus.

Disease indices (DI) should be obtained after medical records are completed and coded (monthly or quarterly). A DI is used in medical records to list and organize diseases and conditions according to the International Classification of Diseases. 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-10-CM diagnosis codes, and admission type.

Electronic DIs in Excel format is preferred and should include a * *Non-Reportable* column. It should be obtained after medical records are completed and coded (monthly or quarterly).

The Excel format **Non-Reportable* column should be marked if it is deemed to be a non- reportable. Refer to the Non-Reportable codes found on page 49.

The ICD-10 CM Casefinding List to review at 100% is found on page 35. The ICD-10 CM 5% Supplementary Codes table is found on page 41. Review at the end of your completed submission year.

Note: The Missed Casefinding/DCO linkage project stems from the facility's Casefinding processes.

Attachment A (page 56 is an example of a DI that can be modified for individual facilities.)

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

- Review the DI for reportable cancer ICD-10-CM codes to ensure the facility has reported all of its reportable cases to 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 DI 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 (accession) 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 DI should be run at the end of the reporting year. Ensure that the ICD-10-CM codes used are the most current for the reporting year. This DI 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.

TCR now provides an avenue for following back to each facility for potentially missed cases. It is the facility's responsibility to maintain a reportable and non-reportable list to assist in the review process of the potentially missed cases list provided annually.

ICD-10-CM CASEFINDING LIST

The FY2025 ICD-10-CM Casefinding List is intended to aid appropriate staff (e.g., Information Services, Data Management) in creating the DI with the required reportable neoplasms and ICD-10-CM codes. Remember to review your ICD-10-CM list at the beginning of each reporting year, as changes may have occurred.

Use the casefinding lists to screen prospective cases and identify cancer cases for inclusion in the registry. A casefinding list is not the same as a reportable list. Casefinding lists are intended for searching a variety of cases so as not to miss any reportable cases.

Two separate DI's must be requested:

1. A DI with reportable Comprehensive ICD-10-CM codes - 100% review required. This DI will include the Inpatient and Outpatient admissions based on ICD-10-CM primary and secondary diagnosis codes.
2. A DI with Supplemental ICD-10-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 two to three years. However, if 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 three or six months.

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

Cytology

Do not accession a case based ONLY on suspicious cytology. Follow back on cytology diagnoses using ambiguous terminology is strongly recommended.

Note: "Suspicious cytology" means any cytology report diagnosis that uses an ambiguous term, including ambiguous terms that are listed as reportable in this manual.

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

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

Table 4.1 ICD-10-CM CASEFINDING LIST, 2025

ICD-10-CM Code (100% Review Required)	Description
C00.0 - C43.9 C4A.0 - C4A.9, C45._ - C96._	Malignant neoplasms (excluding category C44 and C49.A), stated or presumed to be primary (of specified site) and certain specified histologies ***Note:*** The following neoplasm codes are new for FY2022 (10/1/2021): C56.3: Malignant neoplasm of bilateral ovaries C79.63: Secondary malignant neoplasm of bilateral ovaries C84.7A: Anaplastic large cell lymphoma, ALK-negative, breast
C44.13 - C44.1392	Sebaceous cell carcinoma of skin of eyelid, including canthus ***Note:*** Effective 10/1/2018
C49.A - C49.A9	Gastrointestinal Stromal Tumors (GIST) ***Note:*** All GIST tumors are now reportable starting in 2021 (per ICD-O-3.2), including GIST, NOS
D00.00 - D03.9 D05 - D05.92 D07.0 - D09.9	In-situ neoplasms ***Note:*** Carcinoma in situ of the cervix (D06._) and Prostatic Intraepithelial Carcinoma (PIN III-8148/2) are not reportable. Other prostate in situ histologies are reportable
D18.02	Hemangioma of any site of intracranial structures
D32.0 - D32.9	Benign neoplasm of meninges (cerebral, spinal, and unspecified)
D33.0 - D33.9	Benign neoplasm of brain and other parts of central nervous system
D35.2 - D35.4	Benign neoplasm of pituitary gland, craniopharyngeal duct, and pineal gland
D42.-, D43.-	Neoplasm of uncertain or unknown behavior of meninges, brain, CNS
D44.3 - D44.5	Neoplasm of uncertain or unknown behavior of pituitary gland, craniopharyngeal duct, and pineal gland
D45	Polycythemia vera (9950/3)
D46. - D46.9	Myelodysplastic syndromes (9980, 9982, 9983, 9985, 9986, 9989, 9991, 9992, 9993)
D47.02	Systemic mastocytosis
D47.1	Chronic myeloproliferative disease (9963/3, 9975/3) ***ICD-10-CM Coding instruction note***: Excludes the following: Atypical chronic myeloid leukemia (BCR)/(ABL) negative (C92.2_) Chronic myeloid leukemia BCR/ABL-positive (C92.1_) Myelofibrosis & Secondary myelofibrosis (D75.81) Myelophthisic anemia & Myelophthisis (D61.82)
D47.3	Essential (hemorrhagic) thrombocythemia (9962/3) Includes: Essential thrombocytosis, idiopathic hemorrhagic thrombocythemia

ICD-10-CM Code (100% Review Required)	Description
D47.4	Osteomyelofibrosis (9961/3) Includes: Chronic idiopathic myelofibrosis Myelofibrosis (idiopathic) (with myeloid metaplasia) Myelosclerosis (megakaryocytic) with myeloid metaplasia) Secondary myelofibrosis in myeloproliferative disease
D47.Z1 -	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9960/3, 9970/1, 9931/3) ***Note***: Post-transplant lymphoproliferative disorder (PTLD) 9971 not reportable from 1/1/21 – 12/31/24 - Refer to Reportable Diagnosis List, page 62 for detailed explanation
D49.6, D49.7	Neoplasm of unspecified behavior of brain, endocrine glands, and other CNS
D72.11-	Hypereosinophilic syndrome [HES] (9964/3)
K31.A22	Gastric intestinal metaplasia with high grade dysplasia
N85.02	Endometrial intraepithelial neoplasia [EIN]
R85.613	**High grade squamous intraepithelial lesion (HGSIL) on cytologic smear of anus**
R85.614	Cytologic evidence of malignancy on smear of anus
R87.614	Cytologic evidence of malignancy on smear of cervix
R87.623	High grade squamous intraepithelial lesion on cytologic smear of vagina (HGSIL)
R87.624	Cytologic evidence of malignancy on smear of vagina
R90.0	Intracranial space-occupying lesion found on diagnostic imaging of central nervous system

^ Based on the International Classification of Diseases, ICD-10-CM Tabular List of Diseases and Injuries, Fiscal Year (FY) 2025

Source: https://seer.cancer.gov/tools/casefinding/icd-10-cm-casefinding-list.20240924.pdf

SUPPLEMENTARY ICD-10-CM CODES

***NOTE*: Cases with the codes in the Supplemental list below should be screened as registry time allows. Experience in the SEER registries has shown that using the supplemental lists increases casefinding for benign brain and CNS, hematopoietic neoplasms, other reportable diseases and treatment related information**

Table 4.2 Supplementary ICD-10-CM Code List

ICD-10-CM Code (5% Review Required)	Description
D06.-	Carcinoma in situ of the cervix
D13.7	Benign neoplasm of endocrine pancreas ***Note:*** Effective 1/1/2021: Review this code to look for the following which were previously a benign tumor of the pancreas, but is now malignant per ICD-O-3.2 • Islet cell adenoma • Nesidioblastoma • Islet cell adenomatosis • Insulinoma • Beta cell adenoma
D21.4	Benign neoplasm of connective and other soft tissue of abdomen ***Note:*** Effective 1/1/2021: Review this code to look for the following which were previously a benign tumor of the pancreas, but is now malignant per ICD-O-3.2 Gastrointestinal stromal tumor, NOS/GIST, NOS/Gastrointestinal autonomic nerve tumor/GANT/Gastrointestinal pacemaker cell tumor (8936/1, now 8936/3)
D23.9	Other benign neoplasm of skin Benign carcinoid tumors of other sites ***Note:*** Effective 1/1/2021: Review these codes to look for the following which were previously benign and borderline tumors, but are now malignant per ICD-O-3.2 • Aggressive digital papillary adenoma (C44_) (8408/1, but now 8408/3)
D35.0-	Benign neoplasm of adrenal gland ***Note:*** Effective 1/1/2021: Review this code to look for the following which was previously a benign (8700/0) tumor of the adrenal gland, but is now malignant per ICD-O-3.2 (8700/3) • Pheochromocytoma • Adrenal medullary paraganglioma • Chromaffin paraganglioma • Chromaffin tumor • Chromaffinoma
D37.8	Neoplasm of uncertain behavior of other specified digestive organs (includes uncertain

ICD-10-CM Code (5% Review Required)	Description
	behavior of pancreas) ***Note:*** Effective 1/1/2021: Review this code to look for the following histologies which were previously borderline tumors, but are now malignant per ICD-O-3.2 • Pancreatic endocrine tumor, not otherwise specified (NOS) (C259, 8150/1, now 8150/3) • Islet cell tumor, NOS (C259, 8150/1, now 8150/3) • Glucagonoma, NOS (C259, 8152/1, now 8152/3) • Alpha cell tumor, NOS (C259, 8152/1, now 8152/3) • Glucagon-like peptid-producing tumor (C259, 8152/1, now 8152/3) • Somastostatinoma, NOS (8156/1, now 8156/3) • Somatostatin cell tumor, NOS (8156/1, now 8156/3) • Endocrine tumor, functioning, NOS (8158/1, now 8158/3) • ACTH-producing tumor (8158/1, now 8158/3)
D3A.-	Benign carcinoid tumors ***Note:*** Effective 1/1/2021: Review these codes to look for the following which were previously benign and borderline tumors, but are now malignant per ICD-O-3.2 • Carcinoid tumor, argentaffinoma, NOS (8240/1, now 8241/3) • Enterochromaffin-like cell carcinoid, NOS (8242/1, now 8241/3)
D44.6	Neoplasm of uncertain behavior of carotid body ***Note:*** Effective 1/1/2021: Review this code to look for the following histologies which were previously borderline tumors, but are now malignant per ICD-O-3.2 • Carotid body tumor/Carotid body paraganglioma (8692/1, now 8692/3)
D44.7	Neoplasm of uncertain behavior of aortic body and other paraganglia ***Note:*** Effective 1/1/2021: Review this code to look for the following histologies which were previously borderline tumors, but are now malignant per ICD-O-3.2 • Paraganglioma, NOS (8680/1, now 8680/3) • Sympathetic paraganglioma (8681/1, now 8681/3) • Parasympathetic paraganglioma (8682/1, now 8682/3) • Glomulus jugulare tumor, NOS/jugular paraganglioma/juglotympanic paraganglioma (8690/1, now 8690/3) • Aortic body tumor/aortic body paraganglioma/aorticopulmonary paraganglioma (8691/1, now 8691/3) • Extra-adrenal paraganglioma, NOS/nonchromaffin paraganglioma, NOS/chemodectoma (8693/1, now 8693/3)
D48.0	Neoplasm of uncertain behavior of bone and articular cartilage ***Note:*** Effective 1/1/2021: Review this code to look for the following histologies which were previously borderline tumors, but are now malignant per ICD-O-3.2 • Clear cell odontogenic tumor (9341/1, now 9341/3

ICD-10-CM Code (5% Review Required)	Description
D48.1	Neoplasm of uncertain behavior of connective and other soft tissue of abdomen ***Note:*** Effective 1/1/2021: Review this code to look for the following which were previously a benign tumor of the pancreas, but is now malignant per ICD-O-3.2 Gastrointestinal stromal tumor, NOS/GIST, NOS/Gastrointestinal autonomic nerve tumor/GANT/Gastrointestinal pacemaker cell tumor (8936/1, now 8936/3)
D49.2	Neoplasm of unspecified behavior of digestive organs (includes unspecified behavior of pancreas) ***Note:*** Review this code to look for the following which were previously unknown behavior tumors of the pancreas, but are now malignant tumors per ICD-O-3.2 (Histology 8150/3) • Pancreatic endocrine tumor, NOS • Islet cell tumor, NOS
D61.810	Antineoplastic chemotherapy induced pancytopenia
D64.81	Anemia due to antineoplastic chemotherapy
D70.1	Agranulocytosis secondary to cancer chemotherapy
D72.10	Eosinophilia, NOS (Note: Screen for incorrectly coded Chronic eosinophilic leukemia, 9964/3)
D75.81	Myelofibrosis (***Note***: this is not primary myelofibrosis [9961/3])
E31.2	Multiple endocrine neoplasia [MEN] syndromes
E34.0	Carcinoid syndrome
E88.3	Tumor lysis syndrome (following antineoplastic chemotherapy)
G89.3	Neoplasm related pain (acute)(chronic)
H47.42	Disorders of optic chiasm in (due to) neoplasm
H47.52-	Disorders of visual pathways in (due to) neoplasm
H47.63-	Disorders of visual cortex in (due to) neoplasm
I31.31	Malignant pericardial effusion in diseases classified elsewhere
J70.0	Acute pulmonary manifestations due to radiation
J70.1	Chronic and other pulmonary manifestations due to radiation
J91.0	Malignant pleural effusion
K12.31	Oral mucositis (ulcerative) due to antineoplastic therapy
K12.33	Oral mucositis (ulcerative) due to radiation
K52.0	Gastroenteritis and colitis due to radiation

ICD-10-CM Code (5% Review Required)	Description
K62.7	Radiation proctitis
K62.82	Dysplasia of anus (Anal intraepithelial neoplasia (AIN) I and AIN II)
K92.81	Gastrointestinal mucositis (ulcerated) (due to antineoplastic therapy)
L58.-	Radiodermatitis
L59.8	Other disorders of skin and subcutaneous tissue related to radiation
L59.9	Disorder of the skin and subcutaneous tissue related to radiation, unspecified
M31.11	Hematopoietic stem cell transplantation-associated thrombotic microangioplasty
M96.2	Postradiation kyphosis
M96.5	Postradiation scoliosis
N30.4-	Irradiation cystitis
N46.024	Azoospermia due to radiation
N46.124	Oligospermia due to radiation
N52.31- N52.32, N52.34- N52.36	Post procedural erectile dysfunction (due to prostatectomy, cystectomy, radiation) (due to prostatectomy, cystectomy, radiation)
O35.6-	Maternal care for (suspected) damage to fetus by radiation
O9A.1-	Malignant neoplasm complicating pregnancy, childbirth and the puerperium
P04.11	Newborn affected by maternal antineoplastic chemotherapy
P04.12	Newborn affected by maternal cytotoxic drugs
Q85.0-	Neurofibromatosis (nonmalignant) (9540/1) ***Note:*** Neurofibromatosis is not cancer. These tumors can be precursors to acoustic neuromas, which are reportable
R18.0	Malignant ascites
R53.0	Neoplastic (malignant) related fatigue
R97.21	Rising PSA following treatment for malignant neoplasm of prostate
T38.6-	Poisoning by antigonadotrophins, antiestrogens, antiandrogens, not elsewhere classified
T38.8-, T38.9	Poisoning by hormones and their synthetic substitutes

ICD-10-CM Code (5% Review Required)	Description
T45.1-	Poisoning by, adverse effect of, and under dosing of antineoplastic and immunosuppressive drugs
T45.8-, T45.9	Poisoning by primary systemic and hematological agent, unspecified
T66.-	Unspecified effects of radiation
T80.81-	Extravasation of other vesicant agent
T80.82-	Complication of immune effector cellular therapy - Complication of chimeric antigen receptor (CAR-T) cell therapy
T86.0-	Complications of bone marrow transplant
Y63.2	Overdose of radiation given during therapy
Y84.2	Radiological procedure and radiotherapy as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure
Z08	Encounter for follow-up examination after completed treatment for malignant neoplasm (medical surveillance following completed treatment)
Z40.0-	Encounter for prophylactic surgery for risk factors related to malignant neoplasms
Z42.1	Encounter for breast reconstruction following mastectomy
Z48.290	Encounter for aftercare following bone marrow transplant
Z48.3	Aftercare following surgery for neoplasm ***ICD-10-CM Coding instruction note***: Use additional code to identify the neoplasm
Z51.0	Encounter for antineoplastic radiation therapy
Z51.1-	Encounter for antineoplastic chemotherapy and immunotherapy
Z51.5, Z51.89	Encounter for palliative care and other specified aftercare
Z79.63-	Long term (current) use of chemotherapeutic agent
Z79.64	Long term (current) use of myelosuppressive agent (hydroxyurea)
Z79.81-	Long term (current) use of agents affecting estrogen receptors and estrogen levels
Z85._	Personal history of malignant neoplasm ***ICD-10-CM Coding instruction note:*** Code first any follow-up examination after treatment of malignant neoplasm (Z08)
Z86.00, Z86.010-011, Z86.0012	Personal history of in situ neoplasms Personal history of benign neoplasms of the brain Personal history of benign carcinoid tumor

ICD-10-CM Code (5% Review Required)	Description
Z92.21, Z92.23, Z92.25. Z92.3	Personal history of antineoplastic chemotherapy, estrogen therapy, immunosuppression therapy or irradiation (radiation)
Z92.26	Personal history of immune checkpoint inhibitor (ICI) (drug) therapy
Z92.850	Personal history of Chimeric Antigen Receptor T-cell therapy- Personal history of CAR-T-cell therapy
Z94.81, Z94.84	Bone marrow and stem cell transplant status

^*Based on the International Classification of Diseases, ICD-10-CM Tabular List of Diseases and Injuries, FY 2025*

***Source**: https://seer.cancer.gov/tools/casefinding/icd-10-cm-casefinding-list.20240924.pdf*

Ambiguous Terminology

Ambiguous terminology may originate in any source document, such as a pathology report, radiology report, or clinical report. The terms listed below are reportable when they are used with a term such as cancer, carcinoma, sarcoma, etc. Ambiguous terms not listed below are not reportable. This list is not to be used to for staging. The lists are not interchangeable.

Ambiguous Terms for Reportability

Apparent(ly)

Appears

Comparable with

Compatible with

Consistent with

Favor(s)

Malignant appearing

Most likely

Presumed

Probable

Suspect(ed)

Suspicious (for)

Typical (of)

Do not substitute synonyms such as “supposed” for presumed or “equal” for comparable. Do not substitute “likely” for “most likely.” There may be ambiguous terms preceded by a modifier, such as “mildly” suspicious. In general, ignore modifiers or other adjectives and accept the reportable ambiguous term.

How to Use Ambiguous Terminology for Case Ascertainment

1. **In Situ and Invasive** (Behavior codes /2 and /3)
    a. If any of the reportable ambiguous terms precede a word that is synonymous with an in situ or invasive tumor (e.g., cancer, carcinoma, malignant neoplasm, etc.), accession the case.

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

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

    b. Discrepancies:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

c. Accession the case when any of the reportable **ambiguous terms precede** either the word "**tumor**" or the word "**neoplasm**".

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

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

e. **Discrepancies:**

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

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

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

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

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

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

Casefinding Instructions for Hematopoietic & Lymphoid Neoplasms

Refer to the Hematopoietic & Lymphoid Neoplasm Coding Manual Case Reportability Instructions for Hematopoietic & Lymphoid Neoplasms **(9590/3-9993/3)** (Reportability Instructions begin on page 27.)

Non-Reportable List (Casefinding)

Personnel responsible for reporting should review the list of terms that indicate a Reportable Neoplasm found in the Reportable Diagnosis List on page 14 of the 2025 SEER Program Coding and Staging Manual. Upon review of the DI, cases may be identified as TCR non-reportable cases. Examples of these would be basal and squamous cell carcinoma of the skin (C44.0 – C44.9) (excluding genital sites), and CIN of the cervix (D06.9). A list of these cases **must be kept each year**.

TCR will review the DI and the non-reportable list when it conducts casefinding audits after facilities have completed reporting for a given year. 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 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 DI. 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 no 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 DI.

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

Non-Reportable Examples

- The ICD-10-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.**
- The discharge summary and face sheet state 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.**
- 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.**
- 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.**
- A patient comes in for lab work. The 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.**
- A patient comes in for a bone scan. The physician orders or imaging document states clinical history or reason as 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.**

- A patient is admitted to rehabilitation hospital after resection of brain tumor. There is no statement from the physician at the reporting facility regarding evidence of disease. **Do not report this case since there is no evidence of disease and no mention of current treatment**.

Reportable List Examples

- 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.**
- 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.**
- A patient was diagnosed with adenocarcinoma of the stomach in 1985 with no evidence of recurrent or metastatic disease. In 2024, the patient was admitted and diagnosed with small cell carcinoma of the lung. **The lung cancer is reportable for 2024 because the patient has active lung cancer.**
- Discharge summary diagnosis states cancer and the ICD-10-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.**
- 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 the patient has active disease.**
- 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.**
- 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.**
- Patient with a recent excisional biopsy for melanoma of skin of the 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.**
- 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.**

- In 2025 a patient comes to your facility for a colonoscopy. The record states that the patient was diagnosed with breast cancer in 2021. 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 or other hormonal therapy, such as Arimidex, 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 hormonal treatment and it is known that the diagnosis was within the past five 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 admittance, do not report the case.
- 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.**
- A patient comes to your facility and has a history of thyroid cancer and is taking Levothroid (or thyroid hormone medication). **Report this case. Synthroid should be coded as hormonal treatment for thyroid cancer. After thyroid surgery, the thyroid hormone medication levothyroxine (Levothroid, Synthroid, etc) is prescribed often for life. This drug has two benefits: it supplies the missing hormone the thyroid would normally produce, and it suppresses the production of thyroid-stimulating hormone (TSH) from the pituitary gland. High TSH levels could conceivably stimulate any remaining cancer cells to grow.**
- A patient comes to your facility for a bone scan. The physician orders state the patient was recently diagnosed with prostate cancer. **Regardless of the results, report this case since the patient was stated to be recently diagnosed; the bone scan is being done for staging purposes.**

Guidelines for Casefinding

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:

- The clinic is owned by the facility OR
- The facility is legally responsible for the medical charts in the clinic OR

- The facility receives revenue from the medical charts at the clinic OR
- The clinical charts are filed in the same location as the facility charts OR
- 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" must 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.

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.

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 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 except for those morphologies listed under non-reportable neoplasms on page 60. This would include but is not limited to radiology reports, pathology reports, consults, history and physicals, and clinic notes.

If you have questions about a case's eligibility, call your TCR health service representative.

Every effort should be made to identify multiple primary tumors. Refer to the *Solid Tumor Rules* and to the *Hematopoietic & Lymphoid Neoplasm Coding Manual* to prevent reporting the same primary twice for a patient. Compare the patient's 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.

Examples for Determining Case Reportability

Example 1: 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 active disease.**

Example 2: 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 active disease.**

Example 3: 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.**

Example 4: A patient is admitted to a facility with a breast lump. The history and physical (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.**

Example 5: 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.**

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 HIM department 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 registry personnel or the registry personnel 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, it is the facility's responsibility to maintain a reportable and non-reportable list to assist in the review process of the potentially missed cases list provided annually.

Complete cancer reporting is an important element in a cancer registry's quality assurance program. 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, accurate cancer information and to meet the state's federal funding obligations. The results of a casefinding audit are reported back to the facility.

Note: For more information on cancer reporting visit TCR's Cancer Reporting webpage.

Contact your regional representative for an assessment of your casefinding procedures to ensure preparedness for an audit.

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, outpatient log sheets, etc.) in alphabetical order and/or by date of diagnosis to assess timeliness of the abstracting process.

ATTACHMENT A: Sample Facility Disease Index

MR#	Name	DOB	SSN	Sex	Pt Class/ Type	Admission Date	Discharge Date	Diagnosis/ Description
123123	Roberts, Jim	2/10/1959	455-66-9090	M	IN, MCR	05/02/25	05/03/25	C7A.010 Mal Carcinoid Tumor Duodenum
431124	Smith, Bob	6/29/1938	422-23-2323	M	IN, MCR	04/05/25	04/07/25	Z51.11 Chemo Encounter
C5412	Smith, Bob	6/29/1938	422-23-2323	M	SCD, MCR	05/11/25	05/11/25	C64.9 Mal Neo Kidney
431124	Smith, Bob	6/29/1938	422-23-2323	M	IN, MCR	09/06/25	09/14/25	C79.1 Sec Mal Neo Brain
431124	Smith, Bob	6/29/1938	422-23-2323	M	IN, MCR	10/15/25	10/22/25	C64.9 Mal Neo of Unsp Kidney
MR421	Sun, Len	11/4/1980	566-66-6666	M	IN, OTH	10/16/25	10/20/25	D63.0 Anemia in Neoplastic Disease
MR311	Timms, Emma	6/15/1959	500-00-5000	F	CLL, MCR	03/22/25	03/22/25	D24.1 Benign Neo Breast
C1234	Timms, Emma	6/15/1959	500-00-5000	F	IN, MCR	05/29/25	06/02/25	C50.419 Mal Neo Breast UOQ
C1234	Timms, Emma	6/15/1959	500-00-5000	F	IN, MCR	05/29/25	06/02/25	C77.3 Mal Neo Lymph-Axilla
MR311	Timms, Emma	6/15/1959	500-00-5000	F	RCR, MCR	07/13/25	07/23/25	Z51.0 Encounter foro Antineoplastic Radiation Therapy
MR311	Timms, Emma	6/15/1959	500-00-5000	F	RCR, MCR	8/23/25	11/13/25	D49.9 GIST

ATTACHMENT B: Non-Reportable List Blank Form

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

Patient Name	Med Rec #	Admit Date	Date of Birth	SSN	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, CIN III

07 – No Cancer Mentioned in Record

08 – Diagnosed Prior to 1995

09 – Lab Only

10 – Other (Include Explanation)

5

REPORTABILITY

Reportable Neoplasms

2024 Definition of Reportable: Meets the criteria for inclusion in a registry. Reportable cases are cases that the registry is required to collect and report. Reporting requirements for SEER registries are established by NCI SEER. **Please note: TCR joined SEER in 2021 and has a different reporting start date than specified in the SEER manual. TCR no longer requires reporting of cases diagnosed prior to 1995.**

Refer to "Reportable Diagnosis List" beginning on page 14 of the 2025 SEER Program Coding and Staging Manual for Reportability List, instructions, acceptable ambiguous terminology, and examples.

Refer to Appendix E1 - 2025 SEER Program Coding And Staging Manual for reportable examples.

Refer to *Chapter III: Standards for Tumor Inclusion and Reportability*, in the 2025 NAACCR Data Standards and Data Dictionary.

Refer to the ICD-O3.2 Updates for new/changed behaviors and terms.

A list of reportable neoplasms can also be found in Appendix A of the TCR *2025 Cancer Reporting Guide.*

Reportable Diagnosis List

Definition of Reportable: Meets the criteria for inclusion in a registry. Reportable cases are cases that the registry is required to collect and report. Reporting requirements for SEER registries are established by NCI SEER. A "Reportable List" includes all diagnoses to be reported by the registry to NCI SEER.

1. Malignant Histologies (In Situ and Invasive)

   a. Report all histologies with a behavior code of /2 or /3 in the International Classification of Diseases for Oncology, Third Edition (ICD-O-3.2) and in approved ICD-O-3 updates, except as noted in section 1.b. of this manual. The following are reportable diagnoses that are either new or are frequently questioned.

      i. Post Transplant Lymphoproliferative Disorder (PTLD) was previously reportable as 9971/3 for 2010-2020 when it was the only diagnosis. In 2021, based on the 4th edition of WHO Hematopoietic Blue Book, PTLD became 9971/1, where it was only reportable if it occurred in the brain. Starting in 2025, PTLD as the only diagnosis will become a /3 (malignant) again and will be reportable for all cases.

      ii. High-grade astrocytoma with piloid features (HGAP) (9421/3) as of 01/01/2023.

      iii. Lymphangioleiomyomatosis (9174/3) is reportable as of 01/01/2023; behavior changed from /1 to /3.

iv. Mesothelioma in situ (9050/2) is reportable as of 01/01/2023.

v. Diffuse leptomeningeal glioneuronal tumor (9509/3) is reportable as of 01/01/2023.

vi. The following diagnoses are reportable (not a complete list).

