
**Department of State Health Services
Texas Cancer Registry
Handbook Quick Reference Sheet**

The Sample Abstract Form can be found in Appendix F in the 2012 CRH.

Data Field 580 DATE OF ADMIT/FIRST CONTACT/ADMIT (YYYYMMDD) (pg 45): Enter year, month and day of the patient's first admission to your facility for diagnosis and/or treatment of this reportable cancer or, if previously diagnosed/treated elsewhere, the date of the first admission to your facility with active cancer or receiving cancer treatment.

Data Field 550 REGISTRY NUMBER (pg 46): The first four digits identify the calendar year the patient was first seen at the facility with a reportable diagnosis. The following five digits identify the numerical order in which the case was entered into the registry. Each year's accession/registry number will start with **00001.mk**

Data Field 540 REPORTING FACILITY NUMBER (pg 46): Enter 3 digit code assigned by TCR. If you do not know your facility number, contact your regional office or call 1-800-252-8059.

Data Field 500 REPORTING SOURCE (pg 47): Enter code for the source documents and/or facility used to abstract the case.

- 1 - Hospital inpatient; Managed health plans with comprehensive, unified medical records
- 2 - Radiation Treatment Centers or Medical Oncology Centers (Facility or Private)
- 3 - Laboratory Only (Facility or Private)
- 4 - Physician's Office/Private Medical Practitioner
- 5 - Nursing/Convalescent Home, Hospice
- 6 - Autopsy Only
- 7 - Death Certificate Only
- 8 - Other hospital outpatient units/surgery centers

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

Data Field 2300 MEDICAL RECORD NUMBER (pg 49): Enter the medical record number (MRN) used for the patient's first admission with a DX of cancer. MRN's less than 11 digits and alpha characters are acceptable. If the MRN is not available (for example, outpatient clinic charts) enter "OP" in this field.

Special Codes:

- RT Radiation Therapy department patient without a medical record number
- SU One-day surgery clinic patient without a medical record number
- UNK Medical Record Number Unknown

Data Field 610 CLASS OF CASE (pg 49): Divides data into analytical and non-analytical categories.

Data Field 2230 PATIENT LAST NAME (pg 54): Enter the name of the patient in capital letters. Hyphens, other special characters, and spaces are allowed. **Do not leave blank.**

Data Field 2240 PATIENT FIRST NAME (pg 54): Enter first name of patient in capital letters. Hyphens, other special characters, and spaces are allowed. **Do not leave blank.**

Data Field 2250 PATIENT MIDDLE NAME (pg 55): Enter the middle name of the patient in capital letters. Hyphens, other special characters, and spaces are allowed. Enter middle initial if full name is unknown. Leave blank if unknown.

Data Field 2390 PATIENT MAIDEN NAME (pg 55): Enter the maiden name of female patients who are or have been married. Hyphens, other special characters and spaces are allowed. Leave blank if unknown.

Data Field 2280 NAME-ALIAS (pg 55): Enter an alternative name or "AKA" used by the patient, if known. If unknown, leave blank

Data Field 2330 STREET ADDRESS (pg 56): Enter the number and street of the patient’s residence at the time the cancer is diagnosed in 25 characters or less. If address is not known, enter “NO ADDRESS” or “UNKNOWN”. DO NOT LEAVE BLANK. Punctuation marks are not allowed in this field. Abbreviate, as needed using standard address abbreviations listed in the *U.S. Postal Service National Zip Code and Post Office Directory* published by the U.S. Postal Service or on the website at <https://www.usps.com/>

Data Field 2335 ADDRESS AT DX SUPPLEMENTAL (pg 58): If the name of a facility is provided instead of an address enter the facility name here. If this space is not needed **leave it blank**.

Data Field 70 PATIENT CITY (pg 59): Enter the city of residence at the time the cancer is diagnosed. If no address is known, record “Unknown”. **Do not leave blank**.

Data Field 80 PATIENT STATE (pg 59): Enter the two letter abbreviation for state of residence at time of diagnosis. Record US for resident of United States, NOS. If resident of foreign country, other than Mexico (MX) or Canada (CD), record either XX if the country is known or YY if the country is unknown. If no address is known, enter “ZZ”.

Data Field 100 PATIENT ZIP CODE (pg 62): Enter patient's zip code at time of diagnosis. If known, enter nine digit extended zip code. If unavailable, refer to National Zip Code Directory or the USPS website: <http://zip4.usps.com/zip4/welcome.jsp>
If resident of foreign country, code all "8's." If address is not available enter “99999”.

Data Field 90 FIPS COUNTY CODE: (pg 63 & APPENDIX C) Enter the three digit Federal Information Processing Standards code found in Appendix C. Code “998” for out-of-state or foreign residents. If address is not available enter “999”.

