2017 Cancer Reporting Handbook

Rules and Guidelines for Cancer Reporting in Texas

Texas Cancer Registry

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INTRODUCTION TO CANCER REPORTING

TEXAS CANCER REGISTRY

Preface

With original authorization from the *1979 Texas Cancer Control Act* and the *Texas Cancer Incidence Reporting Act*, Chapter 82, Health and Safety Code (amended April 2015), the Texas Cancer Registry (TCR) of the Texas Department of State Health Services (DSHS) collects information on each patient seeking diagnosis and/or treatment for cancer at health care facilities, clinical laboratories, as well as physician and other outpatient offices (in certain circumstances), within the State of Texas. Texas Administrative Code, Chapter 91, Subchapter A (amended April 2017) specifies the rules necessary to implement this act. The cancer reporting law and rules may be accessed on the TCR website at the following location: https://www.dshs.texas.gov/tcr/lawrules.aspx.

The mission of the TCR is to collect, maintain, and disseminate high quality cancer data that contribute towards cancer prevention and control, research, improving diagnoses, treatment, survival, and quality of life for all cancer patients. It is estimated that in 2017 there will be 120,173 Texans newly diagnosed with cancer, and another 44,523 will die of the disease. A statewide cancer registry is the foundation for cancer prevention and control. The effectiveness of the Cancer Registry is dependent on complete, timely and accurate reporting.

The TCR is the 4th largest cancer registry in the United States. Over 190,000 reports of cancer are received annually from over 550 hospitals, cancer treatment centers, ambulatory surgery centers, and pathology laboratories located throughout the state. The Texas Cancer Registry *2017 Cancer Reporting Handbook* serves as the instruction manual to provide rules and guidelines which assure the consistent collection and coding of relevant cancer case information. This edition should be used for reportable cases diagnosed January 1, 2017 and forward. The contents of this manual are based on the guidelines and standards for cancer reporting established by the National Program of Cancer Registries (NPCR) at the Centers for Disease Control and Prevention (CDC), the North American Association of Central Cancer Registries (NAACCR), the Surveillance, Epidemiology, and End Results Program (SEER) at the National Cancer Institute (NCI), and the American College of Surgeons (ACoS).

The handbook may be accessed on the TCR website on the following page: https://www.dshs.texas.gov/tcr/training/2017-handbook.aspx.

For any problems please contact the TCR. Please remember to monitor the TCR website for training opportunities. This information can be found at https://www.dshs.texas.gov/tcr/training.aspx.

HANDBOOK SOURCES

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

- *SEER Program Coding and Staging Manual 2016* (Updated January 4, 2017). Surveillance, Epidemiology, and End Results Program, National Cancer Institute, Bethesda, MD 20850-9765. https://seer.cancer.gov/tools/codingmanuals/.
- *Facility Oncology Registry Data Standards (FORDS): Revised for 2016.* Commission on Cancer, American College of Surgeons, Chicago, IL 60611-3211. https://www.facs.org/quality-programs/cancer/ncdb/registrymanuals/cocmanuals/fordsmanual.
- *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary, Record Layout Version 16* (Revised November 2015). North American Association of Central Cancer Registries, Springfield, IL 62704-4194. https://www.naaccr.org/data-standards-data-dictionary/.
- *International Classification of Diseases for Oncology, Third Edition (ICD-O-3).* Geneva: World Health Organization, 2013. http://codes.iarc.fr/.
- *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). https://www.dshs.texas.gov/tcr/lawrules.aspx.
- *Multiple Primary and Histology Coding Rules Manual* (Revised August 24, 2012). Surveillance, Epidemiology, and End Results Program, National Cancer Institute, Bethesda, MD 20850-9765. https://seer.cancer.gov/tools/mphrules/download.html.
- *Hematopoietic and Lymphoid Neoplasm Coding Manual* (Rev. January 14, 2015). Surveillance, Epidemiology, and End Results Program, National Cancer Institute, Bethesda, MD 20850-9765. https://seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules.pdf.
- *Hematopoietic and Lymphoid Neoplasm Database* (Heme DB). Surveillance, Epidemiology, and End Results Program, National Cancer Institute, Bethesda, MD 20850-9765. https://seer.cancer.gov/seertools/hemelymph/.
- *SEER*Rx Interactive Antineoplastic Drugs Database* (Web-based). Surveillance, Epidemiology, and End Results Program, National Cancer Institute, Bethesda, MD 20850-9765. https://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/seerinquiry/index.php.
- *Collaborative Stage Version 02.05 (CS v02.05) Coding Instructions*. Collaborative Stage Data Collection System, American Joint Committee on Cancer. Chicago, IL 60611-3211. https://cancerstaging.org/cstage/coding/Pages/Version-02.05.aspx.
- *California Cancer Reporting System Standards, Volume I: Abstracting and Coding Procedures;* Version 1.0, April 2017. http://www.ccrcal.org/PAQC_Pubs/V1_2017_Online_Manual/.
- *Physician Data Query (PDQ).* National Cancer Institute, Bethesda, MD 20850-9765. https://www.cancer.gov/publications/pdq.