• Lobular carcinoma in situ (LCIS) of breast

• Intraepithelial neoplasia, high grade, grade II, grade III

Examples: (Not a complete list. See ICD-O-3.2)

- AIN II of the anus or anal canal (C210-C211)
- AIN III of the anus or anal canal (C210-C211)
- Biliary intraepithelial neoplasia, high grade
- Conjunctival intraepithelial neoplasia with severe dysplasia, or Grade III; squamous intraepithelial neoplasia Grade II of conjunctiva
- Differentiated vulvar intraepithelial neoplasia (VIN) or differentiated exophytic vulvar intraepithelial lesion (DEVIL)
- Endometrioid intraepithelial neoplasia (atypical hyperplasia), EIN)
- (dysplasia), high grade or Grade III
- Glandular intraepithelial neoplasia, high grade
- High grade dysplasia of esophagus, stomach, small intestine
- High grade squamous dysplasia of larynx
- High grade squamous intraepithelial lesion (HGSIL of the anus
- High grade vulvar intraepithelial neoplasia
- Intraductal papillary neoplasm with high grade intraepithelial neoplasia
- Intraepithelial neoplasia, grade III
- Laryngeal intraepithelial neoplasia (LIN) II (C320-C329)
- Laryngeal intraepithelial neoplasia III (LIN III) (C320-C329)
- Lobular neoplasia (LN) grade II /LIN grade II breast (C500-C509)
- LN grade III / LIN grade
- (LIN III) breast (C500-C509)
- Pancreatic intraepithelial neoplasia (PanIN) III (C250-C259)
- Penile intraepithelial neoplasia (PeIN), grade II (C600-C609)

- PeIN grade III (C600-C609)
- Squamous intraepithelial neoplasia, grade II excluding cervix (C53_) and skin sites coded to C44_
- Squamous intraepithelial neoplasia (SIN) III excluding cervix and skin
- sites coded to C44_
- Vaginal intraepithelial neoplasia (VAIN) II (C529)
- VAIN III (C529)
- Vulva Intraepithelial neoplasia (VIN) (C510-C519)
- VIN III (C510-C519)

vii. Non-invasive mucinous cystic neoplasm (MCN) of the pancreas with high grade dysplasia is reportable. For neoplasms of the pancreas, the term MCN with high grade dysplasia replaces the term mucinous cystadenocarcinoma, non-invasive.

viii. Mature teratoma of the testes in adults is malignant and reportable as 9080/3.

ix. Urine cytology positive for malignancy is reportable for diagnoses in 2013 and forward.

Exception: When a subsequent biopsy of a urinary site is negative, do not report.

- Code the primary site to C689 in the absence of any other information
- Do not implement new/additional casefinding methods to capture these cases

Do not report cytology cases with ambiguous terminology (see page 46 for ambiguous terms)

b. Do not report (Exceptions to reporting requirements)

i. Skin primary (C440-C449) with any of the following histologies:

Malignant neoplasm (8000-8005)

Epithelial carcinoma (8010-8046)

Papillary and squamous cell carcinoma (8050-8084)

Squamous intraepithelial neoplasia III (8077) arising in perianal skin (C445)

Basal cell carcinoma (8090-8110)

Note 1: If the registry collects basal or squamous cell carcinoma of skin sites (C440-C449), sequence them in the 60-87 range and do not report to SEER.

Note 2: Squamous cell carcinoma of sites coded to C44_ (for example, C442 located in the head or neck) is not reportable. Do not use AJCC staging to determine reportability. Follow cancer registry instructions for reportability.

ii. Carcinoma in situ of cervix (/2), cervical intraepithelial neoplasia (CIN III) or SIN III of the cervix (C530-C539).

Note: Collection stopped effective with cases diagnosed 01/01/1996 and later. As of the 2018 data submission, cervical in situ carcinoma is no longer required for any diagnosis year. Sequence all cervix in situ cases in the 60-87 range regardless of diagnosis year.

iii. Prostatic intraepithelial neoplasia (PIN) III (C619)

Note: Collection stopped effective with cases diagnosed 01/01/2001 and later.

iv. Colon atypical hyperplasia

v. High grade dysplasia in colorectal sites (C180-C189, C199, and C209)

vi. Adenocarcinoma in situ, HPV associated (8483/2) (C53)

c. "Carcinomatosis" (8010/9) and "metastatic" tumor or neoplasm (8000/6) indicate malignancy and could be indicative of a reportable neoplasm. Review all of the available information to determine the origin of the carcinomatosis or the origin of the metastases.

2. Benign/Non-Malignant Histologies

a. See Required Sites for Benign and Borderline Primary Intracranial and Central Nervous System Tumors table.

Note 1: Benign and borderline tumors of the cranial bones (C410) are not reportable.

Note 2: Benign and borderline tumors of the peripheral nerves (C47_) are not reportable.

b. Report Pilocytic/Juvenile astrocytoma; code the histology and behavior as 9421/1 for **all** CNS sites as of 01/01/2023.

c. Report diffuse astrocytoma, MYB- or MYBL1-altered and diffuse low-grade glioma, MAPK pathway-altered (9421/1) as of 01/01/2023.

d. Report multinodular and vacuolating neuronal tumor (9509/0) as of 01/01/2023.

e. Report juvenile xanthogranuloma (9749/1) as of 01/01/2023 (C715 is the most common site).

f. Neoplasm and tumor are reportable terms for brain and CNS because they are listed in ICD-O-3 and approved ICD-O-3.2 updates with behavior codes of /0 and /1.

g. "Mass" and "lesion" are not reportable terms for intracranial and CNS because they are not listed in ICD-O-3.2 with behavior codes of /0 or /1.

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

General Term	Specific Sites	ICD-0-3 Topography Code
Meninges	Cerebral meninges Spinal meninges Meninges, NOS	C700 C701 C709
Brain	Cerebrum Frontal lobe Temporal lobe Parietal lobe Occipital lobe Ventricle, NOS Cerebellum, NOS Brain stem Overlapping lesion of brain Brain, NOS	C710 C711 C712 C713 C714 C715 C716 C717 C718 C719
Spinal cord, cranial nerves, and other parts of the central nervous system	Spinal cord Cauda equina Olfactory nerve Optic nerve Acoustic nerve Cranial nerve, NOS Overlapping lesion of brain and central nervous system Nervous system, NOS	C720 C721 C722 C723 C724 C725 C728 C729
Pituitary, craniopharyngeal duct, and pineal gland	Pituitary gland Craniopharyngeal duct Pineal gland	C751 C752 C753

- **Prostate cancer cases with a PI-RADS category of 4 or 5 is reportable for cases diagnosed 2017 forward.** Please see https://seer.cancer.gov/seer-inquiry/inquiry-detail/20170023/

- **Liver cases with an LI-RADS category LR-4 (1/1/2021 forward) or LR-5 (1/1/2016 forward)** Please see Appendix E - Reportable and Non-Reportable Examples

  ***Note*: PI-RADS, LI-RADS category of 4 or 5 are reportable to SEER and TCR and date of diagnosis is the date of imaging.**

  ***Note CoC facilities:* PI-RAD and LI-RADS, alone are not reportable for CoC to National Cancer Database (NCDB). Date of diagnosis for NCDB is the date of the positive biopsy or physician confirmation of a reportable neoplasm per STORE page 45. CoC facilities will report PI-RADS and LI-RAD ONLY cases to TCR as a non-analytic case.**

  Neither SEER nor CoC recognize BI-RADS. The American College of Radiology defines Category 4 as "Suspicious abnormality." This is not reportable terminology – abnormality is not a reportable term. Category 5 is defined as "Highly suggestive of malignancy." "(Highly) suggestive" is not reportable ambiguous terminology.

- Microcarcinoid tumors of the stomach are reportable. The ICD-O-3.2 histology code is 8240/3. Microcarcinoid is a designation for neuroendocrine tumors of the stomach when they are less than 0.5 cm in size. Neuroendocrine tumors of the stomach are designated carcinoid when they are 0.5 cm or larger. The term microcarcinoid tumor is not equivalent to carcinoid tumorlet.
- As of 1/1/2021, early or evolving melanoma in situ, or any other early or evolving melanoma, is reportable.
- Mature teratoma of the testis when diagnosed after puberty (malignant). For testis: Mature teratoma in adults is malignant (9080/3).

  ***Note*: Do not report when diagnosed in a child (benign). Do not report mature teratoma of the testis when it is not known whether the patient is prepubescent or postpubescent. Pubescence can take place over a number of years; review physical history and do not rely only on age.**
- Mammary analogue secretory carcinoma (MASC). MASC is a tumor that predominantly arises in the parotid gland. If the primary site is submandibular gland, assign C080. Then assign 8502/3. Override any edits triggered by the combination of C080 and 8502/3.
- Ulcerated histologically malignant spindle cell neoplasm, consistent with atypical fibroxanthoma; an exhaustive immunohistochemical work-up shows no melanocytic, epithelial or vascular differentiation. Atypical fibroxanthoma is a superficial form of a malignant fibrous histiocytoma. This case is reportable. The pathologist has the final say on behavior for a particular case. In this case, the pathologist states that this tumor is malignant.
- Aggressive adult granulosa cell tumor with one of two lymph nodes positive for malignant metastatic granulosa cell tumor. This case is reportable because malignant granulosa cell tumor is reportable. The lymph node metastases prove malignancy.
- Ovarian mucinous borderline tumor with foci of intraepithelial carcinoma. This case is reportable because there are foci of intraepithelial carcinoma (carcinoma in situ).

- Low-grade appendiceal mucinous neoplasm (LAMN) Report LAMN beginning with January 1, 2022 diagnoses. LAMN is assigned a behavior of /2 or /3 making it reportable. LAMNs are slow-growing neoplasms that have the potential for peritoneal spread and can result in patient death. LAMNs demonstrate an interesting biology in that they do not have hematogenous dissemination risk, but risk for appendiceal perforation, which can result in peritoneal dissemination, repeated recurrences after surgery and even death.
- Positive histology from needle biopsy followed by a negative resection is reportable. The fact that no residual malignancy was found in the later specimen does not disprove the malignancy diagnosed by the biopsy.

Non-Reportable Neoplasms

Reporting requirements for SEER registries are established by NCI SEER.

Refer to "Reportability" beginning on page 6 of the 2025 SEER Program Coding and Staging Manual for Reportability List, instructions, acceptable ambiguous terminology, and examples.

Refer to Appendix E2 - 2025 SEER Program Coding And Staging Manual for non-reportable examples.

Refer to the ICD-O3.2 Updates for new/changed behaviors and terms.

Examples:

- High grade dysplasia (8148/2) in gastrointestinal sites other than stomach, small intestine, and esophageal primary sites. The non-reportable gastrointestinal sites include colorectal primaries (C180-C189, C199, and C209).
- Diffuse idiopathic pulmonary neuroendocrine cell hyperplasia (DIPNECH) is not reportable. It is a generalized proliferation of scattered single cells, small nodules (neuroendocrine bodies), or linear proliferation of pulmonary neuroendocrine cells (PNCs).
- Lentiginous melanocytic lesion is not reportable.
- Brain lesions associated with multiple sclerosis are not reportable. These brain lesions are not neoplastic; they are part of the disease process of multiple sclerosis.
- HGSIL, HSIL, carcinoma in situ (CIS), and AIN III (8077) arising in perianal skin (C445) are not reportable.
- Ecchordosis physaliphora, a lesion within the prepontine cistern, is not reportable.
- Low to intermediate grade neuroendocrine neoplasm or middle ear adenomatoid tumor (MEANT) is non-reportable.
- Ovarian mucinous borderline tumor with microinvasion. For an ovarian mucinous borderline tumor, the term "microinvasion" is not an indication of malignancy. Low malignant potential/borderline ovarian tumors are defined by the pathology of the primary tumor and are

not affected by microinvasion or invasion in implants. Though a case may be staged, this does not mean it is reportable.

6

CHANGING INFORMATION ON THE ABSTRACT

Changing Information on the Abstract

There are some circumstances under which the information originally coded in the abstract should be updated. **For information and examples of circumstances, please refer to "Changing Information on the Abstract" beginning on page 24 of the 2025 SEER Program Coding and Staging Manual.**

Example 1: Patient has surgery for a benign argentaffin carcinoid (8240/1) of the sigmoid colon in May 2024. In January 2025, the patient is admitted with widespread metastasis consistent with malignant argentaffin carcinoid. The registrar accessions the malignant argentaffin carcinoid as a 2025 diagnosis. Two months later, the pathologist reviews the slides from the May 2024 surgery and concludes that the carcinoid diagnosed in 2024 was malignant. Change the date of diagnosis to May 2024 and histology to 8241 and the behavior code to malignant (/3).

Example 2: At the time of diagnosis, a patient is diagnosed with liver metastasis, but the 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 *Staging* and *Surgery Codes*. Document the new information in the appropriate text fields.

Example 3: A patient is diagnosed with lung cancer by a CT exam alone. An abstract is submitted with the histology of cancer (8000/3) and diagnostic confirmation code 7. At a later admit the history and physical (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.

Modified Records (also referred to as M, Correction, or Updated Records)

The Texas Cancer Registry accepts modified (correction) records. If your software can create modified records, then utilize this function to submit corrected or updated information for diagnosis year 2022 and forward. Modified records should be submitted quarterly.

The purpose of the modified record process is to provide a way for facilities to easily submit corrections to critical data items. Software vendors are provided a list of data items for which corrections are required. If any of these data items are changed after the case has been sent to the central registry, the software will include that case in a modified record file.

Hospital registry software should be modified to accommodate this requirement. Contact your registry software vendor to understand the process for generating M record files. For all other questions on this process, including data items that may require M record reporting, please contact TCRTechSupport@dshs.texas.gov.

Notes:

- If your software does not have the ability to create modified record files, then your regional representative will work with you to address any facility-specific issues related to data completeness and quality.
- New cases are to be reported as NAACCR record type A (Abstract). DO NOT send new cases as type M records.
- If treatment has not been completed within six months of diagnosis or first contact, type A records should be submitted with the information available. When first course of treatment is completed, M records should be submitted with the updated treatment information.
- M records should only be submitted for updates to cases previously sent.

Utilize type A to submit a missed case or resubmission file, DO NOT use type M.

7

DETERMINING MULTIPLE PRIMARIES

The determination of how many primary cancers a patient has is a medical decision, but a review of the *Solid Tumor Rules* is needed in order to ensure consistency of reporting by cancer reporters.

When a patient has more than one tumor in the same or different organs, **multiple primaries** may be present, requiring more than one abstract. However, multiple tumors may also be considered a **single primary,** requiring only one abstract.

A **single primary** is a term used to describe the original, or first, tumor in the body. Cancer cells from a primary cancer may spread to other parts of the body and form new, or secondary, tumors.

A **single primary** can be:

- Single tumor
- Simultaneous multiple tumors abstracted as a **single primary**
- Subsequent tumor(s) which are a reappearance of disease, rather than a multiple primary

A **recurrence** is defined as either:

- Reappearance of disease that was thought to be cured or inactive (in remission). It starts from cancer cells that were not removed or destroyed by the original therapy.
- A **new tumor** in the same primary site. It is a new occurrence of cancer that arise from cells that have nothing to do with the earlier (first) cancer. Another **single primary** to be abstracted. Be sure to follow the *Solid Tumor Rules* in determining the number or primaries even if stated to be a recurrence.

Solid Tumors

To determine multiple primaries for solid tumors, refer to "Determining Multiple Primaries" beginning on page 25 of the SEER Program Coding and Staging Manual 2025 .

Refer to the Solid Tumor Rules for the general instructions and site-specific instructions for determining multiple primaries.

Hematopoietic & Lymphoid Neoplasms

To determine multiple primaries for hematopoietic & lymphoid neoplasms, refer to the Hematopoietic & Lymphoid Neoplasm Coding Manual for the instructions and rules for determining multiple primaries for hematopoietic & lymphoid neoplasms (9590/3-9993/3).

Transplants

To determine multiple primaries for transplanted sites or organs refer to "Determining Multiple Primaries" beginning on page 25 of the SEER Program Coding and Staging Manual 2024.

8

DOCUMENTATION OF CANCER DIAGNOSIS, EXTENT OF DISEASE, AND TREATMENT

Text Documentation of Cancer Diagnosis, Extent of Disease, and Treatment

(NAACCR) Text Item #s 2520, 2530, 2540, 2550, 2560, 2570, 2580, 2590, 2600, 2610, 2620, 2640, 2650, 2660, 2670, 2680)

Text documentation to support cancer diagnosis, stage, and treatment codes **must be provided by all facilities**.

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

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 check or 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 are also required to be documented.

Contact your Public Health Region representative 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 a magnetic resonance imaging (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 Staging and must be noted in the Summary Stage Documentation field to support coding. Patient demographics can also be found in the H&P. Include 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 SSDIs. Source documents to be used for the information to code the SSDIs can be found in the SSDI manual.

Always use text to document certain basic information:

- Specific subsite of primary site (Example: upper outer quadrant of left breast).
- The diagnostic impression, final diagnosis, or final conclusion if one is given (Example: ductal carcinoma of left breast).
- Demographic information such as age at diagnosis, race, and sex of the patient should be recorded in text fields (Example: 76-year-old Caucasian male).
- The date of the examination or procedure (Example: 6/15/2021); keep dates in chronological order.
- The name of the examination or procedure (Example: excisional biopsy).
- The results of the examination or procedure, i.e. any pertinent positive or negative information (Examples: negative margins, chest X-ray negative, liver biopsy positive for metastasis).
- Specific number, chain of lymph nodes examined, and results (Example: 3/16+ left axillary lymph nodes).
- 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).
- The planned treatment, whether or not it is known if treatment was given (Example: chemotherapy planned after left modified mastectomy).
- The date and type of treatment given, even if it was done at another institution (Example: 6/15/2021 5FU administered at ABC hospital).
- 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.

Tips for Text Documentation

- Review all the medical documents to get an understanding of the case.
- Highlight pertinent information regarding the diagnosis, work-up, extent of disease, and treatment plan.
- Enter the pertinent information in the text fields using phrases, not long sentences. Do not copy/paste to the text fields.
- Give a complete story of the patient regarding their history, the diagnosis, the extent of spread (lymph nodes, other sites), and the treatment (what was done at all facilities, whether completed or not).
- Use NAACCR recommended abbreviations only.
- After entering all the coded data in their data item fields, review the text to assure the accuracy and consistency of your codes, and that coded fields have applicable text documentation.
- Refer to *Using the Informational Abstracts in Your Registry* on the NCRA website for more information.

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.
9. Refer to 2025 NAACCR Data Dictionary for a list of data items to be verified by the text fields.

Text Remarks - Other Pertinent Information

(NAACCR Item #2680)

1. NAACCR-approved abbreviations should be utilized.
2. Do not repeat information from other text fields.

3. Additional comments from other text fields can be continued in the Remarks field. For text documentation that is continued from one text field to another, use asterisks (*) or other symbols to indicate the connection with preceding text.
4. If information is missing from the record, state that it is missing.
5. Do not include irrelevant information.
6. Do not include information that the registry is not authorized to collect.

Suggestions for text:

- Age, sex, and race of patient
- Spanish/Hispanic origin
- Place of birth
- Insurance/primary payer information
- Name of follow-up physician
- Smoking history
- Comorbidities
- Personal history of cancer
- Information on sequence numbers if a person was diagnosed with another primary out-of-state or before the registry's reference date
- Family history of cancer
- Unknown demographic information (ex. Unknown SSN or address at diagnosis)
- Justification of over-ride flags
- Information clarifying anything unusual such as reason for reporting a case seemingly not reportable for that facility or reason for coding numerous fields as "unknown"

Summary Stage Documentation

(NAACCR Item #2600) (Alternate Name: Text-Staging)

Description: Additional text area for staging information not already entered in other Text fields.

Note: Web Plus users cannot leave this text field blank.

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 - History & Physical Exam

(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.

Suggestions for Text

- Date of physical exam
- History that relates to cancer diagnosis
- Primary site
- Histology (if diagnosis is 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 - Imaging

(NAACCR #2530)

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

Suggestions for text

- Date(s) and type(s) of X-ray/Scan(s)
- Facility name
- 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.

Suggestions for Text

- Date(s) of endoscopic exam(s)
- Facility name
- 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 - Laboratory Tests

(NAACCR Item # 2550)

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

Suggestions for Text

- Date of lab test(s)
- Type of relevant 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.
- Tumor markers included, but are not limited to:

- Breast Cancer – Estrogen Receptor Assay (ERA), Progesterone Receptor Assay (PRA), Her2/neu
- Prostate Cancer – PSA
- Testicular Cancer – Human Chorionic Gonadotropin (hCG), Alpha Fetoprotein (AFP), Lactate Dehydrogenase (LDH)

Summary Stage Documentation - Operative Procedure

(NAACCR Item # 2560)

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

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 - Pathology

(NAACCR Item # 2570)

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

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 Clinic, etc.
- Record any additional comments from the pathologist, including diagnoses considered and any ruled out or favored

First Course Treatment Text Fields

(NAACCR Rx Text Surgery #2610, Rx Text Radiation #2620, 2630, Rx Text Chemo #2640, Tx Text Hormone #2650, Rx Text BRM) #2660, Rx Text Other #2670)

Document all types of the first course of definitive treatment administered, regardless of where the treatment was received in chronological order. Documentation is necessary to verify all coded fields regarding types and timing of treatment. Please see First Course Treatment Definitions.

Text Field Documentation Suggestions

After manual entry of the text fields, ensure that the text entered both agrees with the coded values and clearly justifies the selected codes. Refer to NAACCR Data Standards and Data Dictionary, Volume II for the complete list of data items that can be verified with text.

Text Document Recommendations Table

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 • Family and personal history of cancer • Comorbidities • Smoking history • Unknown demographic information (unknown SS#, unknown address at diagnosis) • Overflow or problematic coding issues	Date of Diagnosis #390 Sex #220 Race 1-5 #160-164 Spanish/Hispanic Origin #190 Age at Diagnosis #230 Birthplace-State #252 Birthplace-Country #254 Primary Payer at Dx #630 Physician Follow Up #2470 Sequence Number #560 Tobacco Use #344

NAACCR Text Field And Data Item#	Text Suggestions	Data Item(S) Verified with Text
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 Diagnosis #390 Diagnostic Confirmation #490 Primary site #400 Laterality #410 Morphology/Behavior # 522, 523 Grade Clin #3843 Grade Path #3844 Grade Post Tx Clin #1068 Grade Post Tx Path #3845 Tumor Size #756 Regional Nodes Positive #820 Regional Nodes Examined #830 SEER Summary Stage #764 EOD Data Items #772, 774, 776 AJCC TNM Data #1001-1036
Summary Stage Documentation –History and Physical Exam #2520	• Date of physical exam • History relating to cancer diagnosis • Primary site • Histology (if dx prior to this admission) • Tumor location • Tumor size • Impression pertaining to cancer diagnosis • Positive and negative clinical findings • Palpable lymph nodes • Treatment plan	Date of First Contact #580 Date of Diagnosis #390 Primary Site #400 Laterality #410 Histology ICD-O-3 #522 SEER Summary Stage 2018 #764 Reason for No Surgery #1340
Summary Stage Documentation-Imaging #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-3 #522 SEER Summary Stage 2018 #764 EOD Data Items #772, 774, 776 AJCC TNM Data #1001-1036

NAACCR Text Field And Data Item#	Text Suggestions	Data Item(S) Verified with Text
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-3 #522 SEER Summary Stage 2018 #764 EOD Data Items #772, 774, 776 AJCC TNM Data #1001-1036
Summary Stage Documentation-Laboratory #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 Diagnostic Confirmation #490 Date of Diagnosis #390 SSDIs #3803-3933
Summary Stage Documentation-Operative Report #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	Date of Diagnosis #390 Date Therapy Initiated #1260 Date of Surgical Procedure #1200 Date of Mst Defn Srg #3170 Diagnostic Confirmation #490 Primary Site #400 Laterality #410 Tumor Size #756 Surgery of Primary Site #1290 Surg Procedure Other Site #1294 Scope of Reg Lymph Nodes #1292 SEER Summary Stage 2018 #764 EOD Data Items #772, 774, 776 AJCC TNM Data #1001-1036

NAACCR Text Field And Data Item#	Text Suggestions	Data Item(S) Verified with Text
Summary Stage Documentation Pathology #2570	• Dates of procedures • Anatomic source of specimen • Type of tissue specimen • 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	Date of Diagnosis #390 Date of Surgical Procedure #1200 Date of Mst Defn Srg #3170 Primary Site #400 Laterality #410 Histologic Type ICD-O-3 #522 Grade Clin #3843 Grade Path #3844 Grade Post Tx Clin #1068 Grade Post Tx Path #3845 Diagnostic Confirmation #490 Surgery of Primary Site #1290 Surgical Margins #1320 Scope Reg Lymph Nodes #1392 Surg Procedure Other Site #1294 SEER Summary Stage 2018 #764 SSDIs #3803-3933 Regional Nodes Positive #820 Regional Nodes Examined #830 Surg/Rad Seq #1380 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	• Histologic Type/Behavior • Grade of tumor	Morphology/Behavior #522, #523 Grade Clin #3843 Grade Path #3844 Grade Post Tx Clin #1068 Grade Post Tx Path #3845

NAACCR Text Field And Data Item#	Text Suggestions	Data Item(S) Verified with Text
Rx Text Surgery #2610	• Date of each surgical procedure • Type(s) of surgical procedure(s), including excisional biopsies and surgery to other and distant sites • Lymph nodes removed • Regional tissues removed • Facility where each procedure was performed • Other treatment information e.g. planned procedure aborted	Date of Initial Treatment #1360 Date Surgery #1300 Date Most Defn Surg #3170 Date Reg LN Dissection #682 Surgery of Primary Site #1290 Scope of Reg LN Surgery #1292 Surg Procedure Other Site #1294 Treatment Status #1285
Rx Text-Radiation #2620	• Date radiation treatment began and ended • Where treatment was given, e.g., at this facility, at another facility • Type(s) of radiation • Planned doses • Other treatment information e.g. discontinued after 2 treatments	Date of Initial Treatment #1360 Date Radiation Started #1310 Radiation Treatment Modality I, II, III #1506, 1516, 1526 Radiation Ext Beam Planning Tech I, II, III #1502, 1512, 1522 Radiation Seq w/Surgery #1380 Treatment Status #1285
Rx Text-Chemo #2640	• Date when chemotherapy began and ended • Where chemotherapy was given, e.g., at this facility, at another facility • Type of chemotherapy (name of agent(s) and doses planned/received) • Other treatment information e.g. treatment cycle incomplete	Date of Initial Treatment #1360 Date Systemic Tx Started #3230 Date Chemo Started #1220 Chemotherapy #1390 Systemic/Surgery Sequence #1639 Treatment Status #1285
Rx Text-Hormone #2650	• Date treatment was started • Where treatment was given, e.g., at this facility, at another facility • Type of hormone or antihormone • Type of endocrine surgery or radiation • Other treatment information e.g. treatment cycle incomplete	Date of Initial Treatment #1360 Date Systemic Tx Started #3230 Date Hormone Tx Started #1230 Hormone Therapy #1400 Systemic/Surgery Sequence #1639 Treatment Status #1285

NAACCR Text Field And Data Item#	Text Suggestions	Data Item(S) Verified with Text
Rx Text-BRM Immunotherapy #2660	• Date treatment began • Where treatment was given e.g. at this facility, at another facility • BRM procedures, e.g. bone marrow transplant, stem cell transplant • Type of immunotherapy given • Type of BRM agent, e.g. Interferon, BCG • Other treatment information e.g. treatment cycle incomplete	Date of Initial Treatment #1360 Date Systemic Tx Started # Date Immunotherapy Started #1240 Immunotherapy #1340 Hematologic Transplant/Endocrine Procedures #3250 Systemic/Surgery Sequence #1639 Treatment Status #1285
Rx Text-Other #2670	• Date treatment was started • Where treatment was given, e.g., at this facility, at another facility • Type of other treatment • Other treatment information e.g. treatment cycle incomplete	Date of Initial Treatment #1360 Date Other Tx Started #1250 RX Summ-Other #1420 Treatment Status #1285

Text Documentation Examples

Case #1 Lung

- Imaging Reports
    - 2/18/25 Veterans Affairs (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 4.8 cm 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: Lobulated soft tissue mass in the right lower lobe consistent with neoplasm. No evidence of adenopathy, mediastinal or hilar spread.
    - 2/28/25 CT brain (Your Hospital): Impression: No evident disease process.
- Pathology Reports
    - 2/28/25 (Your Hospital): Final Diagnosis: Fine Needle Aspirate, right lower lobe lung: positive for malignant cells.
    - 3/1/25 (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
    - 3/15/25: 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)

2/18/25 (VA Clinic) 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.

2/28/25 (Your Hospital) FNA RLL lung: positive for malignant cells.

2/28/25 (VA Clinic) CT Brain: No evident dz process.

3/1/25 (Your Hospital) RLL Resection: MD Squamous cell ca, 2 nodules 5cm and 0.5cm, margin free, 0/3 peribronchial, paratracheal and pretracheal ln(s), No information on visceral and parietal pleural invasion, ALK or EGFR.

Treatment Documentation (2610, 2620, 2640, 2650, 2660, 2670)

3/1/25 (Your hospital) RLL lobectomy with mediastinal ln dissection.

3/15/25 (Your hospital) 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
    - 6/25/25 River Ranch Radiology CT chest: I see no pneumothorax or pleural effusion. There is an 11.7 x 8.5 cm 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.
    - 7/1/25 Oncology Associates bone scan: Non-specific increased uptake at L3 and L5, no obvious metastasis.

- 7/1/25 Oncology Associates MRI brain: Diffuse cerebral atrophy.