Data Field 2320 PATIENT SSN (pg 64): Every resource should be exhausted to obtain social security number. If not available, code all "9's" **as a last resort only**. Take caution to enter the patient's number and not the spouse's number. Dashes and slashes are not allowed in this field.

Data Field 240 PATIENT DATE OF BIRTH (YYYYMMDD) (pg 64): DOB must be coded. Enter year, month and day of patient's birth. **Unknown date of birth will not be accepted**

Data Field 250 PLACE OF BIRTH (pg 65 and Appendix G) Record patient’s place of birth (if available) using the SEER Geocodes in Appendix G. If the place of birth is unknown, code 999.

Data Field 160 RACE 1 (page 66): Enter the 2 digit code to identify the primary race of the patient.

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

Data Field 161, 162, 163 & 164 RACE 2, RACE 3, RACE 4, & RACE 5 (pg 68): If the patient is multi-racial, code all

the races using items (RACE 2) through (RACE 5) Use code "88" for no further race documented.

Data Field 190 SPANISH/HISPANIC ORIGIN (pg 69): This code identifies persons of Spanish or Hispanic origin. The information may be coded from the medical record or may be based on Spanish/Hispanic names. **Persons of Spanish or Hispanic origin may be of any race.** (A list of Spanish/Hispanic surnames is on the TCR website in Appendix M)

- | | |
|---|--|
| 0 Non-Spanish; non Hispanic (includes Portuguese and Brazilian) | 5 Other specified Spanish/Hispanic |
| 1 Mexican (includes Chicano, NOS) | 6 Spanish, NOS; Hispanic, NOS; Latino, NOS |
| 2 Puerto Rican | 7 Spanish surname only |
| 3 Cuban | 9 Unknown whether Spanish or not |
| 4 South Central American (Except Brazil) | |

Data Field 220 PATIENT SEX (pg 71): Enter the code to identify the gender of the patient.

- | | | |
|----------|-------------------------|----------------------|
| 1 Male | 3 Other (Hermaphrodite) | 9 Not stated/Unknown |
| 2 Female | 4 Trans-sexual | |

Data Field 320 TEXT USUAL INDUSTRY (pg 71) Document the patient's usual industry to the extent that the information is available in the medical record.

Data Field 310 TEXT USUAL OCCUPATION (pg 72): Document the patient's usual occupation to the extent that the information is available in the medical record.

Data Field 2680 OTHER PERTINENT INFORMATION (pg 74) Document other pertinent information for which adequate or appropriate space has not been provided on the reporting form. Such information may include additional staging or treatment information, history of disease or comments regarding lack of documentation in the medical record. Document the name of the facility that referred the patient or the name of the facility that the patient was referred to in this field. Document age and race of the patient in this field.

Data Field 2470 PHYSICIAN FOLLOW UP (pg 74): Record the state license number of the physician currently responsible for following the patient. Physician license numbers for Texas can be found at the following website: <http://www.docboard.org/tx/df/txsearch.htm>

Data Field 560 SEQUENCE NUMBER (pg 75): Indicates the chronological sequence of this reportable neoplasm IN THE PATIENT'S LIFETIME. Each PRIMARY tumor is assigned a different number.

Malignant Primaries

- 00 One malignant primary only
- 01 First of multiple malignant primaries
- 02 Second of multiple malignant primaries
- 03 Third of multiple malignant primaries
- 99 Unspecified number of malignant primaries

Benign Primaries

- 60 One benign primary only
- 61 First of multiple benign primaries
- 62 Second of multiple benign primaries
- 63 Third of multiple benign primaries
- 88 Unspecified number of benign primaries

Data Field 2220 OTHER PRIMARY TUMORS (SITE, MORPHOLOGY, AND DATE) (pg 76): Complete **if the patient has other reportable tumors during their lifetime.** Record the site, morphology, and date of any other primaries. **DO NOT INCLUDE SECONDARY/METASTATIC LESIONS.**

Data Field 630 PRIMARY PAYER AT DX (pg 77): Record the type of insurance the patient has.

- | | |
|--|--|
| 01 Not insured | 62 Medicare-Administered through a managed care plan |
| 02 Not insured, self pay | 63 Medicare with private supplement |
| 10 Insurance, NOS | 64 Medicare with Medicaid eligibility |
| 20 Private Insurance: Managed Care, HMO, PPO | 65 TRICARE |
| 21 Private Insurance: Fee-for-Service | 66 Military |
| 31 Medicaid | 67 Veterans Affairs |
| 35 Medicaid-Administered through a managed care plan | 68 Indian/Public Health Services |
| 60 Medicare without supplement, Medicare, NOS | 99 Insurance status unknown |
| 61 Medicare with supplement, NOS | |

Non-NAACCR Standard Data Fields 9965 (TOBACCO USE CIGARETTES), 9966 (TOBACCO USE OTHER SMOKE), 9967 (TOBACCO USE SMOKELESS), and 9968 (TOBACCO USE NOS) (pg 79-81): Record the patient's past or current use of tobacco. Record from sections such as Nursing Interview Guide, Vital Stats, or Nursing Assessment section.