Acknowledgment

We wish to acknowledge that some information presented in this handbook was taken verbatim from the SEER Program Coding and Staging Manual 2016 [Adamo M, Dickie L, Ruhl J. (January2016) *SEER Program Coding and Staging Manual 2016*. National Cancer Institute, Bethesda, MD 20850-9765.]

HELPFUL WEBSITES

https://www.dshs.texas.gov/tcr/

https://seer.cancer.gov/registrars/

https://www.cancer.gov/

https://www.ncra-usa.org/

https://www.naaccr.org/

https://www.cancer.org/

http://cancerbulletin.facs.org/forums/help

https://cancercontrolplanet.cancer.gov/

https://facs.org/cancer/coc/fordsmanual.html

https://cancerstaging.org/CSE/Registrar/Pages/default.aspx

https://tools.usps.com/go/ZipLookupAction_input

https://www.cdc.gov/niosh/docs/2011-173/

https://www.bls.gov/soc/

https://www.nccn.org/

http://www.breastcancer.org/

https://www.nlm.nih.gov/

http://www.anatomyatlases.org/

https://www.melissa.com/

http://oralcancerfoundation.org/

http://www.pathologyoutlines.com/

https://www.txhima.org/

http://www.whonamedit.com/

ACRONYMS

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

OVERVIEW OF REPORTING AND CODING CHANGES

Standard Setters Reporting Requirements for 2017

CDC NPCR

Beginning with cases diagnosed January 1, 2017 and forward, CDC-NPCR will continue using the record layout and data collection requirements as published in NAACCR Standards Volume II, Version 16. There are no changes to CDC reporting requirements for 2017.

NCI SEER

The codes and instructions in the *2016 SEER Program Coding and Staging Manual* remain in effect for 2017.

CoC

Beginning with cases diagnosed January 1, 2017 and forward, the CoC will continue using the record layout and data collection requirements as published in NAACCR Standards Volume II, Version 16. There are no changes to CoC reporting requirements for 2017.

Small updates will be released via *FORDS: Revised for 2017:*

1. The allowable values listed in the header for Sex [#220] were corrected to 1-6, 9 to reflect the addition of codes 5 and 6 in 2015.
2. For Mets at DX—Other [#1117] the following code has been added:

   2 Generalized metastases such as carcinomatosis.
3. Minor coding clarifications were made to Tumor Size Summary [#756].
4. Pagination was corrected for the First Course of Treatment section of the manual.
5. The coding clarification in APPENDIX B: Site-Specific Surgery Codes for SKIN was updated to state “1 cm or more.”

Staging Transition

CDC NPCR

The CDC requires directly assigned SEER Summary Stage 2000 and AJCC TNM 7th Edition Clinical and Pathologic Stage in lieu of CSv2. The Collaborative Stage Data Collection System Version 02.05 will continue to be used for cases diagnosed 2004-2015 and for the collection of the Site-Specific Factors (SSFs) for cases diagnosed 1/1/2016 and forward. In addition to the SSFs, Regional Nodes Positive and Examined and Lymph-vascular Invasion will continue to be required. All other CS input data items are no longer required.

CSv2 Data Items that Continue to be Required
Regional Nodes Positive [820]
Regional Nodes Examined [830]
Lymph-Vascular Invasion [1182]
CS Version Input Original [2935]
CS Version Input Current [2937]
CS Site-Specific Factors 1, 2, 5, 6, 8, 9, 10, 11, 13, 14, 15, 16, 25 [2880, 2890, 2920, 2930, 2862-2865, 2867-2870, 2879] (Tables 1.1 and 1.2)

Data Items No Longer Required/Required Historically
CS Site-Specific Factors 3, 4, 7, 12, 17-24 [2900, 2910, 2861, 2866, 2871-2878]
CS Tumor Size [2800]
CS Extension [2810]
CS Tumor Size/Ext Eval [2820]
CS Lymph Nodes [2830]
CS Mets at DX [2850]
CS Version Derived [2936]
Derived SS2000 [3020]
Derived SS2000-Flag [3050]
CS Lymph Nodes Eval [2840]
CS Mets Eval [2860]
Derived AJCC-7 T [3400]
Derived AJCC-7 T Descript [3402]
Derived AJCC-7 N [3410]
Derived AJCC-7 N Descript [3412]
Derived AJCC-7 M [3420]
Derived AJCC-7 M Descript [3422]
Derived AJCC-7 Stage Grp [3430]
Over-ride CS 1-20 [3750-3769]