- Bronchoscopy Report
  - 6/26/25 Bronchoscopy (Your Hospital): 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
  - 6/26/25 Right upper lobe mass biopsy (Your Hospital) Final diagnosis: Non-small cell carcinoma.
- Clinical Reports
  - 7/5/25 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.
  - 7/15/25 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)

6/25/25 (RRR) CT chest: 11.7 cm mass in rt apex, highly suspicious for lung carcinoma, marked mediastinal LAD, enlarged nodes in anterior mediastinum, enlarged nodes lateral to main pulmonary artery, in pretracheal and precarinal region and in rt hilum, L lung appears normal, no pneumothorax or pleural effusion.

6/26/25 (Your hospital) Bronchoscopy: vocal cords appear to move normally, no endobronchial, RLL or RML lesions.

6/26/25 (Your hospital) RUL mass bx: Non-small cell carcinoma.

7/1/25 (Onc Assoc) Bone scan: no mets.

7/1/25 (Onc Assoc) MRI brain: diffuse cerebral atrophy.

No information on visceral and parietal pleural invasion, ALK or EGFR.

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

7/5/25 (Onc Clinic) concurrent chemo/radiation therapy recommended.

7/15/25 Discharge Summary: PT has been treated with VP-16 x 3 days along with daily radiation therapy.

Case #3 Breast

- Imaging Reports
    - 1/2/25 Mammogram: Left breast: No dominant masses, suspicious calcifications, or architectural disturbances are present. In the right breast there is a 3.5 x 4.6 cm irregular spiculated mass in the lower-outer quadrant.
    - Impression: Large mass in the lower-outer quadrant of the right breast, biopsy is recommended.
    - 1/13/25 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
    - 1/10/25 Core biopsy right breast lower outer quadrant: Final Diagnosis: Infiltrating ductal carcinoma, poorly differentiated, ER and PR positive, HER2 ICH 0, negative.
- Clinical Reports
    - 1/15/25 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.

- 2/1/25 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)

1/2/25 Mammogram: Rt breast 4.6cm mass in LOQ, biopsy recommended. Lt breast no masses.

1/10/25 Bx rt breast LOQ Infil ductal car, PD, ER, and PR positive, HER2 IHC 0-Negative, No information oncotype or multigene.

1/13/25 CT Chest: Bone destruction posterior ribs/spine, probably mets from breast ca, CT Abdomen/Pelvis: no abnormal findings.

1/15/25 Surg consult: marked lymphadenopathy in rt axilla.

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

1/15/24 Surg Consult: Patient referred to radiation oncology for consideration of radiation therapy to bony mets.

2/1/24 Oncology note: Pt has decided to try alternative therapy, declined radiation therapy and chemotherapy.

Case #4 Breast

- Imaging Reports
    - 6/1/25 Mammogram: In the right breast there is a 1.2 x 1.5 cm mass in the upper-outer quadrant. There is no evidence of axillary lymphadenopathy. The left breast appears normal.
    - 6/14/25 Chest X-ray: Within normal limits.
    - 6/14/25 Bone scan: Impression: No evidence of skeletal disease. Thoracic and lumbar spine negative for metastases.
- Pathology Reports
    - 6/8/25 Right breast FNA cytology: Adenocarcinoma.
    - 6/15/25 Right breast modified radical mastectomy: Final Diagnosis: Infiltrating ductal carcinoma, tubular type, 1.4 cm, 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

- 6/1/25 History and Physical: Family physician noted 2 cm 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.
- 10/13/25 Oncology Clinic follow-up note: Patient started 3 cycles of adjuvant Adriamycin and Cytoxan on 7/20/24, recently completed and now has begun Tamoxifen.

Summary Stage Documentation (2520, 2530, 2540, 2550, 2560, 2570, 2600)

6/1/25 Mammogram: 1.5cm mass rt breast UOQ, no lymphadenopathy, lt breast appears normal.

6/1/25 H&P 2cm mass in right breast, no masses palpated in lt breast, no enlarged lymph nodes.

6/14/25 CXR: WNL; Bone Scan: no evident mets.

6/8/25 Rt Breast fine needle aspiration = adenoca.

6/15/25 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. No information on Oncotype/Multigene.

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

6/15/25 Rt breast modified radical mastectomy.

10/13/25 Oncology note: pt had 3 cycles Adriamycin and Cytoxan begun on 7/20/24, recently completed and has begun Tamoxifen.

Case #5 Colon/Rectum

- Imaging Reports
  - 4/20/25 CT abdomen and pelvis:
    - 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.
    - History of uterine cancer in 2003 with evidence of prior hysterectomy. This is not usually a cause of cystic liver metastasis.
    - Otherwise, unremarkable CT scan of the abdomen and pelvis with other incidental findings as noted above.

    - 4/25/25 Whole Body PET Scan:
        - Conclusion: 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
    - 4/15/2025 Final diagnosis: Colon biopsy at 135 cm moderately differentiated adenocarcinoma, mucin producing signet ring cell, high grade.
    - 5/1/2025 Final diagnosis right hemicolectomy:
        - High-grade mucin-producing signet ring cell carcinoma, 4 cm in size and located in colon near ileocolic junction, tumor invades pericolonic adipose tissue, (TNM stage PT3).
        - No evidence of lymph node metastasis among seven lymph nodes. (PNO).
        - Excision margin is negative.
        - KRAS mutated.
        - Normal heterozygous state (Normal LOH).
- Operative Reports
    - Date of Procedure: 5/1/25.
    - 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: 5/15/25:
    - 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, 2025.

- 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)

4/15/25 Colon biopsy at 135 cm: Moderately differentiated adenoca, mucin producing signet ring cell, high grade.

4/20/25 Ct abdomen and pelvis: Two 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.

4/25/25 Whole body PET scan: no focal areas of increased uptake in liver to suggest hepatic mets.

5/1/25 Operative report: Liver palpated, found to be unremarkable, no lesion in colon other than rt colon.

5/1/25 Right hemicolectomy: High-grade mucin producing signet ring cell carcinoma, 4 cm, located near ileocolic junction, invades pericolonic adipose tissue, 0/7LNS positive, excision margin is negative; MSI-stable, KRAS mutated, normal LOH.

5/15/25 Oncology consult: The patient may benefit from adjuvant chemotherapy; unknown if chemotherapy given.

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

5/1/25 Right Hemicolectomy.

Case #6 Melanoma

- Imaging Reports
    - 5/10/25 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
    - 5/3/25 Final Diagnosis: Shave biopsy skin of left forearm, Malignant melanoma.
    - 5/11/25 Final Diagnosis: Wide excision of skin of left forearm, Malignant melanoma, nodular type, Clark's Level III, Breslow's depth 1.0 mm, papillary dermis invaded, no ulceration present, no mitosis present. Margins of resection free, but within less than 2 mm. LDH Less than 1.5 upper limit of normal for lactate dehydrogenase (LDH) assay.

- Oncology Report
    - 6/15/25 The patient was started on an interferon regimen today.

Summary Stage Documentation (2520, 2530, 2540, 2550, 2560, 2570, 2600)

5/3/25 Shave bx skin of lt forearm: Malignant melanoma.

5/10/25 CT chest: Probably malignant involvement of lt axillary lymph nodes, remainder of exam normal.

5/11/25 Wide exc skin of lt forearm: Malignant melanoma, nodular type, Clark's Level 3, Breslow's depth 1.0 mm, papillary dermis invaded, no ulceration, no mitosis, margin free but within less than 2 mm, LDH Range 1: Less than 1.5 upper limit of normal for lactate dehydrogenase (LDH) assay.

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

5/11/25 Wide excision of skin of lt forearm.

6/15/25 Started interferon regimen.

Case #7 Melanoma

- Imaging Reports
    - 11/18/25 Chest X-ray: Within normal limits.
    - 11/24/25 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:
        - 11/13/25 Final Diagnosis: Excision of lesion on right side of neck, 1.5 x .0.8 x 0.5 cm specimen contains a pigmented, 0.4 x 0.3 cm area consistent with malignant melanoma in situ, extending to margins of excision.
    - (Your Facility):
        - 11/25/25 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)

11/18/25 CXR: Within normal limits.

11/24/25 CT chest/abdomen/pelvis: No evidence of mets in chest, abdomen, or pelvis.

No information on LDH, breslow, ulceration, mitotic, or clinical margin.

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

11/13/25 Exc of lesion rt side of neck: 0.4x0.3 cm malignant melanoma in situ, Ext to margin.

11/25/25 Wide re-excision of skin rt neck, negative for residual melanoma, margins negative.

Case #8 Lymphoma

- Imaging Reports
    - 2/2/25 CT chest impression: Extensive right and left hilar lymphadenopathy, enlarged lymph nodes in the mediastinum.
    - 2/2/25 CT abdomen impression: Splenomegaly, otherwise within normal limits.
    - 2/4/25 PET scan: Intense focus of tracer uptake seen in peri-portal region consistent with lymphoma.
- Pathology Reports
    - 2/3/25 Biopsy of left axillary lymph nodes, Follicular Lymphoma, Gr 1.
    - 2/2/25 H&P: Patient presents with bilateral cervical and axillary lymphadenopathy, night sweats, and fevers for last couple of months.
- Oncology Consult
    - 2/13/25 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)

2/2/25 H&P: Pt has bilateral cervical and axillary lymphadenopathy, hx of night sweats, fevers.

2/2/25 CT chest: rt and lt hilar lymphadenopathy, enlarged lymph nodes in the mediastinum.

2/2/25 CT abdomen: Splenomegaly, otherwise within normal limits.

2/3/25 Biopsy lt axillary lns: Follicular Lymphoma, Gr 1.

2/4/25 PET scan: focus of tracer uptake in peri-portal region consistent with lymphoma.

No information on B symptoms or HIV status

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

2/5/25 Combination chemotherapy including Rituxan, other types of chemo not mentioned.

Case #9 Prostate

- Imaging Reports
    - 4/14/25 CT abdomen/pelvis impression: Tiny cyst in the liver. No lymphadenopathy in abdomen or pelvis.
    - 4/14/25 Bone scan impression: Evidence of previous fracture in right 13th rib, otherwise negative bone scan.
- Pathology Reports
    - 4/1/25 Final Diagnosis: Prostate core needle biopsy, adenocarcinoma present in 8 of 13 cores, Gleason Score 3+3=6.
- Clinical Reports
    - 3/27/25 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.
    - 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 6/15/25.

Summary Stage Documentation (2520, 2530, 2540, 2550, 2560, 2570, 2600)

3/27/25 PE: DRE shows slightly enlarged prostate with no nodularity or induration, abdomen, and pelvis with no palpable abnormalities, PSA 6.

4/1/25 Prostate core needle biopsy: adenocarcinoma in 8/13 cores, Gleason Score 3+3=6.

4/14/25 CT Abdomen/Pelvis: No lymphadenopathy in abdomen or pelvis.

4/14/25 Bone scan: Negative.

Treatment Documentation (2610, 2620, 2630, 2640, 2650, 2660, 2670)

External beam radiation therapy completed on 6/15/25, start date not given; Estimate start date 5/2025.

9

BASIC RECORD IDENTIFICATION

Reporting Facility

(NAACCR) Item #540)

Description

Identifies the facility or institution reporting the case.

Rationale

This data item is used to identify a reporting facility in the central registry database and is useful for monitoring data submissions, ensuring the accuracy of data, and for identifying areas for special studies.

Alternate Names: Facility Identification Number, Institution ID Number, Reporting Hospital

Coding Instructions

1. Enter the three- or four- digit facility number assigned by TCR. This is a 10-digit code. The three- or four- digit facility number should be coded with 6 or 7 leading zeros.
2. If you do not know your facility number, contact your Public Health Region office or the Central Office in Austin. See page 13 for contact information.

Medical Record Number

(NAACCR Item #2300)

Description

Records medical number used by facility to identify the patient.

Rationale

This number identifies the individual patients in a facility. It can be used by a central registry to point back to the patient record, and it helps identify multiple reports 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 Optional Medical Record Identifier Codes below for other optional medical record identifiers.

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 HIM number
SU	One-day surgery clinic patient without HIM number
UNK	Medical record number unknown

Note: Other standard abbreviations may be used to indicate departments within the facility for patients without HIM numbers assigned.

Accession Number

(NAACCR Item #550) (STORE page 42)

Coding Instructions

1. When a patient is deleted from the database, do not reuse the accession number for another patient.
2. The first four numbers specify the year, and the last five numbers are the numeric order in which the patient was entered into the registry database.
3. Numeric gaps are allowed in accession numbers.
4. A patient's accession number is never reassigned.

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

Examples:

Patient enters the hospital in 2025 and is diagnosed with breast cancer. The patient is the thirty-third patient accessioned in 2025. **Code 202500033**

Patient with the accession number 201500033 for a breast primary returns to the hospital with a subsequent colon primary in 2025. The accession number will remain the same. Sequence Number [560] will distinguish this primary. **Code 201500033**

Patient diagnosed in November 2002 at another facility enters the reporting facility in January 2025 and is the tenth case accessioned in 2025. **Code 202500010.**

Patient diagnosed in staff physician office in December 2022 enters the reporting facility in January 2025 and is the twelfth case accessioned in 2025. **Code 202500012**.

First patient diagnosed and/or treated and entered into the registry database for 2025. **Code 202500001**.

Nine hundred ninety-ninth patient diagnosed and/or treated and entered into the registry database for 2025. **Code 202500999**.

One thousand five hundred fourth patient diagnosed and/or treated and entered into the registry database for 2025. **Code 202501504.**

10

INFORMATION SOURCE

Type of Reporting Source

(NAACCR Item #500) (SEER pages 34-36)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025, and forward refer to the SEER Program Coding and Staging Manual 2025

Date of First Contact

(NAACCR Item #580) (STORE pages 79-80)

Alternate Names: Date of Adm/First Contact

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

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 YYYYMMDD
   Example: The patient is first seen at this facility on January 4, 2025, with a diagnosis of cancer. **Record the date of admit: 20250104.**
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.

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 and is NOT a free-standing entity. The class of case should be coded to 43 and the reporting source would be 3.

Examples:

- On March 28, 2025, a patient is admitted to the hospital with complaints of abdominal pain and 20-pound weight loss over the last month. A CT of the abdomen and pelvis is performed on March 29, 2025, showing a mass in the colon and a liver lesion that is suspicious for metastatic malignancy. **Enter the date of first contact as 20250329, the diagnosis date for the reporting facility.**
- A patient presents to your facility on January 13, 2025, for radiation oncology consultation after being diagnosed with cancer elsewhere three weeks prior. Staging scans are ordered and are performed on January 17, 2025. Simulation takes place on January 23, 2025. Radiation therapy

begins on January 29, 2025. **Enter the date of first contact as 20250113, the date of first contact with the patient w/ active disease.**

- A patient has a biopsy in a staff physician's office on March 17, 2025, 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, 2025, for a wide re-excision. **Record the date of first contact as 20250317, the date the specimen was collected by the reporting facility's pathology**.
- A patient has a lymph node biopsy at a small hospital on May 15, 2025. 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 20250515 as the date of first contact, the day the path sample was collected.**

Class of Case

(NAACCR Item #610) (STORE pages 73-76)

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 it is not known that the patient went somewhere else, code Class of Case 10.
3. It is possible that information for coding Class of Case will change during the patient's first course of care. If that occurs, change the code accordingly.
4. CoC Facilities: Code 34 or 36 for type of case that is **not required by CoC to be accessioned but they are reportable to TCR** (for example vulva (VIN III), vagina (VAIN III), and anus (AIN III). **This also includes cases diagnosed by LI-RADS and PI-RADS Category 4 or 5 ONLY which are reportable to SEER and TCR.**
5. Physicians who are not employed by the hospital but are under contract with it or have routine admitting privileges there are described in codes 10-12 and 41 as physicians with admitting privileges. Treatment provided in the office of a physician with admitting privileges is provided "elsewhere". That is because care given in the physician's office is not within the hospital's realm of responsibility.
6. If the hospital purchases a physician practice, it will be necessary to determine whether the practice is now legally considered part of the hospital (their activity is coded as the hospital's) or not. If the practice is not legally part of the hospital, it will be necessary to determine whether the physicians involved have routine admitting privileges or not, as with any other physician.
7. "In-transit" care is care given to a patient who is temporarily away from the patient's usual practitioner for continuity of care. If these cases are abstracted, they are Class of Case 31. Monitoring of oral medication started elsewhere is coded Class of Case 31. If a patient begins

first course radiation or chemotherapy infusion elsewhere and continues at the reporting facility, and the care is not in-transit, then the case is analytic (Class of Case 21).

8. First course maintenance treatment provided at the reporting facility prior to disease progression or recurrence is reportable IF the maintenance treatment is part of first course treatment plan and is provided by reported facility with documentation of prescription/administration. For example, if a patient is diagnosed and treated at another facility per the treatment plan, was started on hormone therapy at the other facility, then presents to your facility for continuation of hormone therapy, the continuation of hormone therapy by your facility must be documented in medical record to assign Class of Case 21 (part of first course treatment elsewhere, part of first course of treatment at the reporting facility). This applies even if there is no longer active disease.

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**.
- **Non-analytical Class of Case codes 49 and 99 are to be used solely by the central registry.**
- **Foreign residents are no longer required to be reported.**

Class of Case Codes Analytic Cases

Analytic Cases	
Initial Diagnosis At Reporting Facility	
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 active surveillance. • 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. ***Note:*** Code 00 applies only when it is known the patient went elsewhere for treatment. If it is not known that the patient went somewhere else, code Class of Case 10.
Class 10*	Initial diagnosis at the reporting facility or in an office of a physician with admitting privileges AND PART OR ALL of first course treatment or a decision not to treat was done at the reporting facility, NOS.

	Note: ACS 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. ***Note:*** If there is no information regarding whether or where the patient was treated, code Class of Case 10.
Class 11	Initial diagnosis in an office of a physician with admitting privileges AND PART of first course treatment was done at the reporting facility.
Class 12	Initial diagnosis in an office of a physician with admitting privileges AND ALL first course treatment or a decision not to treat was done at the reporting facility.
Class 13*	Initial diagnosis at the reporting facility AND PART of first course treatment was done at the reporting facility; part of first course treatment was done elsewhere.
Class 14*	Initial diagnosis at the reporting facility AND ALL first course treatment or a decision not to treat was done at the reporting facility.
Initial Diagnosis Elsewhere, Facility Involved In First Course Of Treatment Or A Decision Not To Treat	
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 first course treatment was done at the reporting facility; part or first course treatment was done elsewhere.
Class 22*	Initial diagnosis elsewhere AND ALL first course of treatment or a decision not to treat was done at the reporting facility.

Class of Case Codes Non-Analytic Cases

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, treatment plan only, staging workup after initial diagnosis elsewhere).
Class 31*	Initial diagnosis and all first course treatment elsewhere AND reporting facility provided in-transit care; or hospital provided care that facilitated treatment elsewhere (for example, stent/port placement). ***Note:*** In-transit care is given when a patient is temporarily away from the patient's usual practitioner for continuity of care. Monitoring an oral medication started elsewhere is coded to this class of case. If the patient begins first course therapy (radiation or chemo) elsewhere and continues at the reporting facility and the care is not in-transit, then case is analytic (Class of Case 21).

Class 32*	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease RECURRENCE OR PERSISTENCE (active disease).
Class 33*	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease HISTORY ONLY (***disease not active***). **History of disease is not reportable to TCR.**
Class 34	Type of case not required by CoC to be accessioned (for example, VIN III, VAIN III, AIN III) 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, VIN III, VAIN III, AIN III) 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 with admitting privileges.
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 other 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.

Class of Case Examples

Code	Reason
00	Leukemia was diagnosed at the facility, and all care was given in an office of a physician with practice privileges.
10	Reporting facility found cancer in a biopsy but was unable to discover whether the homeless patient actually received any treatment elsewhere.
11	A patient is diagnosed with melanoma in a staff physician's office. He has a wide excision at the reporting facility and is then 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 presents to the reporting facility for thyroidectomy that was diagnosed elsewhere. The physician notes state the treatment plan is for a thyroidectomy followed by hormone therapy. We don't know where or if the patient went for hormone therapy.
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.
31	Patient receives chemotherapy while visiting relatives in the reporting facility city, then returned to the originating facility for subsequent treatments.
31	Initial diagnosis and all first course treatment elsewhere AND reporting facility provided port placement for chemotherapy 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. After treatment failure, the patient was admitted to the facility for supported care.
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.

11

DEMOGRAPHIC INFORMATION

First Name

(NAACCR Item #2240) (SEER page 39)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

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

Middle Name

(NAACCR Item #2250) (SEER page 40)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Last Name

(NAACCR Item #2230) (SEER page 41)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Name Suffix

(NAACCR Item #2270)

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

Birth Surname

(NAACCR Item #2232) (SEER page 42)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2024 and forward refer to the SEER Program Coding and Staging Manual 2025

Alias Name

(NAACCR Item #2280)

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 the alias first name.
3. Mixed case, embedded spaces, hyphens, and apostrophes are allowed.

4. No other special characters are allowed.

Examples:

Example 1: Ralph Williams uses the name Bud Williams. **Record Williams Bud in the *NAME-ALIAS* field.**

Example 2: Samuel Clemens uses the name Mark Twain. **Record Twain Mark in the *NAME-ALIAS* field.**

Social Security Number

(NAACCR Item #2320) (SEER page 43)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

- If the SSN 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.

Note: **For Web Plus users: If only the last four digits are available, enter it in the following format: enter leading 7's and the last four digits of the SSN provided in the nine-character field:**

Example: **777771234**

- All efforts must be made to obtain the complete social, but if only the last four digits are provided, they can now be used in the SSN field and documented in the *Other Pertinent Information* text box.

Place of Residence

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2024 and forward refer to the SEER Program Coding and Staging Manual 2025

Address at Diagnosis - Number and Street

(NAACCR Item #2330) (SEER page 46)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Address at Diagnosis - Supplemental

(NAACCR Item #2335) (SEER page 47)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Address at Diagnosis - City

(NAACCR Item #70) (STORE page 45) (SEER page 54)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Address at Diagnosis - State

(NAACCR Item #80) (STORE page 46) (SEER page 55)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Examples:

- Residents of foreign countries are no longer reportable to TCR.
- If every valid attempt has been made to obtain the address and it is still unknown, record ZZ in the state field. If there is not enough information to determine patient is a foreign resident, the case must be reported to TCR.

Address at Diagnosis - Postal Code (ZIP Code)

(NAACCR Item #100) (STORE page 48) (SEER page 56)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

If the zip code is not available, refer to the *National Zip Code Directory* or to the USPS website. This website is useful in obtaining missing address information in order to record a complete address.

County

(NAACCR Item #90) (STORE page 50) (SEER page 48)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

- Use codes issued by the Federal Information Processing Standards (FIPS) publication, Counties and Equivalent Entities of the United States, Its Possessions, and Associated areas. U.S. Census Bureau's online FIPS County Code Look-up Tool.

Address at Dx - Country

(NAACCR Item #102) (STORE page 49)

Coding Instructions

1. Enter the appropriate alpha-three-digit code for the country of residence. Use codes issued by the United States Postal Service.
2. Residents of foreign countries are no longer reportable to TCR**.**

Country Code Examples:

Code	*Country*
USA	United States
CAN	Canada
MEX	Mexico
SLV	El Salvador
VNM	Vietnam

Current Address - Number and Street

(NAACCR Item #2350) (SEER page 69)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Current Address - Supplemental

(NAACCR Item #2355) (SEER page 70)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Current Address - City

(NAACCR Item #1810) (SEER page 71)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Current Address - State

(NAACCR Item #1820) (SEER page 72)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Current Address - Postal Code (ZIP Code)

(NAACCR Item #1830) (SEER page 73)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Current Address – Country

(NAACCR Item # 1832)

Coding Instructions

1. Enter the appropriate alpha-three-digit code for the country of residence. Use codes issued by the United States Postal Service.
2. Residents of foreign countries are no longer reportable to TCR**.**

Country Code Examples:

Code	Country
USA	United States
CAN	Canada
MEX	Mexico
SLV	El Salvador
VNM	Vietnam

Telephone

(NAACCR Item #2360) (SEER page 74)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Birthplace – State

(NAACCR Item #252) (STORE page 51) (SEER page 75)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Coding Instructions: Code ZZ if Birthplace - State is unknown or not mentioned in patient record.

Birthplace - Country

(NAACCR Item #254) (STORE page 52) (SEER page 76)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Coding Instructions: Code ZZU if Birthplace – Country is unknown or not mentioned in patient record.

Date of Birth

(NAACCR Item #240) (STORE page 53) (SEER pages 77-78)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

- **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.**

  Note: If the complete date of birth is not available, documentation must be provided in *Other Pertinent Information.*

  Example: Medical records indicate only month and year of date of birth.

- 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.

- If the patient's age is 100 years or older, check the accuracy of the date of birth and date of diagnosis and document both in a text field.

Place of Death – State

(NAACCR Item #1942) (SEER page 79)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Place of Death – Country

(NAACCR Item #1944) (SEER page 80)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Race 1, 2, 3, 4, 5

(NAACCR Item #160-#164) (STORE pages 55-56) (SEER pages 82-86)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Refer to Appendix D of the SEER Manual, "Race and Nationality Descriptions from the 2000 Census and Bureau of Vital Statistics" when race is unknown or not stated in the medical record and birthplace is recorded.

Spanish Surname or Origin

(NAACCR Item #190) (STORE page 57) (SEER page 88-90)

Alternate Names: Spanish/Hispanic Origin, Spanish Origin

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Use codes 1–5 if specific ethnicity is known.

- Use code 6 when you know the patient is Hispanic but cannot classify him/her to codes 1–5.
- Use code 9 when Spanish/Hispanic origin is not documented or is unknown.
    - **Example:** The patient's race is white or black, they were born in the United States, their last name is not on a Spanish surname list, and there is no mention of Spanish origin in the patient record.

Sex

(NAACCR Item #220) (STORE page 58) (SEER page 92)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Marital Status at Diagnosis

(NAACCR Item #150) (SEER page 93)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Primary Payer at Diagnosis

(NAACCR Item #630) (STORE pages 59-61) (SEER pages 94-95)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Medicare Beneficiary Identifier (MBI)

(NAACCR Item #2315)

Coding Instructions

1. The MBI has eleven characters. Each MBI is randomly generated. The MBI's characters are "non-intelligent" so they don't have any hidden or special meaning. MBIs are numbers and upper-case letters; 1-9 and all letters from A to Z, except for S, L, O, I, B, and Z.
2. Leave blank when MBI is not available, not applicable, unknown, or a non-Medicare patient.

Note: The MBI format and information on understanding the MBI can be found at: https://www.cms.gov/Medicare/New-Medicare-Card/Understanding-the-MBI-with-Format.pdf

Text Usual Industry

(NAACCR Item #320)

Coding Instructions

1. Record the primary type of activity carried on by the business/industry at the location where the patient was employed for the greatest number of years before diagnosis of this tumor. Be sure to distinguish among "manufacturing," "wholesale," "retail," and "service" components of an industry that performs more than one of these components. Refer to "A Cancer Registrar's Guide to Collecting Industry & Occupation.
2. If the primary activity carried on at the location where the patient worked is unknown, it may be sufficient for facility registrars to record the name of the company (with city or town) in which the patient performed his/her usual industry.

   Example:

   Inadequate: "ABC, Inc."
   Adequate: "ABC, Inc., Kyle, TX"
3. In those situations where the usual occupation is not available or is unknown, the patient's current or most recent occupation is recorded, if available.
4. Be descriptive and specific.

Examples:

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

Inadequate: "Mine"
Adequate: "Copper mine"

Inadequate: "Retail"
Adequate: "Retail bookstore"

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

   Example:

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

6. If no information is available regarding patient's industry, document "Unknown" in the text field. This should be used only as a last resort. If patient record states "Retired", document as "Unknown".

Text Usual Occupation

(NAACCR Item #310)

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**. Do not record "Retired."**
2. If a patient has been a homemaker for most of her/his adult life, but has ever worked outside the home, report the occupation held outside the home.
3. 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"

4. If the patient's usual occupation is not known, record the patient's current or most recent occupation, or any available occupation.
5. If no information is available regarding the patient's occupation, 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)

For data item description, coding instructions, and examples refer to Documentation Chapter of the 2025 TCR Guide. **Refer to 2025 NAACCR Data Dictionary for list of data items to be verified by the text fields.**

Physician Follow Up

(NAACCR Item #2470)

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 here.
2. Cancer reporters using third party software must check with their vendor to ensure the physician's state license number transmits to TCR.
3. This field must be populated for cases diagnosed 2006 and forward. If the information is unknown, code 99999999 and document in *Text Remarks - Other Pertinent Information* that the follow up physician is unknown.

Note: This item is not supported by CoC as of January 1, 2010, (the respective NPI item is required). TCR will continue to require this data item.