- 0 Never used
- 1 Current user
- 2 Former user, quit within one year of the date of diagnosis
- 3 Former user, quit more than one year prior to the date of diagnosis
- 4 Former user, unknown when quit
- 9 Unknown/not stated/no smoking specifics provided

Data Field 390 DATE OF INITIAL DIAGNOSIS (YYYYMMDD) (pg 83): Enter the date of initial diagnosis of this cancer by a recognized medical practitioner **by any method** (for example, a positive finding from a radiology report); regardless of whether the diagnosis was made at this facility or elsewhere. The date of diagnosis for "Death Certificate Only" or "Autopsy Only" is the date of death. For vague dates, estimate month and year. For cases with unknown date of diagnosis code month and year of date of first contact (for June 2010 code 201006) and document "Date of dx unknown" in Other Pertinent Information Text Field. This should be used as a last resort after exhausting all available resources. Every effort must be made to obtain date of diagnosis.

Data Field 420, 430 MORPHOLOGY ICD-O-2: TYPE AND BEHAVIOR (pg 86): The International Classification of Diseases for Oncology, (ICD-O) 2nd Edition, is to be used for coding and reporting the morphology and behavior of tumors diagnosed before January 1, 2001. **Adequate documentation of tumor cell type must be provided in the FINAL DIAGNOSIS** section of the reporting form. Use all pathology reports available; generally tissue from a resection or excision is most representative of the tumor's histology.

Data Field 522 & 523 MORPHOLOGY ICD-O-3: TYPE AND BEHAVIOR (pg 86): The International Classification of Diseases for Oncology, (ICD-O) 3rd Edition is to be used for coding and reporting the morphology and behavior of tumors diagnosed on or after January 1, 2001. **Adequate documentation of tumor cell type must be provided in the**

FINAL DIAGNOSIS section of the reporting form to support coding. Use all pathology reports available; generally tissue from a resection or excision is most representative of the tumor's histology.

Note: Refer to Multiple Primary/Histology Rules (MP/H), Appendix O for cases diagnosed on or after 1/1/2007. Refer to Appendix E for hematopoietic and lymphoid malignancies diagnosed before 1/1/2010. For hematopoietic and lymphoid malignancies diagnosed on or after 1/1/2010 refer to <http://seer.cancer.gov/tools/heme/index.html>.

Data Field 400 PRIMARY SITE (pg 88): Record the specific topography code from ICD-O. **Adequate documentation must be provided in the FINAL DIAGNOSIS** (Data Fields 2590 and 2580) section of the reporting form to support coding.

Data Field 440 GRADE OF TUMOR (pg 96): The grade or differentiation of the tumor describes the resemblance of the tumor cells to their normal tissue counterparts. The more undifferentiated the tumor, the greater the incidence of metastases and the more rapid the clinical course. **Do not code the grade of a metastatic site.** If the grade for the primary is unknown enter "9" in this field.

- 1 Grade I Well differentiated
- 2 Grade II Moderately differentiated, moderately well differentiated, intermediate differentiation, partially well differentiated, partially differentiated, low grade NOS
- 3 Grade III Poorly differentiated, moderately undifferentiated, relatively undifferentiated, slightly undifferentiated, medium grade NOS
- 4 Grade IV Undifferentiated, anaplastic, dedifferentiated, high grade NOS
- 9 Grade or differentiation not determined, not stated, or not applicable

Codes for T-cell and B-cell designation for lymphomas and leukemia:

- 5 T-cell, T-precursor

- 6 B-cell, pre B; B-precursor
- 7 Null cell; non T-non B (for leukemia only)
- 8 Natural Killer (NK) cell
- 9 Grade or differentiation not determined, not stated or not applicable

Note: For lymphomas, do not code the descriptions “high grade”, “low grade”, or “intermediate grade” in this field.

Refer to Appendix A of the CRH for specific coding guidelines on grade for Prostate, Breast, Kidney, Astrocytoma, Lymphoma, Leukemia, and Sarcoma primaries.

Data Field 441 GRADE PATH VALUE (pg 100): Documents the numerator (first number) of a tumor grade reported in a 2, 3, or 4 grade system.

- 1 Recorded as Grade I or 1
- 2 Recorded as Grade II or 2
- 3 Recorded as Grade III or 3
- 4 Recorded as Grade IV or 4
- Blank No 2, 3, or 4 grade system available; Unknown

Data Field 449 GRADE PATH SYSTEM (pg 101): Documents the denominator (second number) of a tumor grade reported in a 2, 3, or 4 grade system.

- 1 Recorded as Grade I or 1
- 2 Recorded as Grade II or 2
- 3 Recorded as Grade III or 3
- 4 Recorded as Grade IV or 4
- Blank No 2, 3, or 4 grade system available; Unknown

Data Field 410 LATERALITY (pg 102): Enter the code to identify the laterality of a paired site.

- 0 Not a paired site
- 1 Right: origin of primary
- 2 Left: origin of primary
- 3 Only one side involved, right or left origin not indicated
- 4 Bilateral involvement, lateral origin unknown: stated to be single primary; includes: both ovaries involved simultaneously with a single histology; bilateral retinoblastoma; bilateral Wilms’ tumors
- 5 Midline in a paired site
- 9 Unknown site, paired site, lateral origin unknown; midline tumor

Data Field 2580 & 2590 FINAL DIAGNOSIS- MORPHOLOGY/BEHAVIOR, GRADE, PRIMARY SITE, AND LATERALITY DOCUMENTATION (pg 107): Record the morphology/behavior, grade, primary site, and laterality descriptions.

Data Field 1182 LYMPH-VASCULAR INVASION (pg 108): Indicates presence or absence of tumor cells in lymphatic channels.

- 0 Lymph-vascular invasion not present
- 1 Lymph-vascular invasion present
- 8 Not applicable
- 9 Unknown if lymph-vascular invasion present

Data Field 490 DIAGNOSTIC CONFIRMATION (pg 109): The best method of confirmation throughout the entire course of the disease. All diagnostic reports in the medical record must be reviewed to determine the most definitive method used to confirm the diagnosis of cancer.

Microscopically Confirmed

- 1 Histology-Microscopic diagnosis based upon tissue specimens from biopsy, frozen section, surgery, autopsy, or D&C. Positive hematologic findings relative to leukemia are also included. Bone marrow specimens (including aspiration biopsies) are coded as “1”.

- 2 Cytology- Cytologic diagnosis with no positive histology such as pap smears bronchial brushings, FNA and peritoneal fluid.
- 3 Positive histology PLUS positive immunophenotyping AND/OR positive genetic studies (to be used only for hematopoietic and lymphoid neoplasms)
- 4 Microscopic Confirmation, NOS -- Diagnosis stated to be microscopically confirmed but method not specified.

Not Microscopically Confirmed

- 5 Laboratory test/marker study -- Clinical diagnosis of cancer based on certain laboratory tests or marker studies.
- 6 Direct Visualization -- Visualization without microscopic confirmation, i.e., exploratory laparotomy or endoscopy.
- 7 Radiology/Imaging -- Radiology and other imaging techniques without microscopic confirmation, i.e. CAT scans and MRI.
- 8 Other (other than 5, 6 or 7) -- Cases diagnosed by clinical methods not mentioned above and for which there were no positive microscopic findings. Physician documented the tumor in the medical record. Refer to ambiguous Terminology List on page 23.

Confirmation Unknown

- 9 Unknown -- Cases for which it is unknown whether or not microscopically confirmed. Also includes "Death Certificate Only" cases.

Data Field 760 Summary Stage 1977 (pg 8): To be used with cases diagnosed/admitted prior to 2001. Summary Stage refers to the extent of disease categorized as in-situ, localized, regional, and distant.

- | | |
|-----------------------------|--|
| 0 In Situ | 4 Regional by both direct extension and regional LN involvement |
| 1 Localized | 5 Regional, NOS |
| 2 Regional direct extension | 7 Distant site(s)/node(s) involved; systemic disease |
| 3 Regional to lymph nodes | 9 Unknown if extension or metastasis (unstaged, unknown, or unspecified) Death Certificate Only case |

Note: Do not use Code "8" for Summary Stage.

Data Field 759 SUMMARY STAGE 2000 (pg 8): To be used with cases diagnosed/admitted January 1, 2001 and after. Summary Stage refers to the extent of disease categorized as in-situ, localized, regional, and distant.

- | | |
|--------------------------------------|--|
| 0 In Situ | 4 Regional by both direct extension and regional LN involvement |
| 1 Localized | 5 Regional, NOS |
| 2 Regional direct extension | 7 Distant site(s)/node(s) involved; systemic disease |
| 3 Regional lymph nodes involved only | 9 Unknown if extension or metastasis (unstaged, unknown, or unspecified) Death Certificate Only case |

Note: Do not use Code "8" for Summary Stage.