Tobacco Use Smoking Status

(NAACCR Item #344) (STORE page 62) (SEER page 96-97)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Secondary Diagnosis 1, 2, 3, 4, 5, 6, 7, 8, 9, 10

(NAACCR Item #3780, #3782, #3784, #3786, #3788, #3790, #3792, #3794, #3796, #3798)

(STORE pages 94-104)

Coding Instructions

1. Use this item to record ICD-10-CM codes.
2. The actual ICD-10-CM code is to be entered for Secondary Diagnosis fields.
3. Omit the decimal points when coding.
4. Secondary diagnoses are found on the discharge abstract. Information from the billing department at your facility may be consulted when a discharge abstract is not available.
5. 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.
6. Report the secondary diagnoses for this cancer using the following priority rules:
    a. Surgically treated patients:
        i. following the most definitive surgery of the primary site
        ii. following other non-primary site surgeries
    b. Non-surgically treated patients:
        i. following the first treatment encounter/episode
    c. In cases of non-treatment:
        i. following the last diagnostic/evaluative encounter
7. If the data item Readmission to the Same Hospital within 30 Days of Surgical Discharge [3190] is coded 1, 2, or 3, report Secondary Diagnosis ICD-10-CM codes appearing on the "readmission" discharge abstract.
8. If no ICD-10-CM secondary diagnoses were documented, then code 0000000 in this data item and leave the remaining Secondary Diagnosis data items blank.
9. If fewer than 10 ICD-10-CM secondary diagnoses are listed, then code the diagnoses listed and leave the remaining Secondary Diagnosis data items blank.

12

DESCRIPTION OF THIS NEOPLASM

Pathology Reports

In general, the SEER Program recommends that information from consult pathology reports be preferred over the original pathology report. This is because consults are usually requested from a more experienced or specialized pathologist/lab and are generally thought to be more accurate.

Date of Diagnosis

(NAACCR) Item #390) (STORE pages 81) (SEER pages 99-103)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2024 and forward refer to the SEER Program Coding and Staging Manual 2025

Note: Appendix E in the SEER Program Coding and Staging Manual lists which PI-RADS, BI-RADS, and LI-RADS are reportable versus non-reportable. If reportable, use the date of the imaging procedure as the date of diagnosis when this is the earliest date and there is no information to dispute the imaging findings.

Note: **PI-RADS, LI-RADS category of 4 or 5 are reportable to SEER and TCR with the Date of Diagnosis the date of the RAD.**

CoC Facilities Note: **PI-RADS, LI-RADS alone are not reportable for CoC but need to be reported to TCR to meet reporting requirements. PI-RADS, LI-RADS confirmed with biopsy or physician statement are reportable to CoC. Date of diagnosis is the date of the positive biopsy.**

Age at Diagnosis

(NAACCR Item #230) (STORE page 55) (SEER page 81)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Note: For users of Web Plus always press the calculator icon in order to calculate age at diagnosis. If diagnosis date or date of birth are changed the calculator must be pressed to recalculate the age at diagnosis.

Sequence Number

(NAACCR Item #560) (STORE page 43-44)

Coding Instructions

1. Codes 00–59 and 99 indicate neoplasms of malignant (in situ or invasive) behavior (Behavior equals 2 or 3). Codes 60–88 indicate neoplasms of non-malignant behavior (Behavior equals 0 or 1).

2. Code 00 only if the patient has a single malignant primary. If the patient develops a subsequent invasive or in situ primary tumor, change the code for the first tumor from 00 to 01 and number subsequent tumors sequentially.
3. Code 60 only if the patient has a single non-malignant primary. If the patient develops a subsequent non-malignant primary, change the code for the first tumor from 60 to 61 and assign codes to subsequent non-malignant primaries sequentially.
4. If two or more invasive or in situ neoplasms are diagnosed at the same time, assign the lowest sequence number to the diagnosis with the worst prognosis. If no difference in prognosis is evident, the decision is arbitrary.
5. Any tumor in the patient's past which is reportable or reportable-by-agreement at the time the current tumor is diagnosed must be considered when sequencing subsequently accessioned tumors. However, do not reassign sequence numbers if one of those tumors becomes non-reportable later.
6. Sequence numbers should be reassigned if the facility learns later of an unaccessioned tumor that affects the sequence.

Examples:

- A person is diagnosed with one malignant primary. **Code the sequence number to 00.**
- A person was diagnosed with lung cancer in 2001. A colon cancer is diagnosed in 2024. **Code the sequence number of the colon cancer to 02 and change the sequence number of the lung cancer to 01.**
- A person was diagnosed with breast cancer in April 2010 and metastasis to the lungs from the breast primary in June 2025. 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.**
- A person was diagnosed with signet ring cell carcinoma of the bladder in 2017. In 2025, 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.**
- A person was diagnosed with carcinoma of the stomach in 2016, squamous cell carcinoma of the left forearm (a non-reportable neoplasm) in 2017, and non-Hodgkin's lymphoma in 2025. **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.**
- A person was diagnosed with a benign meningioma in June 2016. MRI at your facility in 2025 shows no change. **Code the sequence number to 60 for the benign meningioma.**

Primary Site

(NAACCR Item #400) (STORE page 82) (SEER pages 108-114)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Refer to the *International Classification of Diseases for Oncology, Third Edition* (ICD-O-3) to code the primary site using the topography codes listed.

Refer to the *Solid Tumor Rules* for site-specific guidelines for primary sites, including Head & Neck, Breast, Lung, Brain, Urinary, and Cutaneous Melanoma.

Refer to the *SEER Program Coding and Staging Manual Appendix C* for site-specific guidelines for primary sites, including Bladder, Breast, Colon, Esophagus, Kaposi Sarcoma of All Sites, Lung, and Rectosigmoid Junction.

Refer to the *Hematopoietic & Lymphoid Neoplasm Database and Coding Manual* for hematopoietic & lymphoid neoplasms (9590/3-9993/3) to determine primary site for hematopoietic & lymphoid neoplasms.

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.

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

Examples:

- The pathology report states right breast resection specimen. The discharge diagnosis states carcinoma in the right breast. The History and Physical (H&P) states examination of the right breast reveals a mass in the upper outer quadrant. **Code to the more detailed description from the H&P, upper outer quadrant of the right breast (C504).**
- Patient presents with headaches and seizures. CT of the brain demonstrates a meningioma in the frontal lobe. **Code the Primary Site field to C70.0 [cerebral meninges], the suggested site code for most meningiomas. Meningiomas arise from the meninges, not the brain (although they can invade brain).**
- Overlapping lesion of oropharynx. **Code C10.8 overlapping lesion when a large tumor involves both the lateral wall of the oropharynx (C10.2) and the posterior wall of the oropharynx (C10.3) and the point of origin is not stated.**
- Overlapping lesion of bladder. **Code C67.8 overlapping lesion of the bladder when a single lesion involves the dome (C67.1) and the lateral wall (C67.2) and the point of origin is not stated.**

- Colon, NOS. Familial polyposis with carcinoma and carcinoma in situ throughout the transverse (C18.4) and descending colon (C18.6) would be one primary and **coded to colon, NOS (C18.9). For a full explanation see the 2024 Solid Tumor Rules.**

Laterality

(NAACCR Item #410) (STORE page 83) (SEER pages 115-117)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Bilateral Site Codes in Alphabetic Order

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
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

Paired Organ Sites - Alphabetic Order	
Primary Site	**ICD-O-3 Code**
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 [IF midline tumor, code 5] *	C443
Skin of upper limb and shoulder	C446
Skin of lower limb and hip	C447
Skin of scalp and neck [IF midline tumor, code 5] *	C44.4
Skin of trunk [IF midline tumor, code 5] *	C445
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

Paired Organ Sites - Alphabetic Order	
Primary Site	**ICD-O-3 Code**
Tonsillar pillar	C091

*Assign code 5 when the tumor originates in the midline for the following sites: C700, C710-C714, C722-C725, C443, C445. 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).

Diagnostic Confirmation

(NAACCR Item #490) (STORE pages 89-90) (SEER pages 118-120)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Refer to the *Hematopoietic & Lymphoid Neoplasm Database and Coding Manual* for coding instructions for diagnostic confirmation for hematopoietic & lymphoid neoplasms (9590/3-9993/3).

Examples:

- 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.**
- 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.**
- 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.**
- 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**.
- FNA is positive for malignant cells. **The diagnostic confirmation code is 2.**

Histology Type ICD-O-3:

(NAACCR Item #522) (STORE page 84) (SEER pages 121-122)

Note: Solid tumor histology can be coded only after the determination of single vs. multiple primaries has been made. Refer to Solid Tumor Rules to determine the number of primaries for solid tumors.

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

- **Check the *Solid Tumor Rules* to determine if the histology is listed.**

- **If the ICD-O code is not in the site-specific histology table or there is no histology table for the site, refer to the ICD-O update tables, and the *ICD-O Coding Table.***

The *Solid Tumor Rules*, the *ICD-O-3.2 Coding Table Excel*, the *Hematopoietic & Lymphoid Neoplasm Coding Manual*, and the *Hematopoietic & Lymphoid Neoplasm Database* are the standard references for histology codes for cases diagnosed 2024 and forward.

The Solid Tumor Rules are revised annually to reflect new terminology, ICD-O codes, and other changes needed to keep in step with current clinical practice. The most recent Solid Tumor Rules should be used as soon as it is released. Each update contains start years for when new codes become valid and when new instructions become active (theoretical examples – "this code should be used for 2021+" or "do not use this code before 2022"). If there is no date associated with a newly added code or instruction, then it can be applied back to 2018 (or 2021 or 2023 for Melanoma and Other Sites, respectively). Rules and other information from previous updates convey to every annual update. Previous versions are archived and should not be used. Tables and rules refer to ICD-O rather than ICD-O-3. The version is not specified to allow for updates. Use the currently approved version of ICD-O.

Behavior Code

(NAACCR Item #523) (STORE pages 85-86) (SEER pages 123-125)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Note: 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*, page 27.

Examples:

- A patient is diagnosed with metastatic brain tumors and an FNA 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).**
- Intraductal carcinoma (8500/2) with focal areas of invasion. **Code behavior as /3.**
- Atypical meningioma (9539/1) invading bone of skull (the meninges, which line the skull, are capable of invading into the bone without being malignant; do not code as malignant unless it is specifically mentioned). **Code behavior as /1.**
- Adenocarcinoma in situ with lymph nodes positive for malignancy. **Code the behavior as malignant (/3).**

Grade Clinical

(NAACCR Item # 3843) (STORE page 87) (SEER page 127)

Refer to the most recent version of the Grade Coding Instructions and Tables.

Grade Post Therapy Clin (yc)

(NAACCR Item # 1068) (STORE page 143) (SEER page 128)

Refer to the most recent version of the Grade Coding Instructions and Tables.

Grade Pathological

(NAACCR Item # 3844) (STORE page 88) (SEER page 129)

Refer to the most recent version of the Grade Coding Instructions and Tables.

Grade Post Therapy Path (yp)

(NAACCR Item # 3845) (STORE page 156) (SEER page 130)

Refer to the most recent version of the Grade Coding Instructions and Tables.

Grade Examples for Colon per Colon Grade - CAnswer Forum**:**

1. Biopsy and no residual on resection; path report states MD adenocarcinoma. **Code Clinical Grade to 2 (for the biopsy) and Pathological Grade to 2 (since there was no residual tumor, use the Clinical Grade information).**
2. Polypectomy and no residual on resection; polypectomy path report states MD adenocarcinoma. **Code Clinical Grade to 2 (since a resection was performed, the polypectomy qualifies for the clinical time frame). Code Pathological Grade to 2 (since there was no residual tumor, use the Clinical Grade information).**
3. Polypectomy only, no resection is performed, path report states MD adenocarcinoma, margins negative. **Code Clinical Grade to 9 (if no further surgical resection is planned; the polypectomy is treatment by default) and Pathological Grade to 2.**
4. Excisional biopsy only intended as treatment, path report states MD adenocarcinoma**. Code Clinical Grade to 9 and Pathological Grade to 2 (based on the intended excisional biopsy as treatment; regardless of margin status).**

Final Diagnosis – Primary Site, and Laterality, Histology, Behavior, Grade Documentation

(NAACCR Items #2580 [Text-Primary Site Title], #2590 [Text-Histology Title])

1. Document the specific location of the primary site, including subsite and laterality.
2. Document the histologic type, behavior, and grade.
3. Do not use the generic ICD-10-CM code statement found on the face sheet.

   Example 1: Morphology: Moderately differentiated mucin-producing adenocarcinoma
   Primary Site: Colon, ascending

   Example 2: Morphology: Grade 3, infiltrating ductal and lobular carcinoma
   Primary Site: Right breast, upper outer quadrant

   Example 3: Morphology: Anaplastic astrocytoma
   Primary Site: Brain, frontal-parietal lobe

   Example 4: Morphology: Intermediate grade large cell carcinoma
   Primary Site: Left lung lower lobe
4. If information is missing, state that it is missing.

Tumor Size Summary

(NAACCR Item #756) (STORE pages 115-118) (SEER pages 132-136)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025.

Example: Patient has a 90 mm triple positive breast tumor and is treated with neoadjuvant TCHP. After completing neoadjuvant therapy, the patient has a mastectomy with no residual disease noted on the final pathology report.

Code the Tumor Size Summary to 090 (clinical tumor size). If size of tumor prior to neoadjuvant was unknown, code would be 999.

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STAGE OF DISEASE AT DIAGNOSIS

Stage of Disease at Diagnosis data items contained within this manual fall under two categories:

- Extent of Disease
- Summary Stage
    - Pediatric Stage (if applicable)

Note: There are no specific instructions for pathology-only cases. **Assign 9s or the appropriate "unknown" code when abstracting stage and related data items from pathology reports or HL-7 reports only and information is not provided. There are instances where additional data items can and should be coded appropriately, for example for benign reportable neoplasms or in situ cancers.**

For additional stage-related data items, refer to Stage-related Data Items section of the SEER Program Coding and Staging Manual 2025.

Extent of Disease Primary Tumor

(NAACCR Item #772) (SEER page 140)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025 and the EOD 2018 Manual

Extent of Disease Regional Nodes

(NAACCR Item #774) (SEER page 141)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025 and the EOD 2018 Manual

Extent of Disease Metastases

(NAACCR Item #776) (SEER page 142)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025 and the EOD 2018 Manual

Extent of Disease Prostate Pathologic Extension

(NAACCR Item #3919)

For data item descriptions, codes, and coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Registrar Staging Assistant EOD Prostate

Summary Stage 2018

(NAACCR Item #764) (SEER page 144)

Refer to Summary Stage 2018 for guidelines, general instructions, and site-specific instructions.

Derived Summary Stage 2018

(NAACCR Item #762) (SEER page 145)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Pediatric Data Collection System

Beginning with cases diagnosed January 1, 2025, and forward, TCR will be collecting applicable data items for Pediatric and Adolescent/Young Adult (AYA) populations. The staging elements collected are based on the *Toronto Childhood Cancer Staging Guidelines, Version 2,* along with additional data items for surveillance purposes. Please see the NAACCR Pediatric Resources webpage for the staging manual, staging guidelines, trainings, and coding questions.

Pediatric Primary Tumor

(NAACCR #1136) (Pediatric Manual pages 19-20)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025, and forward refer to the Pediatric Data Collection System and Staging Manual

Pediatric Regional Nodes

(NAACCR #1137) (Pediatric Manual pages 21-24)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025, and forward refer to the Pediatric Data Collection System and Staging Manual

Pediatric Mets

(NAACCR #1138) (Pediatric Manual pages 25-26)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025, and forward refer to the Pediatric Data Collection System and Staging Manual

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STAGE-RELATED DATA ITEMS

Lymphovascular Invasion

(NAACCR Item #1182) (STORE page 97-101) (SEER page 148-150)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Macroscopic Evaluation of the Mesorectum

(NAACCR Item #3950) (STORE page 102) (SEER page 180)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Mets at Diagnosis - Bone

(NAACCR Item #1112) (STORE pages 119-120) (SEER pages 152-153)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Mets at Diagnosis - Brain

(NAACCR Item #1113) (STORE pages 121-122) (SEER pages 154-155)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Mets at Diagnosis - Liver

(NAACCR Item #1115) (STORE pages 125-126) (SEER pages 156-157)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Mets at Diagnosis - Lung

(NAACCR Item #1116) (STORE pages 127-128) (SEER pages 158-159)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Mets at Diagnosis - Distant Lymph Node(s)

(NAACCR Item #1114) (STORE pages 123-124) (SEER pages 160-161)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Mets at Diagnosis - Other

(NAACCR Item #1117) (STORE pages 129-130) (SEER pages 162-163)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

SEER Site-specific Factor 1

(NAACCR Item #3700) (SEER pages 164-165)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

SSDIs

(SEER page 166-169)

For the list of required SSDI for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025.

For information about Schema IDs, descriptions, codes, and coding instructions for site-specific data items refer to the SSDI Manual.

For information about Pediatric staging and SSDIs refer to the Pediatric Data Collection System and Manual.

SEER has developed a staging tool referred to as SEER*RSA that provides information (primary site/histology/other factors defined) about each cancer schema.

AJCC TNM STAGING SYSTEM

AJCC TNM data items is required only from facilities accredited by the ACS and only for analytical cases.

For hospitals and cancer centers that are not ACS accredited, these data items are required for analytical cases only *as available* (class of case 00-22).

For data item descriptions, codes, and coding instructions for cases diagnosed January 1, 2025, and forward refer to the STORE 2025 Manual.

TNM Edition Number

(NAACCR) Item #1060)(STORE page 286)

AJCC TNM Clin T

(NAACCR Item #1001) (STORE page 132)

AJCC TNM Clin T Suffix

(NAACCR Item #1031) (STORE page 133)

AJCC TNM Clin N

(NAACCR Item #1002) (STORE page 134)

AJCC TNM Clin N Suffix

(NAACCR Item #1034) (STORE page 135)

AJCC TNM Clin M

(NAACCR Item #1003) (STORE page 136)

AJCC TNM Clin Stage Group

(NAACCR Item #1004) (STORE page 137)

AJCC TNM Path T

(NAACCR Item #1011) (STORE page 144)

AJCC TNM Path T Suffix

(NAACCR Item #1032) (STORE page 145)

AJCC TNM Path N

(NAACCR Item #1012) (STORE page 146)

AJCC TNM Path N Suffix

(NAACCR Item #1035) (STORE page 147)

AJCC TNM Path M

(NAACCR Item #1013) (STORE page 148)

AJCC TNM Path Stage Group

(NAACCR Item #1014) (STORE page 149)

AJCC TNM Post Therapy Clin T

(NAACCR #1062) (STORE page 138)

AJCC TNM Post Therapy Clin T Suffix

(NAACCR #1063) (STORE page 139)

AJCC TNM Post Therapy Clin N

(NAACCR #1064) (STORE page 140)

AJCC TNM Post Therapy Clin N Suffix

(NAACCR #1065) (STORE page 141)

AJCC TNM Post Therapy Clin M

(NAACCR #1066) (STORE page 142)

AJCC TNM Post Therapy Path T

(NAACCR #1021) (STORE page 150)

AJCC TNM Post Therapy Path T Suffix

(NAACCR #1033) (STORE page 151)

AJCC TNM Post Therapy Path N

(NAACCR #1022) (STORE page 152)

AJCC TNM Post Therapy Path N Suffix

(NAACCR #1036) (STORE page 153)

AJCC TNM Post Therapy Path M

(NAACCR #1023) (STORE page 154)

AJCC TNM Post Therapy Path Stage Group

(NAACCR #1024) (STORE 2022 page 155)

15

FIRST COURSE OF THERAPY

Definitions

First Course of Treatment includes **all methods of treatment recorded in the treatment plan** and administered to the patient **before disease progression or recurrence**. See section Treatment Timing, for detailed information on timing and treatment plan documentation requirements. Active surveillance is a form of planned treatment for some patients. "No therapy" is a treatment option that occurs if the patient refuses treatment, the family or guardian refuses treatment, the patient dies before treatment starts, the physician recommends no treatment be given, or the physician recommends palliative care for pain management only. If the first course of treatment plan changes due to an improvement in the tumor burden, the added treatment would still be considered first course. An example is palliative chemotherapy/radiation is recommended and administered per the first course treatment plan. Initially resection of primary tumor was contraindicated due to tumor size and location. Follow up imaging shows an improvement in tumor burden and treatment plan changed since tumor is now resectable to include surgery. Even though the primary tumor resection was not noted in the first course of treatment plan, the resection would be captured as first course of treatment since there was no progression of tumor.

First Course of Therapy includes **all treatments** administered to the patient **after the original diagnosis** of cancer in an attempt to **destroy or modify the cancer tissue.**

Active Surveillance: A treatment plan that involves closely watching a patient's condition but not giving any treatment unless there are changes in test results that show the condition is getting worse. Active surveillance may be used to avoid or delay the need for treatments such as radiation therapy or surgery, which can cause side effects or other problems. During active surveillance, certain exams and tests are done on a regular schedule. It may be used in the treatment of certain types of cancer, such as prostate cancer, urethral cancer, and intraocular (eye) melanoma. It is a type of expectant management. Its use is coded in the *RX Summ--Treatment Status* item. (Source: https://www.cancer.gov/publications/dictionaries/cancer-terms/def/active-surveillance)

Cancer tissue: Proliferating malignant cells; an area of active production of malignant cells. Cancer tissue includes primary tumor and metastatic sites where cancer tissue grows. Cells in fluid such as pleural fluid or ascitic fluid are not "cancer tissue" because the cells do not grow and proliferate in the fluid.

Concurrent therapy: A treatment that is given at the same time as another, such as chemotherapy and radiation therapy.

Disease recurrence: For solid tumors, see the *Solid Tumor Rules* and for hematopoietic & lymphoid neoplasms see the *Hematopoietic & Lymphoid Neoplasm Coding Manual* and the *Hematopoietic Database* to determine disease recurrence.

Hospice: A program that provides special care for people who are **near the end of life** and for their families either at home, in freestanding facilities, or within hospitals. **Hospice care may include treatment that destroys or modifies cancer tissue. If performed as part of the first course, treatment that destroys or modifies cancer tissue is collected when given in a hospice setting**. "Hospice, NOS" is not specific enough to be included as first course treatment.

Maintenance treatment: A treatment given as part of the first course of planned care (for example, for leukemia) is first course treatment and cases where patient is receiving treatment are analytic.

Neoadjuvant therapy: Systemic therapy or radiation therapy given prior to surgery to shrink the tumor.

"**No therapy**": A treatment option that occurs if the patient refuses treatment, the family or guardian refuses treatment, the patient dies before treatment starts, or the physician recommends no treatment be given. If the patient refuses all treatment, code "patient refused" (code 7 or 87) for all treatment modalities.

Palliative treatment: Treatment that improves the quality of life by preventing or relieving suffering. Palliative therapy is also part of the first course of therapy when the treatment destroys or modifies cancer tissue.

Example: The patient was diagnosed with stage IV cancer of the prostate with painful boney metastases. The patient starts radiation treatment intended to shrink the tumor in the bone and relieve the intense pain. The radiation treatments are palliative because they relieve the bone pain; the radiation is also first course of therapy because it destroys proliferating cancer tissue.

Surgical Procedure: Any surgical procedure coded in the fields *Surgery of Primary Site, Scope of Regional Lymph Node Surgery (excluding code 1),* or *Surgical Procedure of Other Site*.

Treatment: Procedures that destroy or modify primary (primary site) or secondary (metastatic) cancer tissue.

Treatment failure: The treatment modalities did not destroy or modify the cancer cells. The tumor either became larger (disease progression) or stayed the same size after treatment.

Watchful waiting: Closely watching a patient's condition but not giving treatment unless symptoms appear or change. Watchful waiting is sometimes used in conditions that progress slowly. It is also used when the risks of treatment are greater than the possible benefits. During watchful waiting, patients may be given certain tests and exams. According to the NCI, "watchful waiting is sometimes used in prostate cancer. It is a type of expectant management." (Source: https://www.cancer.gov/publications/dictionaries/cancer-terms/def/watchful-waiting)

Treatment Timing

Note: **Treatment** is therapy (destroys or modifies cancer tissue) **or** active surveillance **or** the decision for "no therapy".

Use the following instructions **in hierarchical order:**

1. Use the **documented** first course of therapy (treatment plan) from the medical record. First course of therapy ends when the treatment plan is **completed** no matter how long it takes to complete the plan unless there is documentation of disease progression, recurrence, or treatment failure (see #2).

   Example 1: The first course of therapy for a breast cancer patient is surgery, chemotherapy, and radiation. The patient completes surgery and chemotherapy. Bone metastases are diagnosed before the radiation was started. The physician says that the patient will

start the radiation treatment as planned. **Code the radiation as first course of therapy since it was given in as planned and the treatment plan was not changed because of disease progression.**

Example 2: Hormonal therapy (e.g., Tamoxifen) after surgery, radiation, and chemotherapy. First course ends when hormonal therapy is completed, even if this takes years, unless there is documentation of disease progression, recurrence, or treatment failure (see #2).

2. First course of therapy ends when there is documentation of **disease progression, recurrence, or treatment failure.**

   Example 1: The documented treatment plan for sarcoma is pre-operative (neoadjuvant) chemotherapy, followed by surgery, then radiation or chemotherapy depending upon the pathology from surgery. Scans show the tumor is not regressing after pre-operative chemotherapy. Plans for surgery are cancelled, radiation was not administered, and a different type of chemotherapy is started. **Code only the first chemotherapy as first course. Do not code the second chemotherapy as first course because it is administered after documented treatment failure.**

   Example 2: The documented treatment plan for a patient with locally advanced breast cancer includes mastectomy, chemotherapy, radiation to the chest wall and axilla, and hormone therapy. The patient has the mastectomy and completes chemotherapy. During the course of radiation therapy, the liver enzymes are rising. Workup proves liver metastases. The physician stops the radiation and does not continue with hormone therapy (the treatment plan is altered). The patient is placed on a clinical trial to receive Herceptin for metastatic breast cancer. **Code the mastectomy, chemotherapy, and radiation as first course of treatment. Do not code the Herceptin as first course of therapy because it is administered after documented disease progression**.

3. When there is **no documentation** of a treatment plan or progression, recurrence, or a treatment failure, first course of therapy 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 or a standard of treatment.**

Coding Instructions

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025 for all diseases (including benign and borderline malignancy, intracranial & CNS tumors) except hematopoietic & lymphoid neoplasms.

For information on first course treatment for hematopoietic & lymphoid neoplasms, refer to the Hematopoietic & Lymphoid Neoplasm Coding Manual.

For information on NCCN treatment by cancer type, refer to the NCCN Treatment Guidelines.

Date Therapy Initiated

Date Therapy Initiated *(NAACCR) Item #1260) (SEER page 175-177)*

Date of First Course of Treatment *(NAACCR Item #1270) (STORE page 160)*

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Treatment Status

(NAACCR Item #1285) (STORE pages 161-162) (SEER page 178)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Examples:

- An elderly patient with pancreatic cancer requested no treatment. **Use code 0.**
- Patient is expected to receive radiation, but it has not occurred yet (*Reason for No Radiation* [NAACCR Item #1430] = 8). **Use code 0 for this field.**
- Treatment plan for a lymphoma patient is active surveillance. **Use code 2.**

Date of First Surgical Procedure

(NAACCR ITEM #1200) (STORE page 164) (SEER page 179)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Examples:

- A patient was found to have a large polyp during a colonoscopy on January 8, 2025. 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 20250108.**
- Patient is seen for treatment recommendations following a mastectomy in March 2025. The exact day of surgery is unknown. **Code the date of surgery as 202503.**
- A patient had a radical prostatectomy in 2024 and is now seen with bone mets. The month and day of the surgery are unknown. **Code the date of surgery as 2024.**
- An incisional biopsy is performed on March 3, 2025, followed by a resection on March 17, 2025. **Record the date of the resection (20250317) as the date of the first surgical procedure. An**

incisional biopsy is a diagnostic procedure, not a cancer-directed surgery.

- February 1, 2025, a patient had a fine needle aspiration of a right breast mass, consistent with infiltrating ductal carcinoma. On February 15, 2025, the patient underwent a right modified radical mastectomy. **The date of surgery would be recorded as 20250215.**
- Patient had a lumpectomy as part of first course of treatment for breast cancer in 2025, but the date is unknown. On June 3, 2025 she comes to your facility to begin chemotherapy. **Record the date of surgery as 2025**.

Date of Most Definitive Surgical Resection of the Primary Site

(NAACCR Item #3170) (STORE page 165) (SEER page 180)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Examples:

- The patient undergoes an excisional biopsy for right breast cancer on 1/2/2025, then undergoes a right modified radical mastectomy on 1/25/2025**. The *Date of First Surgical Procedure* is 20250102 since this is the date of the first surgery done as first course of treatment. 20250125 is the *Date of Most Definitive Surgical Resection of the Primary Site* since the right modified mastectomy is more extensive than the excisional biopsy.**
- The patient undergoes a colonoscopy on 2/20/2025 and is found to have a suspicious polyp. A polypectomy is performed and is positive for adenocarcinoma. The patient proceeds to a segmental resection of the colon for margins done on 3/2/2025. The resection shows no residual disease. **The *Date of the First Surgical Procedure* is 20250220. The *Date of Most Definitive Surgical Resection of the Primary Site* is 20250302 even though no cancer is found in the specimen.**

Surgery of Primary Site 2023

(NAACCR Item #1291) (STORE page 168-169) (SEER pages 181-183)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Use the site-specific coding scheme corresponding to the primary site or histology. **Refer to the Site-specific Surgery Codes in Appendix C of the SEER Manual or Appendix A of the STORE Manual.**

Surgery of Primary Site at this Facility

(NAACCR Item #671) (STORE page 166-167)

Alternate Name: Rx Hosp-Surg 2023

Instructions

1. Site-specific surgical codes for this data item are found in Appendix A.
    a. All surgery codes begin with the letter A except for skin.
    b. Skin surgery codes begin with the letter B to indicate a significant change in coding.
2. For diagnosis year 2023 and forward, this data item must be completed.
3. For diagnosis years 2003 – 2022, this data item should be left blank.
    a. Complete data item Surgical Procedure of Primary Site at this Facility [NAACCR #670] utilizing the STORE manual that is applicable for the date of diagnosis.
4. If registry software allows only one procedure to be collected, document the most invasive surgical procedure for the primary site.
5. If registry software allows multiple procedures to be recorded, this item refers to the most invasive surgical procedure for the primary site.
6. For codes A000 through A790, the response positions are hierarchical. Last-listed responses take precedence over responses written above.
7. Use codes A800 and A900 only if more precise information about the surgery is not available.
8. Code A980 for any case coded to primary site C420, C421, C423, C424, C760-C768, C809.
9. Excisional biopsies (those that remove the entire tumor and/or leave only microscopic margins) are to be coded in this item.
10. If a needle biopsy precedes an excisional biopsy or more extensive surgery and upon the excisional biopsy or more extensive surgery the surgical margins are clear (i.e., no tumor remains), DO NOT consider the needle biopsy to be an excisional biopsy. The needle biopsy should be recorded as such in the Surgical Diagnostic and Staging Procedure [1350] (if this data item is collected by your facility) and the excisional biopsy or more extensive surgery in the RX Summ-Surg 2023 [1291].

    Note: Per SEER page 182 Code an excisional biopsy, even when documented as incisional, when

    - **All disease is removed (margins free), OR**
    - **All gross disease is removed and there is only microscopic residual at the margin**

      Example: Breast core needle biopsy with diagnosis of infiltrating duct carcinoma; subsequent re-excision with no residual tumor noted. Code as excisional biopsy.

Do not code an incisional biopsy as an excisional biopsy when there is macroscopic residual disease.

Shave or punch biopsies are most often diagnostic. Code as a surgical procedure only when the entire tumor is removed, and margins meet the criteria above.

Example: Shave biopsy performed for a suspicious lesion on the skin of the right arm that has been changing in size and color. The shave biopsy pathology report showed malignant melanoma with only microscopically positive margins. Code the shave biopsy as an excisional biopsy.

11. Surgery to remove regional tissue or organs is coded in this item only if the tissue/organs are removed in continuity with the primary site.
12. If a previous surgical procedure to remove a portion of the primary site is followed by surgery to remove the remainder of the primary site, then code the total or final results. Do not rely on registry software to perform this task for you.
13. If the procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item Palliative Care at This Facility [3280] (if this data item is collected by your facility).
14. For cases diagnosed prior to January 1, 2023, this data item should be blank.
15. For any site other than C420, C421, C423, C424, C760-768, C809, this data item can be blank.
16. Clinical Margin Width [3961] collected in the SSDI following SEER coding rules and instructions.
17. For melanoma skin surgical codes ONLY:
    a. The priority order for sources used to assign surgery codes:
        i. Operative report, statement from a physician, description of the surgical procedure on a pathology report, results of the pathology report. Code based on the description of the procedure.
        ii. Do not code based on margin status documented in the pathology report.

Surgical Procedure of Primary Site Codes

Code	Type	Description
A000	None	No surgical procedure of primary site. Diagnosed at autopsy.
A100-A190	Site-specific codes; tumor destruction	Tumor destruction, no pathologic specimen produced. Refer to *Appendix A in the STORE manual* for correct site-specific procedure code.
A200-A800	Site-specific codes; resection	Refer to *Appendix A in the STORE manual* for correct site-specific procedure code.
A900	Surgery, NOS	A surgical procedure to the primary site was done, but no information on the type of surgical procedure is provided.
A980	Site-specific surgery codes; special	Special code. Refer to *Appendix A in the STORE manual* for the correct site-specific code for the procedure. Code A980 for the following sites/schema unless the case is death certificate only: Any case coded to primary site C420, C421, C423, C424, C760-C768, C809 When Surgery of Primary Site is coded A980 1. Code Surgical Margins of the Primary Site (#1320) to 9 2. Code Reason for No Surgery of Primary Site (#1340) to 1
A990	Unknown	Patient record does not state whether a surgical procedure of the primary site was performed and no information is available. Death certificate only.

Breast Reconstruction

(NAACCR Item #1335) (STORE pages 172-173) (SEER pages 184-185)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Breast Reconstruction at this Facility

(NAACCR Item #751) (STORE Pages 170-171)

For data item descriptions, codes, and coding instructions for cases diagnosed January 1, 2025 and forward refer to the STORE 2025 Manual.

Surgical Margins of the Primary Site

(NAACCR Item #1320) (STORE pages 176-177) (SEER page 186-187)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Scope of Regional Lymph Node Surgery

(NAACCR Item #1292) (STORE page 178-183) (SEER pages 188-191)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Examples:

- Patient has a sentinel node biopsy of a single lymph node. **Assign code 2 (Sentinel lymph node biopsy [only]).**
- Local excision of breast cancer. Specimen includes an intra-mammary lymph node. **Assign code 4 (One to three regional lymph nodes removed).**
- Patient has excision of a positive cervical node. The pathology report from a subsequent node dissection identifies three cervical nodes. **Assign code 5 (Four or more regional lymph nodes removed).**
- Patient has a Cystoprostatectomy and pelvic lymph node dissection for bladder cancer. Pathology identifies prostate cancer as well as the bladder cancer and 4/21 nodes positive for metastatic adenocarcinoma. **Code Scope of Regional Lymph Node Surgery to 5 (Four or more regional lymph nodes removed) for both primaries.**
- Patient has a radical neck dissection and the number of lymph nodes removed is not stated. **The appropriate code would be 3.**
- 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.**
- 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.**

Scope of Regional Lymph Node Surgery at This Facility

(NAACCR Item #672) (STORE pages 184-188)

Instructions

1. The scope of regional lymph node surgery is collected for each surgical event even if surgery of the primary site was not performed.
2. If a surgical procedure which aspirates, biopsies, or removes regional lymph nodes to diagnose or stage this cancer, record the scope of regional lymph nodes surgery in this data item. Record the date of this surgical procedure in data item Date of First Course of Treatment [1270] and/or Date of First Surgical Procedure [1200] as appropriate (excluding code 1).
3. Record the date of this procedure in Date of Sentinel Lymph Node Biopsy [832] or Date Regional Lymph Node Dissection [682], if applicable.
4. Codes 0–7 are hierarchical. If only one procedure can be recorded, code the procedure that is numerically higher.
    a. If two or more surgical procedures of regional lymph nodes are performed, the codes entered in the registry for each subsequent procedure must include the cumulative effect of all preceding procedures. For example, a sentinel lymph node biopsy followed by a regional lymph node dissection at a later time is coded 7. Do not rely on registry software to determine the cumulative code.
5. Code 9 for:
    a. Any Schema ID with primary site: C420, C421, C423, C424, C589, C700-C709, C710-C729, C751-C753, C761-C768, C770-C779, C809.
6. Do not code distant lymph nodes removed during surgery to the primary site for this data item. They are coded in the data field Surgical Procedure/Other Site [1294].
7. Refer to the current AJCC Cancer Staging Manual for site-specific identification of regional lymph nodes or EOD 2018.
8. If the procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item Palliative Care at This Facility [3280] (if your facility collects this data item).

***Note*:** One important use of registry data is the tracking of treatment patterns over time. In order to compare contemporary treatment with previously published treatment based on former codes, or to data unmodified from pre-1998 definitions, the ability to differentiate surgeries in which four or more regional lymph nodes are removed is desirable. However, it is very important to note that the distinction between codes 4 and 5 is made to permit comparison of current surgical procedures with procedures coded in the past when the removal of fewer than four lymph nodes was not reflected in surgery codes. It is not intended to reflect clinical significance when applied to a particular surgical procedure. It is important to avoid inferring, by data presentation or other methods, that one category is preferable to another within the intent of these items.

Scope of Reg Ln Surgery Codes at this Facility

The following instructions should be applied to all surgically treated cases for all types of cancers. It is important to distinguish between sentinel lymph node biopsies (SLNBx) and more extensive dissection of regional lymph nodes.

Scope of Reg Ln Surgery Codes at this Facility Instructions

Code	Description	General Instructions	Additional Notes Specific To Breast (C50.X)
		Use the operative report as the primary source document to determine whether the operative procedure was a SLNBx, or a more extensive dissection of regional lymph nodes, or a combination of both SLNBx and regional lymph node dissection. The operative report will designate the surgeon's planned procedure as well as a description of the procedure that was actually performed. The pathology report may be used to complement the information appearing in the operative report, but the operative report takes precedence when attempting to distinguish between SLNBx and regional lymph node dissection or a combination of these two procedures. Do not use the number of lymph nodes removed and pathologically examined as the sole means of distinguishing between a SLNBx and a regional lymph node dissection.	Use the operative report as the primary source document to determine whether the operative procedure was a SLNBx, an axillary lymph node dissection (ALND), or a combination of both SLNBx and ALND. The operative report will designate the surgeon's planned procedure as well as a description of the procedure that was actually performed. The pathology report may be used to complement the information appearing in the operative report, but the operative report takes precedence when attempting to distinguish between SLNBx and ALND, or a combination of these two procedures. Do not use the number of lymph nodes removed and pathologically examined as the sole means of distinguishing between a SLNBx and an ALND.

Code	Description	General Instructions	Additional Notes Specific To Breast (C50.X)
0	None	No regional lymph node surgery.	
1	Biopsy or aspiration of regional lymph node(s), NOS	Review the operative report of to confirm whether an excisional biopsy or aspiration of regional lymph nodes was actually performed, and it did not include the use of dye or tracer for a SLNBx procedure (coded 2). If additional procedures were performed on the lymph nodes, use the appropriate code 2-7.	Excisional biopsy or aspiration of regional lymph nodes for breast cancer is uncommon. Review the operative report of to confirm whether an excisional biopsy or aspiration of regional lymph nodes was actually performed; it is highly possible that the procedure is a SLNBx (code 2) instead. If additional procedures were performed on the lymph nodes, such as axillary lymph node dissection, use the appropriate code 2-7.

Code	Description	General Instructions	Additional Notes Specific To Breast (C50.X)
2	Sentinel lymph node biopsy (only)	• The operative report states that a SLNBx was performed. • Code 2 SLNBx when the operative report describes a procedure using injection of a dye, radio label, or combination to identify a lymph node (possibly more than one) for removal/examination. • When a SLNBx is performed, additional non-sentinel nodes can be taken during the same operative procedure. These additional non-sentinel nodes are palpably abnormal and selectively removed (or harvested) as part of the SLNBx procedure by the surgeon or may be discovered by the pathologist. Code this as a SLNBx (code 2). If review of the operative report confirms that a regional lymph node dissection followed the SLNBx, code these cases as 6.	• If a relatively large number of lymph nodes, more than 5, are pathologically examined, review the operative report to confirm the procedure was limited to a SLNBx and did not include an ALND. • Infrequently, a SLNBx is attempted and the patient fails to map (i.e. no sentinel lymph nodes are identified by the dye and/or radio label injection) and no sentinel nodes are removed. Review the operative report to confirm that an axillary incision was made and a node exploration was conducted. Patients undergoing SLNBx who fail to map will often undergo ALND. Code these cases as 2 if no ALND was performed, or 6 when ALND was performed during the same operative event. Enter the appropriate number of nodes examined and positive in the data items Regional Lymph Nodes Examined [830] and Regional Lymph Nodes Positive [820].

Code	Description	General Instructions	Additional Notes Specific To Breast (C50.X)
Codes 3 – 5 are used for regional lymph node dissection/removal; these do NOT include SLNBx.			
3	Number of regional lymph nodes removed unknown or not stated; regional lymph nodes removed, NOS	The operative report states that a regional lymph node dissection was performed (a SLNBx was not done during this procedure or in a prior procedure). • Code 3 (Number of regional lymph nodes removed unknown, not stated; regional lymph nodes removed, NOS). Check the operative report to ensure this procedure is not a SLNBx only (code 2), or a SLNBx with a regional lymph node dissection (code 6 or 7). • Code 4 (1-3 regional lymph nodes removed) should be used infrequently. Review the operative report to ensure the procedure was not a SLNBx only. • Code 5 (4 or more regional lymph nodes removed). If a relatively small number of nodes 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).	Generally, ALND removes at least 7-9 nodes. However, it is possible for these procedures to remove or harvest fewer nodes. Review the operative report to confirm that there was not a SLNBx in addition to a more extensive regional lymph node dissection during the same procedure (code 6 or 7).
4	1–3 regional lymph nodes removed		

Code	Description	General Instructions	Additional Notes Specific To Breast (C50.X)
5	4 or more regional lymph nodes removed	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.	

Code	Description	General Instructions	Additional Notes Specific To Breast (C50.X)
6	Sentinel lymph node biopsy and code 3, 4, or 5 at same time, or timing not stated	• SNLBx and regional lymph node dissection (code 3, 4, or 5) during the same surgical event, or timing not known. • Generally, SLNBx followed by a regional lymph node completion will yield a relatively large number of nodes. However, it is possible for these procedures to harvest only a few nodes. • If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only. • Infrequently, a SNLBx is attempted and the patient fails to map (i.e. no sentinel lymph nodes are identified by the dye and/or radio label injection.) When mapping fails, the surgeon usually performs a more extensive dissection of regional lymph nodes. Code these cases as 6.	• SLNBx and regional lymph node dissection (code 3, 4, or 5) during the same surgical event, or timing not known. Generally, look for a report to the Operating Room (OR) by the pathologist on the SLNBx results prior to the regional node dissection. If the SLNBx shows positive nodes, then a dissection may be done. If the nodes are negative, it is rare that a node dissection is performed. • Generally, SLNBx followed by ALND will yield a minimum of 7-9 nodes. However, it is possible for these procedures to harvest fewer (or more) nodes. • If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx, or whether a SLNBx plus an ALND was performed.

Code	Description	General Instructions	Additional Notes Specific To Breast (C50.X)
7	Sentinel node biopsy and code 3, 4, or 5 at different times	• SNLBx and regional lymph node dissection (code 3, 4, or 5) in separate surgical events. • Generally, SLNBx followed by regional lymph node completion will yield a relatively large number of nodes. However, it is possible for these procedures to harvest only a few nodes. • If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only.	• Generally, SLNBx followed by ALND will yield a minimum of 7-9 nodes. However, it is possible for these procedures to harvest fewer (or more) nodes. • If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only, or whether a SLNBx plus an ALND was performed.
9	Unknown or not applicable	• The status of regional lymph node evaluation should be known for surgically treated cases (i.e., cases coded 19-90 in the data item *Surgery of Primary Site* [NAACCR Item #1290]). Review surgically treated cases coded 9 in *Scope of Regional Lymph Node Surgery* to confirm the code.	

Date of Sentinel Lymph Node Biopsy

(NAACCR Item #832) (STORE page 104) (SEER page 192)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Note: This data item is required for breast and cutaneous melanoma cases only

Sentinel Lymph Nodes Positive

(NAACCR Item #835) (STORE pages 107-108) (SEER pages 194-195)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Sentinel Lymph Nodes Examined

(NAACCR Item #834) (STORE pages 105-106) (SEER page 193)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Date of Regional Lymph Node Dissection

(NAACCR Item #682) (STORE page 109) (SEER page 196)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Regional Nodes Positive

(NAACCR item # 820) (STORE pages 112-113) (SEER page 197-199)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Note: When definition of regional nodes differs between the *AJCC Cancer Staging Manual* and the *SEER Program Coding and Staging Manual*, use the AJCC definition.

Regional Nodes Examined

(NAACCR Item # 830) (STORE pages 110-111) (SEER pages 200-202)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Note: When definition of regional nodes differs between the *AJCC Cancer Staging Manual* and the *SEER Program Coding and Staging Manual*, use the AJCC definition.

Surgical Procedure of Other Site

(NAACCR Item #1294) (STORE pages 189-190) (SEER pages 203-204)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Examples:

- The incidental removal of the appendix during a surgical procedure to remove a primary malignancy in the right colon is **coded to 0**.
- Surgical biopsy of metastatic lesion from liver with an unknown primary is **coded to 1**.
- Surgical ablation of solitary liver metastasis with a hepatic flexure primary is **coded to 2 (Site regional by stage).**
- Excision of distant metastatic lymph nodes with a rectosigmoid primary is **coded to 3**.
- Removal of a solitary brain metastasis with a lung primary is **coded to 4 (Site distant by stage).**
- Excision of a solitary liver metastasis and hilar lymph node with a rectosigmoid primary is **coded to 5.**

Surgical Procedure/Other Site at This Facility

(NAACCR Item #674) (STORE page 191-192)

Coding Instructions

1. If other tissue or organs are removed during primary site surgery that are not specifically defined by the site-specific Rx Hosp – Surg 2023 [1291] or Rx Summ -Surg 2023[671] code, assign the highest numbered code that describes the surgical resection of other tissue or organs beyond the primary site surgical code.
2. Assign the highest numbered code that describes the surgical resection of other tissue or organs beyond the primary site surgical code.
3. Assign the highest numbered code that describes the surgical resection of distant lymph node(s).
4. Incidental removal of tissue or organs is not a “Surgical Procedure/Other Site.”
5. If multiple first course surgical procedures coded in this item are performed for a single primary, the code should represent the cumulative effect of those surgeries. Do not rely on registry software to perform this task for you.
6. Surgical Procedure/Other Site is collected for each surgical event even if surgery of the primary site was not performed.

7. Code 1 for:
    a. Any case coded to primary site C420, C421, C423, C424 C760-C768, C770-C779, C809 Excluding cases coded to the Cervical Lymph Nodes and Unknown Primary 00060.
8. If the procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item Palliative Care at This Facility [3280].

RX Summ - Surg Other Reg/Dist RX Codes

Code	Description	Definition
0	None	No non-primary surgical site resection 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.
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 (DCO) cases.

Reason for No Surgery of Primary Site

(NAACCR Item #1340) (STORE pages 196-197) (SEER pages 205-207)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Examples:

- 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.**
- 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 Text Surgery

(NAACCR Item #2610)

1. For data item description, coding instructions, and examples refer to Documentation Chapter of the 2025 Cancer Reporting Guide. **Refer to 2025 NAACCR Data Dictionary for list of data items to be verified by the text fields.**

Date Radiation Started

(NAACCR Item #1210) (STORE page 199) (SEER page 208)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Radiation Primary Treatment Volume - Phase I, II, III

(NAACCR # 1504, 1514, 1524) (STORE pages 202-207)

Coding Instructions

1. Phase I [1504] data item should be used to indicate the primary target volume, which is typically the primary tumor or tumor bed. If the primary tumor or primary tumor bed was not targeted, record the other regional or distant site that was targeted.
2. Subsequent phase may be referred to as a boost or cone down and would be recorded in fields with subsequent phases recorded as Phase II [1514], Phase III [1524], etc. accordingly.
3. Draining lymph nodes may also be concurrently targeted most commonly during the first phase. Whether draining lymph nodes were targeted and which ones were targeted will be identified in a separate data item Phase I-II-III Radiation to Draining Lymph Nodes [1505, 1515, 1525].
4. When the primary volume is a lymph node region, draining lymph nodes are not targeted. Record code 88 in the Phase I-II-III Radiation to Draining Lymph Nodes [1505, 1515, 1525] when primary volume is a lymph node region. Use codes 01 to 09 only when the lymph nodes are the primary target (for example, in lymphomas).
5. Note that for many of the treatment volumes, the same code should be used when the anatomic structure is targeted or when the surgical bed of the resected anatomical structure is targeted. For example, when prostate cancer is treated with radiation alone, code 64 will be the Primary Treatment Volume. Similarly, when prostate cancer is treated with radiation after radical prostatectomy, code 64 will be the Primary Treatment Volume. **There is an exception to the rule for breast cancer.** In patients with breast cancer, code 41 (Breast- partial) in patients who have had a lumpectomy and were treated with partial breast irradiation (sometimes called accelerated partial breast irradiation (APBI)), code 40 (Breast – whole) in patients who had a lumpectomy and whole breast radiation, and code 42 (chest wall) in patients who had a mastectomy and post-mastectomy radiation.

6. A new paradigm of treatment called on-line adaptive (or on-table adaptive) radiation may be a source of confusion when coding the Primary Treatment Volume. New linear accelerators may now be attached to such high-quality imaging devices that they can function as both simulation scanners for planning and radiation delivery systems. If a new radiation plan is created while the patient is on the radiation delivery table to take into account that day's anatomy, this is referred to "on-line" or "on- table" adaptive radiation. If a new radiation plan is created while the patient is not on the delivery table, then it is referred to as "off-line" or "off-table" adaptive therapy. Off-line adaptive therapy treatments are relatively common, but MR-guided and CT-guided on-line adaptive therapy treatments are just emerging. In adaptive therapy, new radiation plans are created to account for changes in the position or shape of a target volume, but this does NOT mean that there has been a change in "phase". When the adaptive therapy paradigm is being used, a new phase should be documented only when there has been a change in the conceptual anatomic target volume (for example, a change from whole prostate to partial prostate) or if there has been a change in the draining lymph node target, dose per fraction, modality, or planning technique.
7. **Code 00 if patient received no radiation treatment and complete all phase I radiation treatment data items.**
8. Code 00 if the tumor was diagnosed at autopsy.
9. Code 99 if diagnosis was by death certificate only.
10. **If the patient received just one phase of treatment, code the Phase II Radiation Treatment Volume to "00" (No treatment). All other Phase II and Phase III data fields should be left blank.**
11. **If the patient received just two phases of treatment, code the phase I and II Radiation Treatment Volume. Phase III Radiation Treatment Volume to "00" and leave all other Phase III data fields blank.**

Radiation Codes

Code	Label	Definition
00	No radiation treatment	Radiation therapy was not administered to the patient. Diagnosed at autopsy.
01	Neck lymph node regions	The primary treatment is directed at lymph node regions of the neck. Example situations include treatment of lymphoma or lymph node recurrence (in the absence of primary site failure) following definitive surgery of the primary tumor. If radiation to the neck lymph nodes includes the supraclavicular region use code 03.

Code	Label	Definition
02	Thoracic lymph node regions	Radiation therapy is directed to one or some combination of hilar, mediastinal, and supraclavicular lymph node regions without concurrent treatment of a visceral organ site. Example situations include treatment of lymphatic recurrence after complete surgical excision of a thoracic primary. Note that the supraclavicular region may be part of a head and neck lymph node region. Use code 03 for treatments directed at neck nodes and supraclavicular nodes with a head and neck primary. Use code 04 if supraclavicular lymph nodes are part of breast treatment.
03	Neck and thoracic lymph node regions	Treatment is directed to lymph nodes in the neck and thoracic region without concurrent treatment of a primary visceral tumor. This code might apply to treatments for lymphatic recurrences following definitive treatment for tumors of the head and neck or thoracic regions.
04	Breast/Chest wall lymph node regions	Radiation is directed primarily to one or some combination of axillary, supraclavicular, and/or internal mammary lymph node regions WITHOUT concurrent treatment of the breast or chest wall. If the breast AND lymph nodes are being treated, then code the Primary Treatment Volume to Breast (codes 40 or 41) and Breast/chest wall lymph nodes (code 04) in Radiation to Draining Lymph Nodes.
05	Abdominal lymph nodes	Treatment is directed to one or some combination of the lymph nodes of the abdomen, including retro-crural, peri-gastric, peri-hepatic, portocaval, and paraaortic node regions. Possible situations might include seminoma, lymphoma or lymph node recurrence following surgical resection of the prostate, bladder, or uterus. If field or target is described as hockey stick, dog leg, and inverted Y then use code 07.
06	Pelvic lymph nodes	Treatment is directed to one or some combination of the lymph nodes of the pelvis, including the common, internal and external iliac, obturator, inguinal, and peri-rectal lymph nodes. This might be done for lymphoma or lymph node recurrence following definitive surgery for a pelvic organ.

Code	Label	Definition
07	Abdominal and pelvic lymph nodes	Treatment is directed to a combination of lymph nodes in both the abdomen and pelvis. This code includes extended fields ("hockey stick", "dog-leg", "inverted Y", etc.) utilized to treat seminomas and lymphomas or recurrence of a solid tumor.
09	Lymph node region, NOS	This category should be used to code treatments directed at lymph node regions that are not adequately described by codes 01-07.
10	Eye/orbit/optic nerve	Treatment is directed at all or a portion of the eye, orbit, and/or optic nerve.
11	Pituitary	Treatment is directed at the pituitary gland.
12	Brain	Treatment is directed at all the brain and its meninges ("Whole brain").
13	Brain (limited)	Treatment is directed at one or more sub-sites of the brain but not the whole brain. Chart may describe "SRS", "Stereotactic Radiosurgery", "Gamma Knife®". Use code 13 when primary tumor volume is brain stem.
14	Spinal cord	Treatment is directed at all or a portion of the spinal cord or its meninges.
20	Nasopharynx	Treatment is directed at all or a portion of the nasopharynx.
21	Oral cavity	Treatment is directed at all or a portion of the oral cavity, which may include the lips, gingiva, alveolus, buccal mucosa, retromolar trigone, hard palate, floor of mouth, and/or oral tongue.
22	Oropharynx	Treatment is directed at all or a portion of the oropharynx, including the soft palate, tonsils, base of tongue, and pharyngeal wall.
23	Larynx (glottis) or hypopharynx	Treatment is directed at all or a portion of the larynx and/or hypopharynx.
24	Sinuses/Nasal tract	Treatment is directed at all or a portion of the sinuses and nasal tract, including the frontal, ethmoid, sphenoid, and maxillary sinuses.
25	Parotid or other salivary glands	Treatment is directed at the parotid or other salivary glands, including the submandibular, sublingual, and minor salivary glands.

Code	Label	Definition
26	Thyroid	Treatment is directed at all or a portion of the thyroid. Code 98 when the thyroid is treated with I-131 radioisotope.
29	Head and neck (NOS)	The treatment volume is directed at a primary tumor of the head and neck, but the primary sub-site is not a head and neck organ identified by codes 20-26 or it is an "unknown primary". Use code 29 when the Primary Tumor Volume is Paraganglioma of the jugular foramen in the middle ear.
30	Lung or bronchus	Treatment is directed at all or a portion of the lung or bronchus.
31	Mesothelium	Treatment is directed to all or a portion of the mesothelium. This code should be used for mesothelioma primaries, even if a portion of the lung is included in the radiation field.
32	Thymus	Treatment is directed to all or a portion of the thymus.
39	Chest/lung (NOS)	The treatment is directed at a primary tumor of the chest, but the primary subsite is unknown or not identified in codes 30-32. For example, this code should be used for sarcomas arising from the mediastinum.
40	Breast – whole	Treatment is directed at all the intact breast. Intact breast includes breast tissue that either was not surgically treated, received a lumpectomy, or partial mastectomy.
41	Breast – partial	Treatment is directed at a portion of the intact breast but not the whole breast. The chart may have terms such as "Mammosite", "interstitial (seed implant)", or "(accelerated) partial breast irradiation". Consider the possibility of partial breast irradiation when Intensity-Modulated Radiation Therapy or "IMRT" is documented in the record.
42	Chest wall	Treatment encompasses the chest wall (following mastectomy).
50	Esophagus	Treatment is directed at all or a portion of the esophagus. Include tumors of the gastro-esophageal junction.
51	Stomach	Treatment is directed at all or a portion of the stomach.
52	Small bowel	Treatment is directed at all or a portion of the small bowel.

Code	Label	Definition
53	Colon	Treatment is directed at all or a portion of the colon.
54	Rectum	Treatment is directed at all or a portion of the rectum.
55	Anus	Treatment is directed at all or a portion of the anus.
56	Liver	Treatment is directed at all or a portion of the liver.
57	Biliary tree or gallbladder	Treatment is directed at all or a portion of the biliary tree or gallbladder.
58	Pancreas or hepatopancreatic ampulla	Treatment is directed at all or a portion of the pancreas or the hepatopancreatic ampulla. Hepatopancreatic ampulla tumors are sometimes referred to as periampullary tumors.
59	Abdomen (NOS)	The treatment volume is directed at a primary tumor of the abdomen, but the primary sub-site is not an abdominal organ defined by codes 50-58 or it is considered to be an "unknown primary". For example, this code should be used for sarcomas arising from the abdominal retroperitoneum.
60	Bladder – whole	Treatment is directed at all the bladder.
61	Bladder – partial	Treatment is directed at a portion of the bladder, but not the whole bladder.
62	Kidney	Treatment is directed at all or a portion of the kidney.
63	Ureter	Treatment is directed at all or a portion of the ureter.
64	Prostate – whole	Treatment is directed at all of the prostate with/without all or part of the seminal vesicles. Use this code even if seminal vesicles are not explicitly targeted.
64	Prostate – partial	Treatment is directed at a portion of the prostate, but not the whole prostate.
66	Urethra	Treatment is directed at all or a portion of the urethra.
67	Penis	Treatment is directed at all or a portion of the penis. Treatments of urethral primaries should be coded as ‘urethra’ (code 66).
68	Testicle or scrotum	Treatment is directed at all or a portion of the testicle and/or scrotum.
70	Ovaries or fallopian tubes	Treatment is directed at all or a portion of the ovaries or fallopian tubes.
71	Uterus or cervix	Treatment is directed at all or a portion of the uterus, endometrium, cervix, or parametrium.