Data Field 2800 CS TUMOR SIZE (Quick Reference Standard CS Tables pg 1): Record for cases diagnosed on or after January 1, 2004. Record the largest dimension or diameter of the **primary tumor** before systemic therapy unless the size of the tumor is greater after neoadjuvant treatment. Always record the size in millimeters. **Documentation in the Summary Stage field is required to support coding**

Data Field 2810 CS EXTENSION (Quick Reference Standard CS Tables pg 6): Record for cases diagnosed on or after January 1, 2004. Code the farthest extension of the primary tumor. Do not code discontinuous metastases in this field. **Documentation in the Summary Stage field is required to support coding.**

Data Field 2820 CS /TUMOR SIZE/EXT EVAL (Quick Reference Standard CS Tables pg 9): Identifies how codes for CS TUMOR SIZE and CS EXTENSION were determined based on the diagnostic methods employed.

Documentation in the Summary Stage text field is required to support coding.

Data Field 2830 CS LYMPH NODES (Quick Reference Standard CS Tables pg 17): Record for cases diagnosed on or after January 1, 2004. Identifies the regional lymph nodes involved with the cancer at the time of diagnosis. Record the specific regional lymph node chain farthest from the primary site that is involved by tumor either clinically or

pathologically. Information can be obtained from; radiological reports, surgical reports, and pathology reports. If the patient receives preoperative (neoadjuvant) systemic therapy (chemotherapy, hormone therapy, and immunotherapy) or radiation therapy, code the farthest involved regional lymph nodes, based on information prior to surgery. **Exception:** In the infrequent event that clinically involved lymph nodes do not respond to neoadjuvant treatment, and are, in fact, more extensively involved at surgery as determined by the pathology report, code the lymph node involvement based on pathology/operative report after surgery.

Use code 988, not applicable, for the following sites or morphologies:

Placenta

Brain and Cerebral Meninges, Other Parts of Central Nervous System

Hodgkin and Non-Hodgkin Lymphoma

Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms

Other and Ill-Defined Primary Sites, Unknown Primary Sites

Data Field 2840 CS LYMPH NODES EVAL (Quick Reference Standard CS Tables pg 24): Record how the code for the item *CS Lymph Nodes* was determined, based on the diagnostic methods employed and their intent. **Documentation in the Summary Stage text field is required to support coding.**

Data Field 820 REGIONAL NODES POSITIVE (Quick Reference Standard CS Tables pg 30): Record the total number of regional lymph nodes pathologically examined and found to be positive. The number of regional lymph nodes positive is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment.

Use code 99 for sites or morphologies for which information about the field is unknown or not applicable:

Examples: Brain

Intracranial Gland

Reticuloendotheliosis

Placenta

Leukemia, Lymphoma

Myeloma and Plasma Cell Disorder

Other and Ill-Defined Primaries, Unknown Primaries

Data Field 830 REGIONAL LYMPH NODES EXAMINED (Quick Reference Standard CS Tables pg 33): Record the total number of regional lymph nodes removed. The number of regional lymph nodes removed is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment. If no regional lymph nodes are identified in the pathology report, code 00.

Use code 99 for sites or morphologies for which information about the field is unknown or not applicable:

Examples: Brain

Intracranial Gland

Reticuloendotheliosis

Placenta

Leukemia, Lymphoma

Myeloma and Plasma Cell Disorder

Other and Ill-Defined Primaries, Unknown Primaries

Data Field 2850 CS METS AT DX (Quick Reference Standard CS Tables pg 35): Record for cases diagnosed on or after January 1, 2004. Identifies the distant site(s) of metastatic involvement at time of diagnosis. Assign the highest applicable code for metastasis at the time of diagnosis. This can be determined clinically or pathologically. Information can be obtained from radiological reports, surgical reports, pathology reports, or physician notes. Metastasis known to

have developed after extent of disease was established should not be considered for this field. **Documentation in the Summary Stage text field is required to support coding.**

Data Field 2860 CS METS EVAL (Quick Reference Standard CS Tables pg 37): Record how the code for the item *CS Mets at DX* was determined based on the diagnostic methods employed. **Documentation in the Summary Stage text**

field is required to support coding.

Data Fields 2880, 2890, 2900, 2910, 2920, 2930, 2861, 2862, 2863, 2864, 2865, 2866, 2867, 2868, 2869, 2870, 2871, 2875, 2876, 2877, 2879 CS SITE-SPECIFIC FACTORS (pg A-1 to A-249): Record for cases diagnosed on or after January 1, 2004. Identifies additional information needed to generate stage or prognostic factors that have an effect on stage or survival for certain primary sites.

Note: For the above Site-Specific Factors, refer to the specified site schemas in Appendix A for coding instructions.

Documentation in the Summary Stage text field is required to support coding.

Data Field 2600 SUMMARY STAGE DOCUMENTATION (pg 172): Text field for documentation of extent of disease to support coding. Include findings from radiology and pathology reports and descriptions of observations from history and physical and operative reports. Include dates and types of procedures and exams. Document information such as lymph node involvement, extent of invasion, extension to adjacent organs, and metastatic spread of disease. Both positive and negative findings that are pertinent to describing the spread of the tumor from the primary site should be recorded. All combined clinical and surgical assessment within **FOUR MONTHS** of diagnosis in the absence of disease progression should be documented. These findings may be obtained from diagnostic reports of radiology, endoscopy, surgery, and laboratory tests prior to treatment. Document both the date and the source of the staging information.

Data Field 1260 DATE OF INITIAL TREATMENT (YYYYMMDD) (pg 118): Enter the date the first course of treatment (surgery, radiation, systemic or other) started at any facility. **Note: This field will no longer be derived.**

Data Field 1261 DATE OF INITIAL RX FLAG (pg 119): This flag explains why there is no appropriate value in the corresponding date field.

Code Description

10 No information whatsoever can be inferred from this exceptional value (e.g., unknown if therapy was administered).

11 No proper value is applicable in this context (e.g. therapy was not administered)

(blank) A valid date value is provided in item *Date of Initial Treatment* (NAACCR Item #1260).

Data Field 1292 SCOPE OF REGLN SURGERY (page 119): Enter the code that defines the removal of regional lymph nodes. If no cancer-directed procedure was performed code (0).

Data Field 1200 RX DATE-SURGERY (YYYYMMDD) (pg 125): Document and enter the date of the **first** definitive cancer-directed surgery performed at any facility. If two or more cancer-directed surgeries are performed, enter the date for the first cancer-directed surgery. If surgery was done but the date is unknown record the year and month of diagnosis and leave the day blank.

Data Field 1201 RX DATE SURGERY FLAG (pg 126): This flag explains why there is no appropriate value in the corresponding date field.

Code Description

10 No information whatsoever can be inferred from this exceptional value (unknown if any surgery performed).

11 No proper value is applicable in this context (for example, no surgery performed)

(blank) A valid date value is provided in item *Date of first surgical procedure* (NAACCR Item #1200).

Data Field 1290 SURGERY RX CODE (pg 127 & APPENDIX A, pg A-251 to A-313): Document and code the most definitive first course cancer-directed surgery at any facility. Cancer-directed surgery is an operative procedure that actually removes, excises, or destroys cancer tissue of the primary site. Surgery performed solely for the purpose of establishing a diagnosis/stage (exploratory surgery), the relief of symptoms (bypass surgery), or reconstruction is not considered cancer-directed surgery. Brushings, washings and aspiration of cells are not surgical procedures.

Data Field 1340 REASON FOR NO SURGERY (pg 129): If no cancer directed surgery to the primary site was performed record the reason.

0 Surgery of the primary site was performed	6 Surgery recommended and unknown why not performed
1 Not part of the planned first course	7 Patient or family refused surgery
2 Not recommended due to patient risk factors	8 Surgery recommended, unknown if performed
5 Patient died prior to planned or recommended surgery	9 Unknown if surgery recommended or performed

Data Field 1294 RX SUMM-SURG.OTH REG/DIST RX CODE (pg 130): Document and code the highest numbered code that describes the surgical resection of Regional/Distant Sites and Distant lymph nodes.

Data Field 1210 DATE RADIATION STARTED (YYYYMMDD) (pg 132): Document and enter the date radiation began at any facility as part of the first course of treatment. Record all zeros when no radiation therapy is delivered or the cancer was diagnosed at autopsy. Record all 9's when it is unknown whether any radiation therapy was delivered.

Data Field 1211 DATE RADIATION FLAG (pg 133): This flag explains why there is no appropriate value in the corresponding date field.

Code	Description
10	No information whatsoever can be inferred from this exceptional value (unknown if radiation given).
11	No proper value is applicable in this context (for example, no radiation given)
15	Information is not available at this time, but it is expected that it will be available later.
(blank)	A valid date value is provided in item <i>Date Radiation Started</i> (NAACCR Item #1210).

Data Field RX SUMM-RAD (pg 134): Document and code type of radiation therapy performed as part of the first course of treatment.