Code	Label	Definition
72	Vagina	Treatment is directed at all or a portion of the vagina. Treatments of urethral primaries should be coded as 'urethra' (code 66).
73	Vulva	Treatment is directed at all or a portion of the vulva. Treatments of urethral primaries should be coded as 'urethra' (code 66).
80	Skull	Treatment is directed at all or a portion of the bones of the skull. Any brain irradiation is a secondary consequence.
81	Spine/vertebral bodies	Treatment is directed at all or a portion of the bones of the spine/vertebral bodies, including the sacrum. Spinal cord malignancies should be coded using 'spinal cord' (code 14).
82	Shoulder	Treatment is directed to all or a portion of the proximal humerus, scapula, clavicle, or other components of the shoulder complex.
83	Ribs	Treatment is directed at all or a portion of one or more ribs.
84	Hip	Treatment is directed at all or a portion of the proximal femur or acetabulum.
85	Pelvic bones	Treatment is directed at all or a portion of the bones of the pelvis other than the hip or sacrum.
86	Pelvis (NOS, non-visceral)	The treatment volume is directed at a primary tumor of the pelvis, but the primary sub-site is not a pelvic organ or is not known or indicated. For example, this code should be used for sarcomas arising from non-visceral soft tissues of the pelvis.
88	Extremity bone, NOS	Treatment is directed at all or a portion of the bones of the arms or legs. This excludes the proximal femur (Hip, code 84). This excludes the proximal humerus (Shoulder, code 82).
90	Skin	Treatment is directed at all or a portion of the skin. The primary malignancy originates in the skin and the skin is the primary target. So-called skin metastases are usually subcutaneous and should be coded as a soft tissue site.
91	Soft tissue	This category should be used to code primary or metastatic soft tissue malignancies when localizing to a region of the body (e.g. pelvis) is not possible or when

Code	Label	Definition
		the case does not fit other categories.
92	Hemibody	A single treatment volume encompassing either all structures above the diaphragm or all structures below the diaphragm. This is almost always administered for palliation of widespread bone metastasis in patients with prostate or breast cancer.
93	Whole body	Treatment is directed to the entire body included in a single treatment, for example as with total body irradiation (TBI).
94	Mantle, mini-mantle (obsolete after 2017)	For conversion of historical data only.
95	Lower extended field (obsolete after 2017)	For conversion of historical data only.
96	Inverted Y (obsolete after 2017)	For conversion of historical data only.
97	Invalid historical Facility Oncology Registry Data Standards (FORDS) value	Conversion to new STORE data item could not take place due to an invalid FORDS Volume code.
98	Other	Radiation therapy administered; treatment volume other than those previously categorized by codes 01-93. For example, code 98 when the radioisotope I-131 is used in the treatment of thyroid cancer.
99	Unknown	This category should be used to code treatments for which there is no information available about the treatment volume or it is unknown if radiation treatment was administered.

Examples:

- An elderly man with mild fatigue is found to have an elevated lymphocyte count on CBC. Bone marrow biopsy in your facility confirms a diagnosis of chronic lymphocytic leukemia. Physician and patient agree that no treatment is indicated at this time. **Record Phase I Radiation Primary Treatment Volume as 00 (No radiation treatment).**
- A man with prostate cancer and status post radical prostatectomy is treated with SBRT, 3500cGy in five fractions to the right seminal vesicle. **Record Phase I Radiation Primary Treatment Volume as 98 because there is no specific code for seminal vesicles**.
- A woman with advanced multiple myeloma is referred for total body irradiation and is treated twice daily for three consecutive days in a total body stand at extended distance with open

rectangular photon fields, 200cGy to mid-body per treatment. **Record Phase I Radiation Primary Treatment Volume as 93 (Whole body).**

Radiation to Draining Lymph Nodes Phase I, II, III

(NAACCR # 1505, 1515, 1525) (STORE pages 208-209)

Coding Instructions

1. When the primary volume is lymph nodes, draining lymph nodes are not targeted. Record code 88 in the Phase I-II-III Radiation to Draining Lymph Nodes [1505,1515,1525]. Use codes 01 to 09 only when the lymph nodes are the primary target, for example, in lymphomas.
2. Code 00 if the tumor was diagnosed at autopsy.
3. Code 99 if diagnosis was by DCO.
4. Phase II and III radiation treatment includes primary tumor or tumor bed in addition to the draining lymph node regions that are associated with the primary tumor or tumor bed. The primary tumor or tumor bed is recorded in the Phase II-III Radiation Primary Treatment Volume [1514, 1524].
5. ***Note:*** When the Phase II Primary Treatment Volume is lymph nodes, draining lymph nodes are not targeted. Record code 88 in this data item.
6. Blanks allowed only for Phase II or III if no radiation treatment administered.

Radiation to Draining Lymph Nodes Phase I, II, III Codes

Code	Label
00	No radiation treatment to draining lymph nodes. Diagnosed at autopsy.
01	Neck lymph node regions.
02	Thoracic lymph node regions.
03	Neck and thoracic lymph node regions.
04	Breast/chest wall lymph node regions.
05	Abdominal lymph nodes.

Code	Label
06	Pelvic lymph nodes.
07	Abdominal and pelvic lymph node regions.
08	Lymph node regions, NOS.
88	Not applicable; Phase I Radiation Primary Treatment Volume is lymph nodes.
99	Unknown if any radiation treatment to draining lymph nodes; Unknown if radiation treatment administered.

Examples:

- A patient with breast cancer was treated with whole breast RT, 5040cGy in 28 fractions. Axillary and supraclavicular nodes treated concurrently with an anterior field covering both regions and a PAB added to the axilla. The medial portion of the anterior field was blocked for the last three treatments to hold the supraclavicular region to a maximum of 4500cGy to minimize the risk of brachial plexus injury. Subsequently, the surgical bed received an electron boost of 1000cGy in 5 fractions using fields shaped to surround surgical bed with 1.5 cm margins. **Record the Phase I Radiation to Draining Lymph Nodes as 04 (Breast/Chest wall lymph node regions).**
- A patient with a left supraclavicular metastasis from a gastric carcinoma received 6,000cGy to the left supraclavicular region. **Record the Phase I Radiation to Draining Lymph Nodes as 88 because Phase I Radiation Primary Treatment Volume is lymph nodes.**
- Prostate cancer patient declines surgery for management of his prostate cancer and opts for EBRT. The treatment summary states that pelvis/prostate were targeted on phase 1 with 180cGy X 25 fx = 45Gy. **Record Phase I Radiation to Draining Lymph Nodes as 06 because when the pelvis is specifically mentioned in the treatment summary, we can assume that regional lymph nodes were targeted.**

Radiation Treatment Modality - Phase I, II, III

(NAACCR Item #1506, 1516, 1526) (STORE pages 210-211) (SEER page 209)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

External Beam Radiation Planning Technique - Phase I, II, III

(NAACCR Item 1502, 1512, 1522) (STORE pages 212-215) (SEER pages 210-212)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Dose per Fraction - Phase I, II, III

(NAACCR Item #1501, 1511, 1521) (STORE pages 216-217)

Coding Instructions

1. In general, phase dose per fraction X phase number of fractions = phase total dose; but there may be inconsistencies in rounding of dose or the way the dose is automatically measured in a treatment, which will result in slight inconsistencies in the math. That is, in some radiation treatment summaries, phase dose per fraction X phase number of fractions ≈ phase total dose.
2. For proton treatment, dosage may occasionally be specified as in Cobalt Gray Equivalent (CGe) units rather than Gy or cGy. 1 CGE = 1 Gy = 100 cGy. For a Phase Total Dose, you would need to multiply dose in CGE by 100 to get dose in cGy.
3. Note that dose is still occasionally specified in "rads". One (1) rad = 1 cGy.
4. If dose is documented in the medical record and includes a fraction of a cGy (e.g. 180.3), round to the nearest cGy. For example, 180.5 cGy should be rounded up to 181 cGy and 180.4 cGy should be rounded down to 180 cGy.
5. Code 99998 when radioisotopes were administered to the patient (codes 13-16) for Phase I-I-III Radiation Treatment Modality [1506, 1516, 1526].
6. Code the actual cGy if available when brachytherapy was administered to the patient (codes 07-12 for Phase I-II-III Treatment Modality [1506, 1516, 1526]). If the dose is not available/provided in cGy for a brachytherapy procedure, code 99999.
7. Record the actual dose delivered (NOT the initially prescribed dose) as documented in the treatment summary.
8. Code 00000 when diagnosed at autopsy.
9. Code 99999 if diagnosis was by DCO.

Dose per Fraction Phase I, II, III Codes

Code	Label
00000	No radiation treatment.
00001-99997	Record the actual Phase I dose delivered in cGy.
99998	Not applicable, radioisotopes administered to the patient.

Code	Label
99999	Regional radiation therapy was administered but dose is unknown; Unknown whether radiation therapy was administered; DCO.

Examples:

- A patient with Stage III prostate carcinoma received pelvic irradiation to 5,000cGy over 25 fractions followed by a Phase II (boost) prostate irradiation to 7,000 cGy**. Record the Phase I dose per fraction as 00200 (5000/25).**
- A patient with a left supraclavicular metastasis from a gastric carcinoma received 6,000 cGy to the left supraclavicular region over 40 fractions. The dose is calculated at the prescribed depth of 3 cm. A secondary calculation shows a Dmax dose of 6,450 cGy. **Record the Phase I dose per fraction as 00150 (6000/40).** Note that deposited radiation dose in the body is 3 dimensional and will vary slightly at any point in the body. Unfortunately, we can't capture this complexity, so we attempt to capture the nominal prescription dose as indicative of the three-dimensional dose.
- A patient with breast cancer was treated with whole breast RT, 5040 cGy in 28 fractions, but axillary and supraclavicular nodes treated concurrently with an anterior field covering both regions and a posterior field (PAB) added to the axilla. The medial portion of the anterior field was blocked for the last three treatments to hold the supraclavicular region to a maximum of 4500cGy to minimize the risk of brachial plexus injury. Subsequently, the surgical bed received an electron boost of 1000cGy in 5 fractions using fields shaped to surround surgical bed with 1.5 cm margins. **Record phase I dose per fraction as 00180 (4500/25).** See a detailed discussion of this example in the *"CTR Guide to Coding Radiation Therapy Treatment in the STORE"*.

Number of Fractions - Phase I, II, III

(NAACCR # 1503, 1513, 1523) (STORE pages 218-219)

Coding instructions

1. A fraction is a session during which radiation was delivered. The number of beams is independent from the number of fractions. If several beam positions were delivered in a session, it is still only considered one fraction (session).
2. Multiple fractions may be delivered in a single day. This may be documented as BID treatment or twice daily treatment. Usually, multiple fractions in a single day are separated by at least four hours.
3. Count each separate administration of brachytherapy, implant, or radioisotope as a single fraction or treatment.
4. Record the actual number of fractions delivered (NOT initially prescribed) as documented in the treatment summary.
5. Code 000 when tumor is diagnosed at autopsy.

6. Code 999 for DCO cases.
7. **Phase I must be coded, however blanks are allowed for Phase II-III if no radiation treatment administered.**

Number of Fractions Phase I, II, III Codes

Code	Label
000	No radiation treatment.
001-998	Number of fractions administered to the patient during the first phase of radiation therapy.
999	Phase I Radiation therapy was administered, but the number of fractions is unknown; it is unknown whether radiation therapy was administered.

Examples:

- A patient with advanced head and neck cancer was treated using "hyperfractionation". Three fields were delivered in each session; two sessions were given each day, six hours apart, with each session delivering a total dose of 150 cGy. Treatment was given for a total of 25 days. The total course dose was 7500cGy. **Record 50 fractions as 050.**
- The patient was given Mammosite® brachytherapy, repeated in 10 separate sessions. **Record 10 fractions as 010.**
- Prostate cancer patient treated with a single administration of seeds. **Record 1 fraction as 001.**

Total Dose Phase I, II, III

(NAACCR # 1507, 1517, 1527) (STORE pages 220-221)

Coding instructions

1. Record the actual total dose delivered (NOT initially prescribed), as documented in the radiation treatment summary. The value recorded for this data item should NOT be auto calculated within the registry abstraction software. In general, Phase Dose per Fraction x Phase Number of Fractions = Phase Total Dose, but there may be inconsistencies in rounding of dose or the way the dose is automatically measured in a treatment which will result in slight inconsistencies in the math. That is, in some radiation treatment summaries, Phase Dose per Fraction x Phase Number of Fractions ≈ Phase Total Dose.
2. For proton treatment, dosage may occasionally be specified as in CGe units (Cobalt Gray Equivalent) rather than Gy or cGy. 1 CGE = 1 Gy = 100 cGy. For a Phase Total Dose, you would need to multiply dose in CGE by 100 to get dose in cGy.

3. Note that dose is still occasionally specified in “rads”. One (1) rad = 1cGy.
4. If dose is documented in the medical record and includes a fraction of a cGy (e.g. 180.3), round to the nearest cGy. For example, 180.5 cGy should be rounded up to 181 cGy and 180.4 cGy should be rounded down to 180 cGy. Code 99998 when radioisotopes were administered to the patient (codes 13-16 for Phase III-III Treatment Modality [1506, 1516, 1526]).
5. Code 000000, radiation therapy not administered, when diagnosed at autopsy.
6. Code 999998 when radioisotopes are administered to the patient (codes 13-16 recorded in the Phase I-II-II Treatment Modality [1506, 1516, 1526]).
7. Code the actual cGy if available when brachytherapy was administered to the patient (codes 07-12 for Phase I-II-III Treatment Modality [1506, 1516, 1526]). If only one fraction of brachytherapy was delivered, then the Phase I Dose per Fraction and the Phase I Total Dose will be the same.
8. Code 000000 when tumor is diagnosed at autopsy.
9. Code 999999 for DCO cases.
10. **Phase I must be coded, however blanks are allowed for Phase II-III if no radiation treatment was administered.**

Total Dose Phase I, II, III Codes

Code	Label
000000	No radiation treatment. Diagnosed at autopsy.
000001-999997	Record the actual total dose delivered in cGy.
999998	Not applicable, radioisotopes administered to the patient.
999999	Radiation therapy was administered, but the total dose is unknown; it is unknown whether radiation therapy was administered or diagnosed by DCO.

Examples:

- A patient with Stage III prostate carcinoma received pelvic irradiation of 5,000 cGy in 25 fractions during Phase I Radiation Treatment. **Record the Phase I Total Dose of 5,000 cGy as 005000.**
- A patient with a left supraclavicular metastasis from a gastric carcinoma received 6,000 cGy to the left supraclavicular region. **Record the Phase I Total Dose of 6,000 cGy as 006000**.
- A patient with breast cancer was treated with whole breast RT, 5040 cGy in 28 fractions, but axillary and supraclavicular nodes treated concurrently with an anterior field covering both

regions and a posterior field (PAB) added to the axilla. The medial portion of the anterior field was blocked for the last three treatments to hold the supraclavicular region to a maximum of 4500cGy to minimize the risk of brachial plexus injury. Subsequently, the surgical bed received an electron boost of 1000cGy in 5 fractions using fields shaped to surround surgical bed with 1.5 cm margins. **Record the Phase I Total Dose of 4500 cGy as 004500**. See a detailed discussion of this example in the "*CTR Guide to Coding Radiation Therapy Treatment in the STORE*".

Number of Phases of Radiation Treatment

(NAACCR # 1532) (STORE page 222)

Coding instructions

A course of radiation is made up of one or more phases and each phase reflects a distinct delivered prescription. STORE has fields for up to three phases of a radiation course to be documented. This field identifies the actual number of distinct radiation phases in a course so that it is clear when only a portion of the course is being captured in the phase summary sections.

1. Code 00 when case is diagnosed at autopsy.
2. Code 99 when case is a DCO case.

Number of Phases of Radiation Treatment Codes

Code	Label
00	No radiation treatment.
01-98	Record the actual number of phases in the radiation course.
99	Unknown number of phases; Unknown if radiation therapy administered.

Examples:

- Radiation therapy was not administered. **Record 00 for no radiation treatment.**
- A patient with advanced head and neck cancer was treated using "hyper-fractionation". Three fields were delivered in each session; two sessions were given each day, six hours apart, with each session delivering a total fractional dose of 150 cGy. Treatment was given for a total of 25 days. The total course dose was 7500cGy. **Record the Number of Phases of Radiation Treatment as 01.**
- A patient with breast cancer was treated with whole breast RT, 5040 cGy in 28 fractions, but axillary and supraclavicular nodes treated concurrently with an anterior field covering both regions and a posterior field (PAB) added to the axilla. The medial portion of the anterior field

was blocked for the last three treatments to hold the supraclavicular region to a maximum of 4500cGy to minimize the risk of brachial plexus injury. Subsequently, the surgical bed received an electron boost of 1000cGy in 5 fractions using fields shaped to surround surgical bed with 1.5 cm margins**. Record 03 as the Number of Phases of Radiation Treatment**. See a detailed discussion of this example in the *"CTR Guide to Coding Radiation Therapy Treatment in the STORE"*.

Radiation Treatment Discontinued Early

(NAACCR # 1531) (STORE pages 223-224)

Coding instructions

1. Use code 00 when tumor is diagnosed at autopsy.
2. Use code 01 when there is no indication in the record that radiation therapy was discontinued or completed early.
3. Use code 02-07 when there is an indication in the record that the radiation therapy discontinued or was completed early.
4. Use code 99 when radiation therapy was administered, but it is not clear if the treatment course was discontinued early, or if it is unknown whether radiation therapy was administered, or it is a DCO case.

Code	Description
00	No radiation treatment.
01	Radiation treatment completed as prescribed.
02	Radiation treatment discontinued early – toxicity.
03	Radiation treatment discontinued early – contraindicated due to other patient risk factors (comorbid conditions, advanced age, progression of tumor prior to planned radiation, etc.).
04	Radiation treatment discontinued early – patient decision.
05	Radiation discontinued early – family decision.
06	Radiation discontinued early – patient expired.

Code	Description
07	Radiation discontinued early – reason not documented.
99	Unknown if radiation treatment discontinued; unknown whether radiation therapy administered. DCO.

Examples:

- A patient with a metastasis from a gastric carcinoma at the L1 vertebral body was planned to receive 3000 cGy over 10 fractions. However, after five fractions, the patient developed cord compression symptoms and imaging evidence of compression and was taken for urgent surgical resection of the mass at L1. He did not resume radiotherapy. **Record Radiation Treatment Discontinued Early field as 03 because there was clear evidence of progression**.
- A patient with muscle-invasive bladder cancer was being treated with radiation to the whole bladder. The initial plan was to treat the whole bladder to 6480 cGy in 36 fractions but after 23 fractions he developed severe radiation enteritis and unrelenting diarrhea requiring a prolonged hospital admission. He discontinued treatment early after a total dose of 4140cGy. **Record Radiation Treatment Discontinued Early field as 02 because treatment was stopped early due to treatment toxicity.**

Radiation Course Total Dose

(NAACCR #1533) (STORE pages 225-226)

Alternate Name: Total Dose

Coding instructions

1. If the total dose for the course is not documented, then add the dose from each of the sequential phases (I, II, III, IV, or more) that target the same body site and document the total cumulative dose. Note when calculating the Radiation Course Total Dose, all of the phases should be used, not just the first three.
2. Doses should ONLY be summed across phases to create a Total Dose when all of the phases were delivered sequentially to the same body site. If phases were delivered to multiple body sites (e.g. simultaneous treatment to multiple metastatic sites), then code the Radiation Course Total Dose as the dose to the body site that received the highest dose.
3. Doses should ONLY be summed across phases to create a Total Dose when all of the phases were delivered using the same major modality type (External Beam, Brachytherapy, or Radioisotopes). If phases were delivered using two or more major different modalities (e.g. external beam and brachytherapy to the same body site), then code 999998, Not applicable.
4. Doses can be summed across phases even if the fraction size of phases is different. That is, if Phase I to the whole prostate and seminal vesicles is 180 cGy x 28 =5040 cGy, Phase II to a partial prostate volume is 200 cGy x 15 = 3000cGy, and these phases are delivered sequentially, then record 8040 cGy as the Radiation Course Total Dose.

5. For proton treatment, dosage may occasionally be specified as in CGe units (Cobalt Gray Equivalent) rather than Gy or cGy. 1 CGE = 1 Gy = 100 cGy. For a Radiation Course Total Dose, you would need to multiply dose in CGE by 100 to get dose in cGy.
6. Note that dose is still occasionally specified in "rads". One (1) rad = 1cGy.
7. If dose is documented in the medical record and includes a fraction of a cGy (e.g. 180.3), round to the nearest cGy. For example, 180.5 cGy should be rounded up to 181 cGy and 180.4 cGy should be rounded down to 180cGy. A dose of Code 999998 when radioisotopes were administered to the patient (codes 13-16 for Phase I Treatment Modality [1506]).
8. Code 000000 when tumor was diagnosed at autopsy.
9. Code 999998 when radioisotopes are administered to the patient (codes 13-16 recorded in the Phase I, Phase II, or Phase III Treatment Modality [1506, 1516, 1526] data items).
10. Code 999999 when it is a Death Certificate Only case.
11. Code the actual cGy if available when brachytherapy was administered to the patient (codes 07-12 for Phase I Treatment Modality [1506]).

Code	Description
000000	No radiation treatment. Diagnosed at autopsy.
000001-999997	Record the actual dose delivered in cGy.
999998	Not applicable, radioisotopes administered to the patient, or the patient was treated with a mixed modality (e.g. external beam and brachytherapy).
999999	Radiation therapy was administered, but the total dose is unknown; it is unknown whether radiation therapy was administered.

Examples:

- A patient with breast cancer was treated with whole breast RT, 5040 cGy in 28 fractions. Axillary and supraclavicular nodes treated concurrently with an anterior field covering both regions and a posterior field (PAB) added to the axilla. The medial portion of the anterior field was blocked for the last three treatments to hold the supraclavicular region to a maximum of 4500 cGy to minimize the risk of brachial plexus injury. Subsequently, the surgical bed received an electron boost of 1000 cGy in 5 fractions using fields shaped to surround surgical bed with 1.5 cm margins. Record the Phase I Total Dose as 004500. Record the Phase II Total Dose as 000540. Record the Phase III Total Dose as 001000. **Record the Radiation Course Total Dose as 006040.**
- A patient with Stage III prostate carcinoma received 5,040 cGy to his pelvic nodes, prostate, and seminal vesicles over 28 fractions using IMRT followed by a Phase II (boost) of 3000 cGy in 30 fractions using proton therapy. Record the Phase I Total Dose as 005040. Record the Phase II Total Dose as 003000. **Record the Radiation Course Total Dose as 008040.**
- A patient with Stage III prostate carcinoma received 4600 cGy to his pelvic nodes, prostate, and seminal vesicles over 23 fractions using IMRT followed by a Phase II (boost) of 11500 cGy using a low dose rate (LDR) brachytherapy implant. Record the Phase I Total Dose as 004600.

Record the Phase II Total Dose as 011500. **Record the Radiation Course Total Dose as 999998 because it is a mixed modality course.**

Radiation Sequence with Surgery

(NAACCR Item #1380) (STORE pages 227-228) (SEER page 213-214)

Alternate Name: Rx Summary-Surgery/Radiation Seq

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2024 and forward refer to the SEER Program Coding and Staging Manual 2025

Reason for No Radiation

(NAACCR Item #1430) (STORE pages 230-231) (SEER page 215)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

RX Text Radiation

(NAACCR Item #2620 and 2630)

For data item description, coding instructions, and examples refer to the Documentation Chapter of the TCR 2025 Cancer Reporting Guide. **Refer to 2025 NAACCR Data Dictionary for list of data items to be verified by the text fields.**

Date Systemic Therapy Started

(NAACCR Item #3230) (STORE page 233) (SEER page 216)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Date Chemotherapy Started

(NAACCR Item #1220) (STORE page 235) (SEER page 217)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Chemotherapy

(NAACCR Item #1390) (STORE pages 235-237) (SEER pages 218-223)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Refer to the SEER*Rx Interactive Drug Database for a list of chemotherapeutic agents.

Chemotherapy at This Facility

(NAACCR Item #700) (STORE 2022 pages 239-240)

Coding Instructions

1. Record only chemotherapy received at this facility. Do not record agents administered at other facilities.
2. **Code 00 if chemotherapy was not administered to the patient and it is known that it is not usually administered for this type and stage of cancer.** Diagnosed at autopsy.
3. Code 00 if the treatment plan offered multiple alternative treatment options and the patient selected treatment that did not include chemotherapy, or if the option of "no treatment" was accepted by the patient.
4. If it is known that chemotherapy is usually administered for this type and stage of cancer but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
5. Code 87 if the patient refused recommended chemotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
6. Code 88 if it is known that a physician recommended the patient receive chemotherapy, but no further documentation is available yet to confirm its administration.
7. Cases coded 88 must be followed to determine what kind of chemotherapy was administered or why it was not.
8. Code 99 if it is not known whether chemotherapy is usually administered for this type and stage of cancer and there is no mention in the patient record whether it was recommended or administered or it is a DCO case.
9. Code chemoembolization as Chemotherapy when the embolizing agent(s) is a chemotherapeutic drug(s) or when the term chemoembolization is used with no reference to the agent. Use SEER*Rx Interactive Drug Database to determine whether the drugs used are classified as chemotherapeutic agents.
10. Code as Chemotherapy when the patient has a primary or metastatic cancer in the liver and the only information about embolization is a statement that the patient had chemoembolization, tumor embolization or embolization of the tumor in the liver. However, if alcohol is specified as the embolizing agent, even in the liver, code the treatment as Other Therapy.
11. Code chemoembolization as 01, 02, 03 depending on the number of chemotherapeutic agents involved.
12. If the managing physician changes one of the agents in a combination regimen and the replacement agent belongs to a different subcategory (chemotherapeutic agents are grouped as alkylating agents, antimetabolites, natural products, or other miscellaneous) than the original agent, the new regimen represents the start of subsequent therapy and only the original agent or regimen is recorded as first course therapy.
13. Refer to the SEER*Rx Interactive Drug Database for a list of chemotherapeutic agents.

14. If chemotherapy was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the chemotherapy administered in the item Palliative Care at This Facility [3280].

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 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. DCO.

Examples:

- 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.**
- 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.**
- 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.**

RX Text Chemo

(NAACCR Item # 2640)

For data item description, coding instructions, and examples refer to Documentation chapter of the TCR 2025 Cancer Reporting Guide. **Refer 2025 NAACCR Data Dictionary for list of data items to be verified by the text fields.**

Date Hormone Therapy Started

(NAACCR Item #1230) (STORE page 242) (SEER page 224)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Hormone Therapy

(NAACCR Item #1400) (STORE pages 243-244) (SEER pages 225-227)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

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.**

Hormone Therapy at This Facility

(NAACCR Item #710) (STORE pages 245-246)

Coding Instructions

1. Record only hormone therapy received at this facility. Do not record procedures done at other facilities.
2. Record prednisone as hormonal therapy when administered in combination with chemotherapy, such as mechlorethamine, vincristine, procarbazine, prednisone (MOPP) or cyclophosphamide, vincristine, procarbazine, prednisone (COPP).
3. Do not code prednisone as hormone therapy when it is administered for reasons other than chemotherapeutic treatment.
4. Tumor involvement or treatment may destroy hormone-producing tissue. Hormone replacement therapy will be given if the hormone is necessary to maintain normal metabolism and body function. Do not code hormone replacement therapy as part of first course therapy.
5. **Code 00 if hormone therapy was not administered to the patient and it is known that it is not usually administered for this type and stage of cancer**. Diagnosed at autopsy.

6. Code 00 if the treatment plan offered multiple alternative treatment options and the patient selected treatment that did not include hormone therapy or if the option of "no treatment" was accepted by the patient.
7. Code 01 for thyroid replacement therapy which inhibits TSH (thyroid-stimulating hormone). TSH is a product of the pituitary gland that can stimulate tumor growth.
8. If it is known that hormone therapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
9. Code 87 if the patient refused recommended hormone therapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
10. Code 88 if it is known that a physician recommended hormone therapy, but no further documentation is available yet to confirm its administration.
11. Cases coded 88 should be followed to determine whether they received hormone therapy or why not.
12. Code 99 if it is not known whether hormone therapy is usually administered for this type and stage of cancer and there is no mention in the patient record whether it was recommended or administered. DCO.
13. Refer to the SEER*Rx Interactive Drug Database for a list of hormonal agents.
14. If hormone therapy was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the hormone therapy administered in the item Palliative Care [3270].

Hormone Therapy Codes

Code	Description
00	None; hormone therapy was not part of the planned first course of therapy; not usually administered for this type and/or stage of cancer; Diagnosed at autopsy only.
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, progression of tumor prior to administration).
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. DCO.

RX Text Hormone

(NAACCR Item #2650)

For data item description, coding instructions, and examples refer to Documentation Chapter of the TCR 2025 Cancer Reporting Guide. **Refer to 2025 NAACCR Data Dictionary for list of data items to be verified by the text fields.**

Date Immunotherapy Started

(NAACCR Item #1240) (STORE page 248) (SEER page 228)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Immunotherapy

(NAACCR Item #1410) (STORE pages 287-288) (SEER pages 229-231)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Refer to the SEER*Rx Interactive Drug Database for immunotherapeutic agents.

Immunotherapy at This Facility

(NAACCR Item #720) (STORE pages 251-252)

Coding Instructions

1. Record only immunotherapy received at this facility. Do not record agents administered at other facilities.
2. Code 00 if immunotherapy was not administered to the patient and it is known that it is not usually administered for this type and stage of cancer.
3. Code 00 if the treatment plan offered multiple alternative treatment options and the patient selected treatment that did not include immunotherapy or if the option of "no treatment" was accepted by the patient.
4. If it is known that immunotherapy is usually administered for this type and stage of cancer but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
5. Code 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 88 if it is known that a physician recommended the patient receive immunotherapy, but no further documentation is available yet to confirm its administration.
7. Code 88 to indicate a referral was made to a medical oncologist about immunotherapy and the registry should follow the case to determine whether it was given or why not. If follow-up to the specialist or facility determines the patient was never there, code 00.
8. Cases coded 88 should be followed to determine whether they received immunotherapy or why not.
9. Code 99 if it is not known whether immunotherapy is usually administered for this type and stage of cancer and there is no mention in the patient record whether it was recommended or administered.
10. Refer to the SEER*Rx Interactive Drug Database for a list of immunotherapeutic agents.
11. If immunotherapy was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the immunotherapy administered in the item Palliative Care at This Facility [3280].

Immunotherapy Codes

Code	Description
00	None; immunotherapy was not part of the planned first course of therapy; not usually administered for this type and/or stage of cancer; Diagnosed at autopsy only.
01	Immunotherapy was delivered 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, progression of tumor prior to administration).
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 an immunotherapy agent(s) was recommended or administered because it is not stated in patient record. DCO.

Hematologic Transplant/Endocrine Procedures

(NAACCR Item #3250) (STORE pages 253-254) (SEER pages 232-234)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

RX Text BRM

(NAACCR Item #2660)

Alternate Name: Tx Text-Immunotherapy

For data item description, coding instructions, and examples refer to Documentation Chapter of the TCR 2025 Cancer Reporting Guide. **Refer to 2025 NAACCR Data Dictionary for list of data items to be verified by the text fields.**

Systemic Treatment/Surgery Sequence

(NAACCR Item #1639) (STORE pages 255-256) (SEER page 232-234)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Neoadjuvant Therapy

(NAACCR Item #1632) (SEER pages 237-241)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Neoadjuvant Therapy - Clinical Response

(NAACCR Item #1633) (SEER pages 242-245)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Neoadjuvant Therapy - Treatment Effect

(NAACCR Item #1634) (SEER pages 246-247)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Date Other Treatment Started

(NAACCR Item #1250) (STORE 2022 page 258) (SEER page 248)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Other Therapy

(NAACCR Item #1420) (STORE pages 259-260) (SEER pages 249-251)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Examples:

- A patient with polycythemia vera is treated with phlebotomies. Use code 1 for polycythemia vera ONLY according to the *Hematopoietic & Lymphoid Neoplasm Coding Manual* page 26 for cases diagnosed January 2010 and later. Phlebotomy may be called blood removal, bloodletting, or venisection.

- A patient with pancreatic cancer is enrolled in a double-blind clinical trial. The treatment agents are unknown. Use code 3.
- A patient was treated for melanoma with f. Code this treatment as *Other Treatment,* code 1.

Other Therapy at This Facility

(NAACCR Item #730) (STORE pages 261-262)

Coding Instructions

1. 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.
2. Supportive care may include phlebotomy, transfusion, or aspirin. In order to report the hematopoietic cases in which the patient received supportive care, SEER and the CoC have agreed to record treatments such as phlebotomy, transfusion, or aspirin as "Other Treatment" (Code 1) for certain hematopoietic diseases ONLY. Consult the most recent version of the *Hematopoietic & Lymphoid Neoplasm Case Reportability and Coding Manual* for instructions for coding care of specific hematopoietic neoplasms in this item.
3. Code 0 when tumor as diagnosed at autopsy.
4. Code 1 for embolization using alcohol as an embolizing agent.
5. Code 1 for embolization to a site other than the liver where the embolizing agent is unknown.
6. Code 1 for PUVA (psoralen and long-wave ultraviolet radiation).
7. Do not code presurgical embolization given for a purpose to shrink the tumor.
8. A complete description of the treatment plan should be recorded in the text field for "Other Treatment" on the abstract.
9. If other treatment was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the other treatment administered in the item Palliative Care at This Facility [3280].
10. Code 8 if it is known that a physician recommended the patient receive treatment coded as Other Treatment, but no further documentation is available yet to confirm its administration.
11. Code 9 for DCO cases.

Other Therapy 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.
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.

RX Text Other

(NAACCR Item #2670)

For data item description, coding instructions, and examples refer to Documentation Chapter of the TCR 2025 Cancer Reporting Guide. Refer to the 2025 NAACCR Data Dictionary for a list of data items to be verified by the text fields.

16

FOLLOW UP INFORMATION

Date of Last Cancer (Tumor) Status

(NAACCR) Item #1772) (*STORE page 271*) *(SEER pagse 253-255*)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Cancer Status

(NAACCR Item #1770) (STORE page 272) (SEER page 256)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Examples:

- When abstracting a *Class of Case* 00 or 10 (reporting facility participated in diagnosis, but NO treatment), We have physician evidence of tumor. **Code *Date of Last Cancer (Tumor) Status* to *Date of Diagnosis*. Code *Cancer Status* to 2 (Evidence of this tumor.**
- When abstracting a *Class of Case* 21 or 22 (reporting facility participated in treatment only) and there is no statement from physician *after* completion of treatment, **code *Date of Last Cancer (Tumor) Status* to blank, code *Cancer Status* to 9.**
- When abstracting a *Class of Case* 32 (physician at your reporting facility is stating active cancer or recurrence), **code *Date of Last Cancer (Tumor) Status* to date the physician states cancer, code *Cancer Status* to 2.**
- Patient is seen by physician 2/2/2025 and stated NED (no evidence of disease), **code *Date of Last Cancer (Tumor) Status* to 2/2/2025 and *Cancer Status* to 1.** If patient does not return but is contacted by registry 3/2/2025, **do not update the *Date of Cancer (Tumor) Status* or *Cancer Status* since there is no physician statement (no change) to the patient's cancer status.**

Recurrence Date - 1st

(*NAACCR Item #1860*) (*STORE pages 267*) (*SEER pages 257-259*)

Note: Document IF available.

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Record the date the physician diagnoses the first progression, metastasis, or recurrence of disease after a disease-free period.

Recurrence Type - 1st

(NAACCR Item #1880) (STORE pages 268-270) (SEER pages 260-261)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Date of Last Follow - Up or Death

(NAACCR Item #1750) (STORE page 273) (SEER page 263-265)

Alternative Name: Date of Last Contact or Death

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Vital Status

(NAACCR Item #1760) (STORE page 274) (SEER page 266)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

Abstracted By

(NAACCR Item #570) (STORE page 278)

Coding Instructions:

- Code the initials of the abstractor.

CoC Accredited Flag

(NAACCR Item #2152) (SEER page 37)

For data item descriptions, codes, coding instructions, and examples for cases diagnosed January 1, 2025 and forward refer to the SEER Program Coding and Staging Manual 2025

A

APPENDIX A: REPORTABLE LIST

This list provides documentation of all conditions TCR considers reportable for cases **diagnosed 1/1/2025 and forward**.

The 2026 ICDO Table and 2024 ICD-O-3.2 Update Table 2 Alpha Table include changes identified during review of recently published *International Histological Classification of Tumors 5th Edition* books. This series covers all principal sites of cancer and includes ICD-O morphology codes for each neoplasm. Each new edition underwent thorough review to identify new histologies and ICD-O codes, behavior changes to existing ICD-O codes, and new terminology. The ICD-O-3 Implementation Work Group recommended adopting the changes for 2025 and implementation of the changes were approved by the standard setting agencies.

2024 ICD-O-3.2 Table 1 Numeric and *2024 ICD-O-3.2 Table 2 Alpha Table* are comprehensive tables listing all changes made after the 2023 update and is effective for cases diagnosed January 1, 2025, forward.

For this list:

- New terms and synonyms for existing ICD-O codes were added.
- Terms **bolded** indicate new terms in ICD-O-3 effective for January 1, 2025.
- 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 9 in the SEER Program Coding and Staging Manual. If the behavior is malignant (2 or 3) the terms are reportable for any site.

Reportable List

- ACTH-producing tumor
- Acute myeloid leukemia with mutated NPM1
- Acute myeloid leukemia with biallelic mutation of CEBPA
- Acute myeloid leukemia with mutated RUNX1
- Acute myeloid leukemia with BCR-ABL1
- Adamantinoma (long bones, malignant, tibial only)
- Adenoacanthoma
- Adenocarcinofibroma
- Adenocarcinoma
- Adenocarcinoma, pancreatobilliary-type
- Adenofibroma (malignant endometrioid only)
- Adenoma**
- Adenoma (carcinoid bronchial and cylindroid bronchial and islet cell)

- Adenoma, Beta cell
- Adenomatous polyp, high grade dysplasia (C160-C166, C168-C169, C170-C173, C178-C179)
- Adenomyoepithelioma with carcinoma
- Adenosarcoma
- Adrenal medullary paraganglioma (C74.1)
- Aggressive digital papillary adenoma (C44._)
- Anal intraepitelial neoplasia (AIN II), grade II of the anus or anal canal
- Anal intraepithelial neoplasia (AIN III), grade III of the anus or anal canal
- ALK positive large B-cell lymphoma
- Ameloblastoma (malignant only)
- Anaplastic large cell lymphoma, ALK-negative/ Breast implant-associated anaplastic large cell lymphoma
- Anaplastic oligodendroglioma, IDH-mutant and 1p/19q-codeleted
- Anaplastic pleomorphic xanthroastrocytoma
- Androblastoma (malignant only)
- Anemia, refractory
- Angioendotheliomatosis
- Angiolipoma**
- Angiomyosarcoma
- Angiosarcoma
- Aortic body tumor (C75.5)
- Aortic body paraganglioma (C75.5)
- Aorticopulmonary paraganglioma (C75.5)
- Argentaffinoma (malignant only)
- Arrhenoblastoma (malignant only)
- Astroblastoma
- Astrocytoma**
- Astroglioma
- B lymphoblastic leukemia/lymphoma
- B-lymphocytic leukemia/lymphoma, BCR-ABL1-like

- Beta cell adenoma (C25.4)
- Biliary intraepithelial neoplasia (BiIN III) (c23.9)
- Blastoma
- Breast implant-associated anaplastic large cell lymphoma
- Bronchus associated lymphoid tissue lymphoma
- Cancer
- Carcinoid, malignant (stromal, argentaffin tumor NOS, enterochromaffin-like cell NOS, and tubular)
- Carcinoid, NOS (C18.1)
- Carcinofibroma
- Carcinoma
- Carcinomatosis
- Carcinosarcoma
- Carotid body paranganglioma (C75.4)
- Carotid body tumor (C75.4)
- CASTLE (Carcinoma showing thymus-like element)
- Cauda equina neuroendocrine tumor (cranial and paraspinal nerves)
- Chemodectoma
- Chloroma
- Cholangiocarcinoma
- Chondroblastoma
- Chondrosarcoma
- Chondrosarcoma, grade 1 (C40._, C41._)
- Chordoma
- Choriocarcinoma
- Chorioepithelioma
- Chorionepithelioma
- Chromaffin paraganglioma (C74.1)
- Chromaffin tumor
- Chronic lymphoproliferative disorder of NK-cells

- CIC-rearranged sarcoma
- Class IV cytology
- Class V cytology
- Clear cell neuroendocrine tumor, non-functioning pancreatic (C25._)
- CNS Embryonal tumor, NEC/NOS
- CNS Embryonal tumor with rhabdoid features
- CNS neuroblastoma, FOXR2-activated
- CNS tumor with BCCR internal tandem duplication
- Combined large cell neuroendocrine carcinoma
- Comedocarcinoma
- Composite paraganglioma (C74.1)
- 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)
- Cystic pancreatic endocrine neoplasm (CPEN)
- Cystic neuroendocrine tumor, non-functioning pancreatic (C25._)
- Cystosarcoma phyllodes (malignant only)
- Cytopenia, refractory of childhood
- Cytopenia, refractory with multilineage dysplasia
- Dermatofibrosarcoma, protuberans, fibrosarcomatous
- Dermatofibrosarcoma, sarcomatous
- Differentiated penile intraepithelial neoplasia
- Differentiated vulvar intraepithelial neoplasia (VIN)
- Differentiated-type vulvar intraepithelial neoplasia
- Diffuse astrocytoma, MYB or MYBL1-altered
- Diffuse hemispheric glioma, H3 G34-mutant

- Diffuse large B-cell lymphoma associated with chronic inflammation of the pleura (C38.4)
- Diffuse leptomeningeal glioneuronal tumor
- Diffuse low-grade glioma, MAPK pathway-altered**
- Diffuse midline glioma, H3 K27-altered
- Diffuse pediatric-type glioma, H3-wildtype and IDH-wildtype
- Diffuse pleural mesothelioma (C38.4)
- Diffuse pulmonary lymphangiomatosis (C34._)
- 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
- Ductal carcinoma in situ, papillary
- Dysgerminoma

- Ectomesenchymoma
- Embryoma
- Embryonal tumor with multilayered rosettes C19MC-altered
- Embryonal tumor with multilayered rosettes, NOS
- Embryonal tumor with rhabdoid features
- Endocrine tumor, functioning, NOS
- Endometriod intraepithelial neoplasia (C54.1)
- Endometriosis, stromal
- Ependymoblastoma
- Ependymoma**
- Epithelioid malignant peripheral nerve sheath tumor
- Epithelioma (NOS, basal cell, malignant, and squamous cell only)
- Erdheim-Chester Disease
- Erythremia (acute and chronic only)
- Erythroleukemia
- Erythroplasia, Queyrat
- Esophageal intrepithelial neoplasia (dysplasia), high grade
- Esthesioneuroblastoma
- Esthesioneurocytoma
- Esthesioneuroepithelioma
- Extra-adrenal paraganglioma, NOS
- Fibrin-associated diffuse B-cell lymphoma (C38.0)
- Fibroblastic reticular cell tumor
- Fibrochondrosarcoma
- Fibrodentinosarcoma
- Fibroepithelioma, of Pinkus type or NOS
- Fibrolipoma**
- Fibroliposarcoma
- Fibroma, NOS**
- Fibromyxosarcoma

- Fibro-odontosarcoma
- Fibrosarcoma
- Fibrosarcomatous dermatofibrosarcoma protuberans
- Fibroxanthoma (malignant only)
- Gangliocytoma**
- Ganglioglioma**
- Ganglioneuroblastoma
- Ganglioneuroma**
- Gastrinoma
- Gastroblastoma (C16._)
- Gemistocytoma
- Germ cell tumors with associated hematological malignancy
- Germinoma
- GIST-Gastrointestinal stromal tumor (malignant)
- Gastrointesitnal autonomic nerve tumor (GANT)
- Gastrointestinal pacemaker cell tumor
- Gastrointestinal stomal tumor (GIST)
- Gladular intraepithelial neoplasia, high grade
- Glioblastoma
- Gliofibroma**
- Glioma**
- Gliomatosis cerebri
- Gliosarcoma
- Glomangiosarcoma
- Glomus jugulare tumor, NOS (C75.5)
- Goblet cell adenocarcinoma
- Glucagonoma
- Granuloma (Hodgkin only)
- Granulosa cell tumor, adult type (C56.9)
- Hemangioblastoma**

- Hemangioendothelioma**
- Hemangioma**
- Hemangiopericytoma**
- Hemangiosarcoma
- Hepatoblastoma
- Hepatocarcinoma
- Hepatocholangiocarcinoma
- Hepatoma (exclude benign)
- Hidradenocarcinoma
- Hidradenoma (malignant only)
- High grade appendiceal mucinous neoplasm (HAMN) (C181)
- High-grade astrocytoma with piloid features (HGAP)
- Histiocytoma (malignant fibrous only)
- Histiocytosis (malignant, and acute progressive X only)
- Histiocytosis, Langerhans cell, disseminated or generalized
- Hutchinson melanotic freckle (melanoma in situ only)
- Hyalinizing clear cell carcinoma
- Hypernephroma
- Immunocytoma
- HPV-associated adenocarcinoma (C530-C531, C538-C539)
- HPV-independent adenocarcinoma, mesonephric type
- Infant-type hemispheric glioma
- Insulinoma, NOS (C25.4)
- Intestinal-type adenoma, high grade (C160-C166, C168-C169, C170-C173, C178, C179)
- Intraductal oncocytic papillary neoplasm, NOS (C25._)
- Intraductal oncocytic papillary neoplasm with associated invasive carcinoma (C250-C254, C257-C259)
- Intraductal papillary neoplasm with high grade intraepithelial neoplasia
- Intraductal neoplasia, grade III
- Intrapulmonary thymoma (C34._)

- Intravascular large B-cell lymphoma
- Islet cell adenoma (C25.4)
- Islet cell adenomatosis (C25.4)
- Islet cell tumor, NOS (C25.4)
- Jugular paraganglioma (C75.5)
- Jugulotympanic paraganglioma (C75.5)
- Juvenile xanthogranuloma (C71.5)
- Keratoacanthoma
- Langerhans cell histiocytosis, multifocal**
- Langerhans cell histiocytosis, unifocal**
- Large B-cell lymphoma arising in HHV8-associated multicentric Castleman disease
- Laryngeal intraepithelial neoplasia II (LIN II) (C320-C329)
- Laryngeal intraepithelial neoplasia III (LIN III) (C320-C329)
- Laryngeal paraganglioma
- LCIS, NOS (lobular carcinoma in situ)
- Leiomyoma (NOS)**
- Leiomyomatosis (NOS)**
- Leiomyosarcoma
- Lentigo maligna
- Leukemia
- LIN III
- Linitis plastica
- Lipoma (atypical or NOS)**
- Liposarcoma (exclude well differentiated liposarcoma, superficial)
- LI-RADS (Liver cases with LI-RADS category LR-4 or LR-5)
- LN2 (of breast also called lobular neoplasia, grade 2 only)
- Lobular carcinoma in situ (LCIS) (C50._)
- Lobular neoplasia grade II (LN II)/lobular intraepithelial neoplasia grade II (LIN II) breast (C50._)
- Lobular neoplasia grade III (LN III)/lobular intraepithelial neoplasia grade III (LIN III) (C50._)

- Localized pleural mesothelioma (C38.4)
- Low-grade appendiceal mucinous neoplasm (LAMN) (C181)
- Low-grade papillary adenocarcinoma (C34._)
- Lymphangioendothelioma (malignant only)
- Lymphangioleiomyomatosis
- Lymphangioma **
- Lymphangiosarcoma
- Lymphoblastoma
- Lymphoepithelioma
- Lymphoma
- Lymphomatoid granulomatosis grade 3
- Lymphosarcoma
- Macroglobulinemia, Waldenstrom
- Malignancy
- Malignant
- Malignant Poorly Differentiated neuroendocrine tumors
- Malignant melanotic nerve sheath tumor
- MALT lymphoma of the dura
- Mastocytoma (malignant only)
- Mastocytosis (malignant only)
- Medulloblastoma
- Medulloepithelioma
- Medullomyoblastoma
- Melanocytoma, meningeal
- Melanoma, early/evolving in situ
- Melanoma, early/evolving invasive
- Melanoma (exclude juvenile)
- Melanocytosis, diffuse**
- Melanomatosis, meningeal
- Melanosis (precancerous only)

- Meningioma**
- Meningiomatosis**
- Mesenchymoma (malignant only)
- Mesonephroma (exclude benign)
- Mesonephric-like adenocarcinoma
- Mesothelioma (exclude benign and cystic)
- Mesothelioma, in situ
- Metaplasia, agnogenic myeloid
- Metaplastic thymoma (C37.9)
- Microglioma
- Micropapillary carcinoma, NOS
- Middle ear paraganglioma (C30.1, C755.5)
- Midline carcinoma of children and young adults with NUT rearrangement
- Mixed acinar ductal carcinoma
- Mixed phenotype acute leukemia
- MPNST, NOS (malignant peripheral nerve sheath tumor)
- Multinodular and vascolating neuronal tumor (MVNT)(C71.2)
- 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

- Myxoid glioneuronal tumor
- Myxoid pleomorphic liposarcoma
- Myxofibrosarcoma
- 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)
- Nesidioblastoma (C25.4)
- Neurilemmoma**
- Neurilemmosarcoma
- Neuroblastoma
- Neurocytoma**, olfactory
- Neuroendocrine tumor, non-functioning pancreatic (C25._)
- Neuroendocrine tumor, well differentiated
- Neuroepithelioma
- Neurofibroma**
- Neurofibromatosis (NOS)**
- Neurofibrosarcoma
- Neuroma (NOS)**
- Neurosarcoma
- Neurothekeoma**
- Nevus (malignant blue only)
- Non-invasive mucinous cystic neoplasm (MCN) of the pancreas with high-grade displasia

- Nonchromaffin paraganglioma, NOS
- NUT carcinoma
- Oncocytic neuroendocrine tumor, non-functioning pancreatic (C25._)
- Odontosarcoma
- Oligoastrocytoma, mixed
- Oligoastrocytoma, Anaplastic
- Oligodendroblastoma
- Oligodendroglioma
- Orchioblastoma
- Osteochondrosarcoma
- Osteoclastoma (malignant only)
- Osteofibrosarcoma
- Osteosarcoma
- Pancreatic endocrine tumor, NOS (C25.4)
- Pancreatic intraepitelial neoplasia (PanIN II) (C25._)
- Pancreatic intraepithelial neoplasia (PanIN III) (C25._)
- Pancreatoblastoma
- Pancreatobilliary-type carcinoma
- Panmyelosis, acute only
- Papillary tumor of the pineal region
- Papillary neoplasm, Pancreatobiliary type, with high grade intraepitelial neoplasia (C24.1)
- Papilloma**
- Paraganglioma
- Paragranuloma, Hodgkin
- PEComa, malignant
- Penile intraepithelial neoplasia, grade II (PeIN II) (C60._)
- Penile intraepithelial neoplasia, grade III (PeIN III) (C60._)
- Perineural MPNST
- Perineurioma**
- Pheochromoblastoma (C74.1)

- Pheochromocytoma
- Pheochromocytoma, NOS (C74.1)
- Pilocytic/Juvenile astrocytomas**
- Pilomatrixoma (malignant only)
- Pilomyxoid astrocytoma
- Pinealoma (NOS)**
- Pineoblastoma
- Pineocytoma**
- PI-RADS (Prostate cancer cases with PI-RADS category 4 or 5)
- Pituicytoma**
- Pituitary Adenoma
- Pituitary neuroendocrine tumor (pitNET) (C75.1)
- Plasmacytoma
- Plasmablastic lymphoma
- PNET (primitive neuroectodermal tumor)
- Pneumoblastoma
- Polycythemia (proliferative, rubra vera, or vera)
- Polyembryoma
- Polymorphic PTLD
- Polymorphous low-grade neuroepithelial tumor of the young
- Polyposis (malignant lymphomatous only)
- Porocarcinoma
- **Post Transplant Lymphoproliferative Disorder (PTLD)**
- Posterior fossa ependymoma, NOS
- Posterior fossa group A (PFA) ependymoma
- Posterior fossa group B (PFB) ependymoma
- Poroma, eccrine (malignant only)
- PPNET (peripheral primitive neuroectodermal tumor)
- Preleukemia
- Primary cutaneous follicle centre lymphoma

- Primary cutaneous gamma-delta T-cell lymphoma
- Primary intracranial sarcoma, DICER1-mutant
- 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
- Rosai-Dorfman disease
- Sarcoma (exclude well differentiated liposarcoma, superficial)
- Sarcomatosis (meningeal only)
- Schwannoma**
- Sclerosing thymoma (C34._)
- Secondary Neuroendocrine tumors
- Seminoma
- Serrated adenocarcinoma
- Serrated dysplasia, high grade (C160-C166, C168-C169, C170-C173, C178-C179)
- SETTLE (spindle epithelial tumor with thymus-like element)
- Solid pseudopapillary neoplasm of the pancreas
- Somatostatinoma
- Spermatocytoma
- Spinal ependymoma, NOS (C72.0)
- Spinal ependymoma, MYCN-applified (C72.0)

- Spiradenoma (malignant only)
- Spongioblastoma
- Spongioneuroblastoma
- Squamous intraepithelial neoplasia, grade II (excludes cervix (C53._) and skin sites coded to C44._)
- Squamous intraepithelial neoplasia, grade III (excludes cervix (C53._) and skin sites coded to C44._)
- Stromatosis, endometrial
- Struma (malignant ovarii and Wuchernde Langhans only)
- Subependymoma**
- Subependymoma-ependymoma, mixed**
- Supratentorial ependymoma, NOS
- Supratentorial ependymoma, YAP1 fusion-positive
- Supratentorial ependymoma, ZFTA fusion-positive
- Sympathicoblastoma
- Syndrome
    - 5q deletion with Myelodysplastic (5q-) syndrome
    - Hypereosinophilic
    - Myelodysplastic
        - NOS
        - with 5q deletion syndrome
        - with multilineage dysplasia
        - with isolated del (5q)
        - with ring sideroblasts and multilineage dysplasia
        - with ring sideroblasts and single lineage dysplasia
        - with single lineage dysplasia
        - therapy-related, NOS
        - therapy-related, alkylating agent related
        - therapy-related, epidopophyllotoxin related
    - Preleukemic

    - Sezary
- Synovioma (NOS and malignant only)
- Syringocystadenocarcioma papilliferum
- 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
- Tall cell carcinoma with reversed polarity
- Teratoblastoma, malignant
- Teratocarcinoma
- Teratoma**
- Teratoma, immature (except for lung, thyroid, and thymus)
- Teratoma, mature (C62._) code the histology and behavior as 9080/3
- Thecoma (malignant only)
- Thrombocythemia (essential, essential hemorrhagic, idiopathic, or idiopathic hemorrhagic)
- Thoracic SMARCA4-deficient undifferentiated tumor (C34._)
- Thymoma, NOS (C37.9)
    - Type A thymoma including atypical variant (C37.9)
    - Type AB thymoma (C37.9)
    - Type B1 thymoma (C37.9)
    - Type B2 thymoma (C37.9)
    - Type B3 thymoma (C37.9)
    - Thymoma, atypical (C37.9)
    - Thymoma, epithelial (C37.9)
- Tumor (include only):
    - ACTH-producing
    - adenocarcinoid
    - adrenal cortical (malignant only)
    - alpha cell (malignant only)

- Aortic body
- Askin
- beta cell (malignant only)
- Brenner (malignant only)
- Burkitt
- carcinoid, NOS (except of appendix)
- carcinoid (malignant only)
- Carotid body
- cells**
- Chromaffin
- desmoplastic small round cell
- dysembryoplastic neuroepithelial**
- embolus
- endocrine, functioning, NOS
- endodermal sinus
- endolymphatic sac
- epithelial**
- Ewing
- fibrous, solitary**
- follicular dendritic cell
- fusiform cell type (malignant only)
- G cell (malignant only)
- gastrin cell (malignant only)
- germ cell
- giant cell (malignant only)
- glomus (malignant only)
- Glomus jugulare tumor, NOS (C75.5)
- granular cell**
- granulosa cell (malignant or sarcomatoid or adult type)
- Grawitz

- interstitial cell (malignant only)
- intravascular bronchial alveolar
- islet
- 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
- mucocarcinoid
- Mullerian mixed
- neuroectodermal (exclude melanotic)
- neuroendocrine, (grade 2, grade 3)
- nonencapsulating sclerosing
- odontogenic (malignant only)
- olfactory, neurogenic
- Pancoast
- Pancreatic endocrine, nonfunctioning
- Pancreatic endocrine, NOS
- Pancreatic neuroendocrine, nonfunctioning
- Papillary glioneuronal tumor
- Parathyroid
- 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
- Rosette-forming glioneuronal tumor
- Secondary
- serous, NOS, of low malignant potential serous, papillary, of low malignant potential
- 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

- Type A thymoma including atypical variant (C37.9)
- Type AB thymoma (C37.9)
- Type B1 thymoma (C37.9)
- Type B2 thymoma (C37.9)
- Type B3 thymoma (C37.9)
- Thymoma, atypical (C37.9)
- Thymoma, epithelial (C37.9)
- Ulcer, rodent
- Urachal carcinoma
- Urine cytology (positive for malignancy)

  Exception*:* when subsequent biopsy of urinary site if negative
- Vagal paraganglioma
- Vaginal intraepithelial neoplasia II (VAIN II) (C529)
- Vaginal intraepithelial neoplasia III (VAIN III) (C529)
- Vulvar intraepithelial neoplasia II (VIN II) (C510-C519)
- Vulvar intraepithelial neoplasia III (VIN III) (C510-C519)
- Vipoma
- Xanthoastrocytoma, pleomorphic

B

APPENDIX B: DATA ITEMS CURRENTLY OR PREVIOUSLY COLLECTED

TCR adheres to reporting requirements mandated by the CDC's NPCR, and the NCI's SEER Program. Additional data items are required to meet requests from our data users.