Code	Description
0	None; Diagnosed at autopsy
1	Beam radiation
2	Radioactive implants
3	Radioisotopes
4	Combination of 1 with 2 or 3
5	Radiation, NOS – method of source not specified
7	Patient or patient's guardian refused radiation therapy
8	Radiation recommended, unknown if administered
9	Unknown if radiation administered

Data Field 1570 RAD-REG RX MODALITY CODE (pg 136): Document and code the dominant modality of radiation therapy used to deliver the clinically most significant dose to the primary volume of interest during first course of treatment.

Data Field 1380 RX SUMM-SURG/RAD SEQ (pg 139): Code the sequence of radiation and surgical procedures given as part of the first course of treatment.

0	No radiation therapy and/or surgical procedures
2	Radiation therapy before surgery
3	Radiation therapy after surgery
4	Radiation therapy both before and after surgery
5	Intraoperative radiation therapy
6	Intraoperative radiation therapy with other therapy administered before or after surgery
7	Surgery both before and after radiation
9	Sequence unknown, but both surgery and radiation were given

Data Field 1430 REASON NO RADIATION (pg 141): Code the reason no regional radiation therapy was administered to the patient.

Code	Description
0	Radiation therapy was administered.
1	Radiation therapy was not administered because it was not part of the planned first course treatment.
2	Radiation therapy was not recommended/administered because it was contraindicated due to other patient risk

factors

- 5 Radiation therapy was not administered because the patient died prior to planned or recommended therapy.
- 6 Radiation therapy was not administered; it was recommended by the patient's physician but was not administered as part of first course treatment. No reason was noted in patient record.
- 7 Radiation therapy was not administered; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in patient record.
- 8 Radiation therapy was recommended, but it is unknown whether it was administered.
- 9 It is unknown if radiation therapy was recommended or administered. Death certificate and autopsy cases only.

Data Field 3230 DATE SYSTEMIC THERAPY STARTED (YYYYMMDD) (pg 142): Document and enter the date systemic therapy began at any facility. Systemic therapy includes: chemotherapy, hormonal agents, immunotherapy, bone marrow transplants, stem cell harvests, surgical and/or radiation endocrine therapy. Record all zeros when no systemic therapy was delivered or the cancer was diagnosed at autopsy. If no systemic therapy was given or it is unknown if systemic therapy was given, leave the field blank.

Data Field 3231 RX DATE SYSTEMIC FLAG (pg 143): This flag explains why there is no appropriate value in the corresponding date field.

Code Description

- 10 No information whatsoever can be inferred from this exceptional value (that is, unknown if any systemic therapy was given).
- 11 No proper value is applicable in this context (for example, no systemic therapy given)
- 15 Information is not available at this time, but it is expected that it will be available later (that is, systemic therapy is planned as part of first course treatment, but had not yet started at the time of the last follow-up).
- (blank) A valid date value is provided in item *Date Systemic Therapy Started* (NAACCR Item #3230).

Data Field 1220 CHEMOTHERAPY DATE STARTED (YYYYMMDD) (pg 144): Record the first or earliest date of chemotherapy. If no chemotherapy was given or it is unknown if chemotherapy was given, leave the field blank.

Data Field 1221 CHEMOTHERAPY DATE STARTED FLAG (pg 144): This flag explains why there is no appropriate value in the corresponding date field.

Code Description

- 10 No information whatsoever can be inferred from this exceptional value (unknown if chemotherapy was given)
- 11 No proper value is applicable in this context (no chemotherapy given)
- 15 Information is not available at this time, but it is expected that it will be available later (chemotherapy is planned as part of first course treatment, but had not yet started at the time of the last follow-up).
- (blank) A valid date value is provided in item *Date Chemotherapy Started* (NAACCR Item #1220).

Data Field 1390 CHEMOTHERAPY CODE (page 145): Document and code the type of chemotherapy the patient received as part of the first course of treatment at any facility. Chemotherapy may involve the delivery of one or a combination of chemotherapeutic agents. Code 88 if the only information available is that the patient was referred to an oncologist. Code 00 if chemotherapy was not delivered

Data Field 1230 DATE HORMONE THERAPY STARTED (YYYYMMDD) (pg 148): Record the first or earliest date on which hormone therapy was given as part of first course of treatment. If no hormone therapy was given or it is unknown if hormone therapy was given, leave this field blank.

Data Field 1231 RX DATE HORMONE FLAG (pg 148): This flag explains why there is no appropriate value in the corresponding date field.

Code Description

- 10 No information whatsoever can be inferred from this exceptional value (unknown if any hormone therapy was given)
- 11 No proper value is applicable in the context (no hormone therapy given)
- 15 Information is not available at this time, but it is expected that it will be available later.