The table below displays the data items in order as they appear in the *2025 Cancer Reporting Guide* and Web Plus. We have also provided this table in alphabetical and numerical order for cancer reporters who use 3rd party software or prefer a different format.

Please refer to the *Data Items Currently or Previously Collected (NUMERICAL ORDER)* or the *Data Items Currently or Previously Collected (ALPHABETICAL ORDER)* found on the TCR Website.

TCR does not allow blanks for the following items:

*Date of Admission/First Contact, NAACCR #580

*Date of Date of Birth, NAACCR #240

Reportable Data Items

Data Item	NAACCR Item Number	Collection Dates	
Reporting Facility	540	1995 - present	
Medical Record Number	2300	1995 - present	
Registry/Accession Number	550	1995 - present	
Type of Reporting Source	500	1995 - present	
Date of Admission/First Contact	580	1995 - present	
NPI Reporting Facility (Derived)	545	2009 - present	Derived
Class of Case	610	1998 - present	
First Name	2240	1995 - present	
Middle Name	2250	1995 - present	
Last Name	2230	1995 - present	
Name--Suffix	2270	2022 - present	
Birth Surname	2232	2021 - present	
Patient Name Alias	2280	1995 - 2002 2006 - present	
Social Security Number	2320	1995 - present	
Address at Dx Street Address	2330	1995 - present	
Address at Dx Supplemental	2335	2006 - present	
Address at Dx City	70	1995 - present	
Address at Dx State	80	1995 - present	

Data Item	NAACCR Item Number	Collection Dates	
Address at Dx Zip Code	100	1995 - present	
FIPS County Code at DX	90	1995 - present	
Address at Dx-Country	102	2013 - present	
Current Address Number and Street	2350	2022 - present	
Current Address Supplemental	2355	2022 - present	
Current Address City	1810	2022 - present	
Current Address – State	1820	2022 - present	
Current Address -Zip Code	1830	2022 - present	
Addr Current--Country	1832	2022 - present	
Telephone	2360	2022 - present	
Birthplace-State	252	2013 - present	
Birthplace-Country	254	2013 -present	
Date of Birth	240	1995 - present	
Place of Death-State	1942	2013 - present	
Place of Death-Country	1944	2013 - 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	
Sex	220	1995 - present	
Marital Status at Dx	150	2022 - present	
Primary Payer at DX	630	2007 - present	
Medicare Beneficiary Identifier	2315	2021 - present	
Text Usual Industry	320	2010 - present	
Text Usual Occupation	310	2010 - present	
Other Pertinent Information	2680	1995 - present	
Physician Follow Up	2470	2006 - present	

Data Item	NAACCR Item Number	Collection Dates	
Tobacco Use Smoking Status	344	2022 - present	
Secondary Diagnosis 1	3780	2023 - present	
Secondary Diagnosis 2	3782	2023 - present	
Secondary Diagnosis 3	3784	2023 - present	
Secondary Diagnosis 4	3786	2023 - present	
Secondary Diagnosis 5	3788	2023 - present	
Secondary Diagnosis 6	3790	2023 - present	
Secondary Diagnosis 7	3792	2023 - present	
Secondary Diagnosis 8	3794	2023 - present	
Secondary Diagnosis 9	3796	2023 - present	
Secondary Diagnosis 10	3798	2023 - present	
Sequence Number Central	380	1995 - present	
Date of Initial Diagnosis	390	1995 - present	
Age at Diagnosis	230	1995 - present	Derived/Calculator
Sequence Number Hospital	560	1995 - present	
Primary Site	400	1995 - present	
Laterality	410	1995 - present	
Final DX Primary Site and Laterality	2580	1995 - present	
Diagnostic Confirmation	490	1995 - present	
Histologic Type ICD-O-3 2001 and forward	522	2001 - present	
Behavior 2001 and forward	523	2001 - present	
Grade Clinical	3843	2018 – present	
Grade Post Therapy Clinical (yc)	1068	2021- present	
Grade Pathological	3844	2018 - present	
Grade Post Therapy Path (yp)	3845	2021 - present	
Final DX Hist/Beh/Grade	2590	1995 - present	
Tumor Size Summary	756	2016 - present	
EOD Primary Tumor	772	2022 - present	
EOD Regional Nodes	774	2022 - present	

Data Item	NAACCR Item Number	Collection Dates	
EOD Metastases	776	2022 - present	
EOD Prostate Pathologic Extension	3919	2022 - present	
Summary Stage 2018	764	2018 - present	
Pediatric Primary Tumor	1136	2025	
Pediatric Regional Nodes	1137	2025	
Pediatric Mets	1138	2025	
Toronto T	1146	2025	
Toronto N	1147	2025	
Toronto M	1148	2025	
Toronto Stage Group	1149	2025	
Lymphovascular Invasion (testis and penis only)	1182	2011 - present	
Mets at Diagnosis-Bone	1112	2022 - present	
Mets at Diagnosis-Brain	1113	2022 - present	
Mets at Diagnosis – Liver	1115	2022 - present	
Mets at Diagnosis-Lung	1116	2022 - present	
Mets at Diagnosis – Distant LNs	1114	2022 - present	
Mets at Diagnosis-Other	1117	2022 - present	
SEER Site Specific Factor 1	3700	2022 - present	
AJCC ID	995	2018 - present	Derived
Schema ID	3800	2018 - present	Derived
Schema Discriminator 1	3926	2018 - present	
Schema Discriminator 2	3927	2018 - present	
Schema Discriminator 3	3928	2022 - present	
Adenoid Cystic Basaloid Pattern	3803	2022 - present	
Adenopathy	3804	2022 - present	
AFP Post-Orchiectomy Lab Value	3805	2022 - present	CoC
AFP Post-Orchiectomy Range	3806	2022 - present	
AFP Pre-Orchiectomy Lab Value	3807	2022 - present	CoC
AFP Pre-Orchiectomy Range	3808	2022 - present	

Data Item	NAACCR Item Number	Collection Dates	
AFP Pretreatment Interpretation	3809	2022 - present	CoC
AFP Pretreatment Lab Value	3810	2022 - present	CoC
ALK Rearrangement	3938	2022 - present	
Anemia	3811	2022 - present	
B symptoms	3812	2022 - present	
Bilirubin Pretreatment Total Lab Value	3813	2022 - present	CoC
Bilirubin Pretreatment Unit of Measure	3814	2022 - present	CoC
Bone Invasion	3815	2022 - present	
BRAF Mutational Analysis	3940	2022 - present	
Brain Molecular Markers	3816	2018 – present	
Brain Primary Tumor Location	3964	2024 - present	
Breslow Tumor Thickness	3817	2018 – present	
CA 19-9 PreTX Lab Value	3942	2022 - present	
CA-125 Pretreatment Interpretation	3818	2022 - present	
CEA Pretreatment Interpretation	3819	2022 - present	
CEA Pretreatment Lab Value	3820	2022 - present	
Chromosome 1p: Loss of Heterozygosity (LOH)	3801	2022 - present	
Chromosome 19q: Loss of Heterozygosity (LOH)	3802	2022 - present	
Chromosome 1q Status	1190	2025	
Chromosome 3 Status	3821	2022 - present	CoC
Chromosome 8q Status	3822	2022 - present	CoC
Chromosome 16q: Loss of Heterozygosity	1189	2025	
Clinical Margin Width	3961	2023 - present	
Circumferential Resection Margin (CRM)	3823	2022 - present	
Creatinine Pretreatment Lab Value	3824	2022 - present	CoC

Data Item	NAACCR Item Number	Collection Dates	
Creatinine Pretreatment Unit of Measure	3825	2022 - present	CoC
EGFR Mutational Analysis	3939	2022 - present	
Estrogen Receptor Percent Positive or Range	3826	2022 - present	CoC
Estrogen Receptor Summary	3827	2018 – present	
Esophagus and EGJ Tumor Epicenter	3829	2022 - present	
EWSR1-FLI1 fusion			
Extranodal Extension Clin (non-Head and Neck)	3830	2022 - present	CoC
Extranodal Extension Head and Neck Clinical	3831	2022 - present	CoC
Extranodal Extension Head and Neck Pathological	3832	2022 - present	
Extranodal Extension Path (non-Head and Neck)	3833	2022 - present	CoC
Extravascular Matrix Patterns	3834	2022 - present	CoC
Fibrosis Score	3835	2018 – present	
FIGO Stage	3836	2022 - present	
FOXO1 Gene Rearrangements	1193	2025	
Gestational Trophoblastic Prognostic Scoring Index	3837	2022 - present	
Gleason Patterns Clinical	3838	2021 - present	
Gleason Patterns Pathological	3839	2021 - present	
Gleason Score Clinical	3840	2021 - present	
Gleason Score Pathological	3841	2021 - present	
Gleason Tertiary Pattern	3842	2021 - present	
hCG Pre-Orchiectomy Lab Value	3848	2022 - present	CoC
hCG Pre-Orchiectomy Range	3849	2022 - present	
hCG Post-Orchiectomy Lab Value	3846	2022 - present	CoC
hCG Post-Orchiectomy Range	3847	2022 - present	
HER2 Overall Summary	3855	2018 – present	

Data Item	NAACCR Item Number	Collection Dates	
Heritable Trait	3856	2022 - present	
High Risk Cytogenetics	3857	2022 - present	
High Risk Histologic Features	3858	2022 - present	
Histologic Subtype	3960	2023- present	
HIV Status	3859	2022 - present	
Intl Neuroblastoma Path Prog Class (INPC)	1187	2025	
Intl Neuroblastoma Risk Grp Stage Sys (INRGSS)	1185	2025	
International Normalized Ratio Prothrombin Time	3860	2022 - present	CoC
Invasion Beyond Capsule	3864	2022 - present	
Ipsilateral Adrenal Gland Involvement	3861	2022 - present	
IRSS Stage for Eye-2	1188	2025	
JAK2	3862	2022 - present	
Ki-67	3863	2022 - present	CoC
KIT Gene Immunohistochemistry	3865	2022 - present	CoC
KRAS	3866	2022 - present	
LDH Pre-Orchiectomy Range	3868	2022 - present	
LDH Post-Orchiectomy Range	3867	2022 - present	
LDH Lab Value	3932	2018 – present	
LDH Level	3869	2022 - present	
LDH Upper Limits of Normal	3870	2022 - present	CoC
LN Assessment Method Femoral-Inguinal	3871	2022 - present	CoC
LN Assessment Method Para-Aortic	3872	2022 - present	CoC
LN Assessment Method Pelvic	3873	2022 - present	CoC
LN Distant Assessment Method	3874	2022 - present	CoC
LN Distant: Mediastinal, Scalene	3875	2022 - present	CoC
LN Head and Neck Levels I-III	3876	2022 - present	

Data Item	NAACCR Item Number	Collection Dates	
LN Head and Neck Levels IV-V	3877	2022 - present	
LN Head and Neck Levels VI-VII	3878	2022 - present	
LN Head and Neck Other	3879	2022 - present	
LN Isolated Tumor Cells (ITC)	3880	2022 - present	
LN Laterality	3881	2022 - present	
LN Positive Axillary Level I-II	3882	2022 - present	
LN Size	3883	2022 - present	
LN Status Pelvic	3957	2022 - present	CoC
LN Status Para-Aortic	3958	2022 - present	CoC
LN Status Femoral-Inguinal	3959	2022 - present	CoC
Lymphocytosis	3885	2022 - present	
Macroscopic Evaluation of the Mesorectum	3950	2022 - present	CoC
Major Vein Involvement	3886	2022 - present	
Measured Basal Diameter	3887	2022 - present	
Measured Thickness	3888	2022 - present	
Methylation of O6-Methylguanine-Methyltransferase	3889	2022 - present	
Microsatellite Instability (MSI)	3890	2018 - present	
Microvascular Density	3891	2022 - present	CoC
Mitotic Count Uveal Melanoma	3892	2022 - present	CoC
Mitotic Rate Melanoma	3893	2022 - present	
Multigene Signature Method	3894	2022 - present	
Multigene Signature Results	3895	2022 - present	
n-MYC Amplification	1186	2025	
NCCN International Prognostic Index (IPI)	3896	2022 - present	
NRAS Mutational Analysis	3941	2022 - present	
Number of Cores Examined	3897	2022 - present	
Number of Cores Positive	3898	2022 - present	

Data Item	NAACCR Item Number	Collection Dates	
Number of Examined Para-Aortic Node	3899	2022 - present	CoC
Number of Examined Pelvic Nodes	3900	2022 - present	CoC
Number of Positive Para-Aortic Nodes	3901	2022 - present	CoC
Number of Positive Pelvic Nodes	3902	2022 - present	CoC
Oncotype Dx Recurrence Score-DCIS	3903	2022 - present	CoC
Oncotype Dx Recurrence Score-Invasive	3904	2022 - present	
Oncotype Dx Risk Level-DCIS	3905	2022 - present	CoC
Oncotype Dx Risk Level-Invasive	3906	2022 - present	CoC
Organomegaly	3907	2022 - present	
PD-L1	1174	2025	
p16	3956	2022 - present	
Percent Necrosis Post Neoadjuvant	3908	2022 - present	CoC
Perineural Invasion	3909	2022 - present	
Peripheral Blood Involvement	3910	2022 - present	
Peritoneal Cytology	3911	2022 - present	
Pleural Effusion	3913	2022 - present	
Post Transplant Lymphoproliferative Disorder-PTLD	1172	2025	
Pretext Clinical Staging	1192	2025	
Progesterone Receptor Percent Positive or Range	3914	2022 - present	CoC
Profound Immune Suppression	3918	2022 - present	
Progesterone Receptor Summary	3915	2018 – present	
PSA (Prostatic Specific Antigen) Lab Value	3920	2018 – present	
Residual Tumor Volume Post Cytoreduction	3921	2022 - present	
Response to Neoadjuvant Therapy	3922	2022 - present	CoC

Data Item	NAACCR Item Number	Collection Dates	
S Category Clinical	3923	2022 - present	
S Category Pathological	3924	2022 - present	
Sarcomatoid Features	3925	2022 - present	
Separate Tumor Nodules	3929	2022 - present	
Serum Albumin Pretreatment Level	3930	2022 - present	
Serum Beta-2 Microglobulin Pretreatment Level	3931	2022 - present	
Thrombocytopenia	3933	2022 - present	
Tumor Deposits	3934	2022 - present	
Ulceration	3936	2022 - present	
Visceral and Parietal Pleural Invasion	3937	2022 - present	
White Blood Cell Count	1184	2025	
Summary Stage Documentation	2520-2570 2600	1995 - present	
TNM Edition Number	1060	2015 - present	
AJCC TNM Clin T	1001	2018 - present	CoC
AJCC TNM Clin T Suffix	1031	2021 - present	CoC
AJCC TNM Clin N	1002	2018 – present	CoC
AJCC TNM Clin N Suffix	1034	2021- present	CoC
AJCC TNM Clin M	1003	2018- present	CoC
AJCC TNM Clin Stage Group	1004	2018 – present	CoC
AJCC TNM Path T	1011	2018 – present	CoC
AJCC TNM Path T Suffix	1032	2021- present	CoC
AJCC TNM Path N	1012	2018- present	CoC
AJCC TNM Path N Suffix	1035	2021- present	CoC
AJCC TNM Path M	1013	2018 – present	CoC
AJCC TNM Path Stage Group	1014	2018- present	CoC
AJCC TNM Post Therapy Clin (yc) T	1062	2021- present	CoC

Data Item	NAACCR Item Number	Collection Dates	
AJCC TNM Post Therapy Clin (yc) T Suffix	1063	2021- present	CoC
AJCC TNM Post Therapy Clin (yc) N	1064	2021- present	CoC
AJCC TNM Post Therapy Clin (yc) N Suffix	1065	2021- present	CoC
AJCC TNM Post Therapy Clin (yc) M	1066	2021- present	CoC
AJCC TNM Post Therapy Path (yc) T	1021	2021 - present	CoC
AJCC TNM Post Therapy Path (yc) T Suffix	1033	2021 - present	CoC
AJCC TNM Post Therapy Path (yc) N	1022	2021 - present	CoC
AJCC TNM Post Therapy Path (yc) N Suffix	1036	2021 –present	CoC
AJCC TNM Post Therapy Path (yc) M	1023	2021 - present	CoC
AJCC TNM Post Therapy Path Stage Group	1024	2021 - present	CoC
Date Regional Lymph Node Dissection	682	2022 – present	CoC
Regional Nodes Positive	820	1998 - present	
Regional Nodes Examined	830	1998 - present	
Date of Initial Treatment	1260	2010 - present	
RX - Summary Treatment Status	1285	2010 - present	
RX Date Mst Defn Srg	3170	2015 - present	
RX Date Surgery	1200	1995 - present	
RX Summ—Surg Prim Site 2023	1291	2023 - present	
RX Summ—Recon Breast	1335	2024 - present	
RX Hosp—Surg Prim Site 2023	671	2023 - present	
RX Hosp--Rcon Breast	751	2024 - present	
Surgical Margins of Primary Site	1320	2022 - present	

Data Item	NAACCR Item Number	Collection Dates	
RX Summary - Scope of Reg LN Surgery	1292	2001 - present	
RX Hosp—Scope of Reg LN Sur	672	2022 - present	
Date of Sentinal Lymph Node Biopsy	832	2022 - present	
Sentinel Lymph Nodes Positive	835	2022 - present	
Sentinel Lymph Nodes Examined	834	2022 - present	
RX Summary - Surgery Other/Dist RX Code	1294	1998 - present	
RX Hosp—Surg Oth Reg/Dis	674	2022 - present	
Reason for No Surgery	1340	1998 - 2002 2006 - present	
RX Text Surgery	2610	2004 - present	
Rx Date Radiation	1210	1995 - present	
Phase I Radiation Primary Treatment Volume	1504	2022 - present	
Phase I Radiation to Draining Lymph Nodes	1505	2022 - present	
Phase I Radiation Treatment Modality	1506	2018 - present	
Phase I Number of Fractions	1503	2022 - present	
Phase I Dose per Fraction	1501	2022 - present	
Phase I Radiation External Beam Planning Tech	1502	2022 - present	CoC
Phase I Total Dose	1507	2022 - present	
Phase II Radiation Primary Treatment Volume	1514	2022 - present	
Phase II Radiation to Draining Lymph Nodes	1515	2022 - present	
Phase II Radiation Treatment Modality	1516	2022 - present	
Phase II Number of Fractions	1513	2022 - present	
Phase II Dose per Fraction	1511	2022 - present	

Data Item	NAACCR Item Number	Collection Dates	
Phase II Total Dose	1517	2022 - present	
Phase II Radiation External Beam Planning Tech	1512	2022 - present	CoC
Phase III Radiation Primary Treatment Volume	1524	2022 - present	
Phase III Radiation to Draining Lymph Nodes	1525	2022 - present	
Phase III Radiation Treatment Modality	1526	2022 - present	
Phase III Number of Fractions	1523	2022 - present	
Phase III Dose per Fraction	1521	2022 - present	
Phase III Total Dose	1527	2022 - present	
Phase III Radiation External Beam Planning Tech	1522	2022 - present	CoC
Radiation Treatment Discontinued Early	1531	2022 - present	
Number of Phases of Rad Treatment to this Volume	1532	2022 - present	
Total Dose	1533	2022 - present	
RX Summary - Surgery/Radiation Sequence	1380	2004 - present	
Reason for no Radiation	1430	1998 - 2002 2011 - present	
RX Text - Radiation	2620, 2630	2004 - present	
RX Date - Systemic	3230	2004 – 2010 2022 - present	CoC
Date Chemotherapy Started	1220	2010 - present	
Chemotherapy Code	1390	1995 - present	
RX Hosp--Chemo	700	2022 - present	
RX Text - Chemotherapy	2640	2004 - present	
Date Hormone Therapy Started	1230	2010 - present	
Hormone Code	1400	1995 - present	

Data Item	NAACCR Item Number	Collection Dates	
RX Hosp--Hormone	710	2022 - present	
RX Text - Hormone	2650	2004 - present	
Date Immunotherapy (BRM) Started	1240	2010 - present	
Immunotherapy (BRM) Code	1410	1995 - present	
RX Hosp—BRM (Immunotherapy)	720	2022 - present	
RX Summary Transplant/Endocrine	3250	2003 - present	
RX Text – Immunotherapy (BRM)	2660	2004 - present	
RX Summary - Systemic/Surgery Sequence	1639	2006 - present	
Neoadjuvant Therapy	1632	2022 - present	
Neoadjuvant Therapy-Clinical Response	1633	2022 - present	
Neoadjuvant Therapy-Treatment Effect	1634	2022 - present	
Date Other Treatment Started	1250	1995 - present	
Other Treatment Code	1420	1995 - present	
RX Hosp--Other	730	2022 - present	
RX Text - Other	2670	2004 - present	
Date of Last Cancer (Tumor) Status	1772	2022 - present	
Cancer Status	1770	2022 - present	
Recurrence Date--1st	1860	2022 - present	
Recurrence Type--1st	1880	2022 - present	
Date of Last Followup or Death (Contact)	1750	1995 - present	
Vital Status	1760	1998 - present	
Underlying Cause of Death	1910	2022 - present	Linkage
Follow Up Source (Derived)	1790	2009 - present	Derived
Follow Up Source	1791	1995 - present	Derived
Date Abstracted	2090	1995 - present	
Abstractor Initials	570	1995 - present	
NAACCR Record Version	50	2003 - present	Current version

Data Item	NAACCR Item Number	Collection Dates	
CoC Accredited Flag	2152	2018 - present	
Pediatric ID	1132	2025	Derived
Pediatric ID Version Current	1133	2025	Derived
Pediatric ID Version Original	1134	2025	Derived
Toronto Version Number	1135	2025	Derived
Derived Pediatric T	1142	2025	Derived
Derived Pediatric N	1143	2025	Derived
Derived Pediatric M	1148	2025	Derived
Derived Pediatric Stage Group	1145	2025	Derived
Historical Data			
Date of Admission/First Contact Flag *	581	2010 – 2021	
Maiden Name	2390	1995 - 2020	
Date of Birth Flag *	241	2010 - 2021	
Place of Birth	250	1998 - 2013	
Physician Managing	2460	2006 - 2010	
Facility Referred From	2410	2001 - 2010	
Facility Referred To	2420	2001 - 2010	
Other Primary Tumors	2200	1995 - 2020	
Comorbidity/Secondary Diagnosis #1	3110	2011 - 2017	
Comorbidity/Secondary Diagnosis #2	3120	2011 - 2017	
Comorbidity/Secondary Diagnosis #3	3130	2011 - 2017	
Comorbidity/Secondary Diagnosis #4	3140	2011 - 2017	
Comorbidity/Secondary Diagnosis #5	3150	2011 - 2017	
Comorbidity/Secondary Diagnosis #6	3160	2011 - 2017	

Data Item	NAACCR Item Number	Collection Dates	
Comorbidity/Secondary Diagnosis #7	3161	2011 - 2017	
Comorbidity/Secondary Diagnosis #8	3162	2011 - 2017	
Comorbidity/Secondary Diagnosis #9	3163	2011 - 2017	
Comorbidity/Secondary Diagnosis #10	3164	2011 - 2017	
Source Comorbidity/Secondary Diagnosis	Non-NAACCR 9970	2011 - 2017	
Date of Diagnosis Flag	391	2010 - 2021	
ICD-O-2 Morph Prior to 2001	420	1995 - 2000	
Behavior prior to 2001	430	1995 - 2000	
Grade of Tumor	440	1995 - 2017	
Grade Path Value	441	2011 - 2013	
Grade Path System	449	2011 - 2013	
Tumor Size Prior to 2004	780	1998 – 2003	
Tumor Size Clinical	752	2022 - 2023	
Tumor Size Pathologic	754	2022 - 2023	
Summary Stage 2000 for appropriate years	759	2001 – 2004, 2014-2017	
Progesterone Receptor Total Allred Score	3916	2022	
Estrogen Receptor Total Allred Score	3828	2022	
CS Tumor Size 2004 and forward	2800	2004 - 2015	
CS Extension	2810	2004 - 2015	
CS Tumor Size/EXT Eval	2820	2008 - 2015	
CS Lymph Nodes	2830	2004 - 2015	
CS Lymph Nodes Eval	2840	2011 - 2015	
CS Mets at DX	2850	2004 - 2015	

Data Item	NAACCR Item Number	Collection Dates	
CS Mets Eval	2860	2011 - 2015	
CS Site Specific Factor 1 NPCR required only	2880	2004 - 2017	
CS Site Specific Factor 2 NPCR required only	2890	2010 - 2017	
CS Site Specific Factor 3 NPCR required only	2900	2004 - 2015	
CS Site Specific Factor 4 NPCR required only	2910	2011 - 2015	
CS Site Specific Factor 5 NPCR required only	2920	2011 - 2017	
CS Site Specific Factor 6 NPCR required only	2930	2011 - 2017	
CS Site Specific Factor 7 NPCR required only	2861	2011 - 2015	
CS Site Specific Factor 8 NPCR required only	2862	2010 - 2017	
CS Site Specific Factor 9 NPCR required only	2863	2010 - 2017	
CS Site Specific Factor 10 NPCR required only	2864	2010 - 2017	
CS Site Specific Factor 11 NPCR required only	2865	2010 - 2017	
CS Site Specific Factor 12 NPCR required only	2866	2010 - 2015	
CS Site Specific Factor 13 NPCR required only	2867	2010 - 2017	
CS Site Specific Factor 14 NPCR required only	2868	2010 - 2017	
CS Site Specific Factor 15 NPCR required only	2869	2011 - 2017	
CS Site Specific Factor 16 NPCR required only	2870	2011 - 2017	
CS Site Specific Factor 17 NPCR required only	2871	2011 - 2015	

Data Item	NAACCR Item Number	Collection Dates	
CS Site Specific Factor 25 NPCR required only	2879	2010 - 2017	
LN Status Femoral-Inguinal, Para-Aortic, Pelvic	3884	2022	
TNM Clinical T	940	2015 – 2017	
TNM Clinical N	950	2015 – 2017	
TNM Clinical M	960	2015 – 2017	
TNM Clinical Stage (Prefix/Suffix) Descriptor	980	2015 - 2017	
TNM Clinical Stage Group	970	2015 - 2017	
TNM Pathologic T	880	2015 – 2017	
TNM Pathologic N	890	2015 - 2017	
TNM Pathologic M	900	2015 - 2017	
TNM Pathologic Stage (Prefix/Suffix) Descriptor	920	2015 – 2017	
TNM Pathologic Stage Group	910	2015 - 2017	
Date of Initial Treatment Flag	1261	2010 - 2021	
RX Date Mst Defn Srg Flag	3171	2015 - 2021	
RX Date Surgery Flag	1201	2010 - 2021	
Rx Summ-Surg Primary Site	1290	1995 - 2022	
RX Summary - Reg LN Examined	1296	2001 - 2005	
RX Date Radiation Flag	1211	2010 - 2021	
RX Summary - Radiation	1360	1998 - 2002 2012 - 2017	
Radiation Regional RX Modality Code	1570	2003 - 2017	
RX Date Chemotherapy Flag	1221	2010 - 2021	
Reason for no Chemotherapy	1440	1998 - 2002	
RX Date Hormone Flag	1231	2010 - 2021	
Reason for no Hormone	1450	1998 - 2002	
RX Date Immunotherapy Flag	1241	2010 - 2021	
RX Date Other Flag	1251	2010 - 2021	

Data Item	NAACCR Item Number	Collection Dates	
Date of Last Follow-up or Death Flag	1751	2010 - 2021	
Height	Non - NAACCR 9960	2011 - 2020	
Weight	Non - NAACCR 9961	2011 - 2020	
Tobacco Use	Non - NAACCR 9965 - 9968	2011- 2020	
COVID-19	Non- NAACCR	SEER	Text field information only