(blank) A valid date is provided in item *Date Hormone Therapy Started* (NAACCR Item #1230).

Data Field 1400 RX SUMM-HORMONE (pg 149): Document and code the type of hormone therapy the patient received as part of the first course of treatment at any facility. Hormonal therapy may involve the delivery of one or a combination of agents. Code 88 when the only information available is the patient was referred to an oncologist. Code 00 if hormone therapy was not delivered

Data Field 1240 IMMUNOTHERAPY DATE STARTED (YYYYMMDD) (pg 152): Record the date of initiation of immunotherapy or a biologic response modifier (BRM) that is part of the first course of therapy. If no immunotherapy was given or it is unknown if immunotherapy was given, leave this field blank.

Data Field 1241 IMMUNOTHERAPY DATE STARTED FLAG (pg 153): This flag explains why there is no appropriate value in the corresponding date field.

Code Description

- 10 No information whatsoever can be inferred from this exceptional value (unknown if immunotherapy was give).
 - 11 No proper value is applicable in this context (no immunotherapy given).
 - 15 Information is not available at this time, but it is expected that it will be available later (immunotherapy is planned as part of first course treatment, but had not yet been started at the time of the last follow-up)
- (blank) A valid date is provided in item *Date Immunotherapy Started* (NAACCR Item #1240)

Data Field 1410 IMMUNOTHERAPY CODE (pg 153): Document and code the type of Immunotherapy the patient received as part of the first course of treatment at any facility. Code to 88 when the only information is that the patient was referred to an oncologist. Code 00 if Immunotherapy was not delivered.

Data Field 3250 TRANSPLANT/ENDOCRINE CODE (pg 156): Code the type of hematologic transplant and/or endocrine procedures the patient received as part of the first course of treatment at any facility. Code 88 if the only information is that the patient was referred to a specialist for hematologic transplant or endocrine procedures. Code 00 if a transplant or endocrine procedure was not done.

Data Field 1639 RX SUMM—SYSTEMIC SURG SEQ (pg 158): Code the administration of systemic therapy in sequence with the first surgery performed, described in the data item **Date of First Surgical Procedure**.

- 0 No systemic therapy and/or surgical procedures
- 2 Systemic therapy before surgery
- 3 Systemic therapy after surgery
- 4 Systemic therapy both before and after surgery
- 5 Intraoperative systemic therapy
- 6 Intraoperative systemic therapy with other therapy administered before or after surgery
- 7 Surgery both before and after systemic therapy
- 9 Sequence unknown

Data Field 1250 DATE OTHER TREATMENT STARTED (YYYYMMDD) (pg 160): Enter the date other treatment is delivered that is not included in surgery, radiation therapy, and systemic treatment. If no other treatment was given or it is unknown if other treatment was given, leave the field blank.

Data Field 1251 RX DATE OTHER FLAG (pg 161): This flag explains why there is no appropriate value in the corresponding date field.

Code Description

- 10 No information whatsoever can be inferred from this exceptional value (unknown if any Other Treatment was given).
- 11 No proper value is applicable in this context (for example, no Other Treatment given).

(blank) A valid date value is provided in item *Date Other Treatment Started* (NAACCR Item #1250).

Data Field 1420 OTHER TREATMENT CODE (pg 162): Document and code the type of “other treatment” the patient received as part of the first course of treatment at any facility. “Other treatment” is designed to modify or control the cancer cells, but is not included in surgery, radiation, or systemic therapy.

Data Field 1285 RX SUMM-TREATMENT STATUS (pg 164): Code whether or not first course treatment was given.

- 0 No treatment given
- 1 Treatment given
- 2 Active surveillance (watchful waiting)
- 9 Unknown if treatment was given

Data Fields 2610, 2620, 2640, 2650, 2660, 2670 TREATMENT DOCUMENTATION (pg 166): Text field used to support codes in the treatment fields. Document all planned treatment even if it is unknown if treatment was given. List dates and types of all treatment given, even if it was done at another facility.

Data Field 1750 DATE OF LAST CONTACT OR DEATH (YYYYMMDD) (pg 164): Enter the date the patient was last seen at your facility, date of last contact, or date of death. If patient is known to be deceased, but date of death is not available, date of last contact should be recorded in this field. In the “Other Pertinent Information” text area, document the patient is deceased and the date of death is not available.

Data Field 1760 VITAL STATUS (pg 165): Patient’s vital status as of the date recorded in the “Date of last contact/death” field.

- 0 Dead
- 1 Alive

Data Field 2090 DATE ABSTRACTED (YYYYMMDD) (pg 165): Record year, month, and day reporting form is completed.

Data Field 570 ABTRACTOR INITIALS (pg 166): Record the initials of the abstractor.