NPCR – TCR REQUIRED CS SITE SPECIFIC FACTORS

Table 1.1 CDC NPCR SSFs Required for Directly-Assigned AJCC TNM Stage

Site (CS Schema)	SSF	Description
Appendix	SSF11	Histopathologic Grading
GISTPeritoneum	SSF 5 and 10	Mitotic Count; Location of Primary Tumor
GIST Esophagus, GIST Small Intestine, GIST Stomach	SSF 6	Mitotic Count
GIST Appendix, GIST Colon, GIST Rectum	SSF 11	Mitotic Count
MycosisFungoides	SSF 1	Peripheral Blood Involvement
Placenta	SSF 1	Prognostic Scoring Index
Prostate	SSF 1, 8 and 10	PSA Lab Value, Gleason Score
Testis	SSF 13, 15, 16	Post Orchiectomy AFP, hCG, and LDH Range
BileDuctsDistal, BileDuctsPerihilar, CysticDuct, EsophagusGEJunction, LacrimalGland, LacrimalSac, Melanoma, CiliaryBody, MelanomaIris, Nasopharynx, PharyngealTonsil, Stomach	25	*Schema Discriminator*

Table 1.2. CDC NPCR SSFs required by NPCR and TCR (but not for AJCC Staging)

Site (CS Schema)	SSF	Description
Brain, CNS Other, Intracranial Gland	1	WHO Grade
Breast	1 2 8 9 11 13 14 15 16	*ERA* *PRA* *HER2: IHC Value* *HER2: IHC Interpretation* *HER2: FISH Interpretation* *HER2: CISH Interpretation* *HER2: Result of other test* *HER2: Summary Result testing* *Combination of ERA, PRA and HER2 Testing*

ICD-0-3 HISTOLOGIES

New Terms and Codes Not Yet Implemented

The NAACCR Guidelines for ICD-O-3 Update Implementation (published December 2013) included a table of new ICD-O-3 codes and terms effective for 2015; however, the use of the new codes was postponed due to issues with adding these codes to the CSv2 software. For diagnosis year 2017, all standard setters have agreed to postpone these codes once again, and to use the alternate codes published in Table 2 of the NAACCR Guidelines for ICD-O-3 Update implementation (Appendix K). It is anticipated that these codes will be implemented in **2018** when the AJCC-TNM 8th Edition goes into effect.

Hospital registrars should look for use, by their pathologists, of the terms included in table 1.3. Since these terms have not yet been officially adopted for cancer surveillance in North America, registrars should abstract cases using the acceptable codes listed in table 1.3 ICD-O-3 Histology Code Crosswalk to report them to central registries and to CoC.

For more information about ICD-O-3 new terms and codes, refer to the NAACCR Implementation Guidelines and Recommendations *What You Need to Know for 2017* found on the NAACCR website: https://www.naaccr.org/implementation-guidelines/.

Table 1.3 ICD-O-3 Histology Code Crosswalk

ICD-O-3 change	New code in ICD-O-3	Description	Comment	Use this code in 2015 and 2016
New term and code	8158/1	Endocrine tumor, functioning, NOS	Not reportable	
New related term	8158/1	ACTH-producing tumor	Not reportable	
New term and code	8163/3	Pancreatobiliary-type carcinoma (C24.1)	DO NOT use new code	8255/3
New synonym	8163/3	Adenocarcinoma, pancreatobiliary-type (C24.1)	DO NOT use new code	8255/3
New term	8213/3	Serrated adenocarcinoma	**Use new code**	8213/3*
New term and code	8265/3	Micropapillary carcinoma, NOS (C18._, C19.9, C20.9)	DO NOT use new code	8507/3*
New code and term	8480/1	Low grade appendiceal mucinous neoplasms (C181.1)	Not reportable	
New term and code	8552/3	Mixed acinar ductal carcinoma	DO NOT use new code	8523/3
New term and code	8975/1	Calcifying nested epithelial stromal tumor (C22.0)	Not reportable	
New term and code	9395/3	Papillary tumor of the pineal region	DO NOT use new code	9361/3*

New term and code	9425/3	Pilomyxoid astrocytoma	DO NOT use new code	9421/3
New term and code	9431/1	Angiocentric glioma	DO NOT use new code	9380/1*
New term and code	9432/1	Pituicytoma	DO NOT use new code	9380/1*
New term and code	9509/1	Papillary glioneuronal tumor	DO NOT use new code	9505/1
New related term	9509/1	Rosetter- forming glioneuronal tumor	DO NOT use new code	9505/1
New term and code	9741/1	Indolent systemic mastocytosis	Not reportable	

*ICD-O-3 rule F applies (code the behavior stated by the pathologist). If necessary, over-ride any advisory messages.

Reportability of NIFTP as a New Term for EFVPTC

Over the last several years, there have been discussions as to how pathologists should be reporting "encapsulated follicular variant of papillary thyroid carcinoma" (EFVPTC). A multidisciplinary international expert panel reviewed this issue and described the criteria for invasive and noninvasive EFVPTC. The panel stated that noninvasive "encapsulated follicular variant of papillary thyroid carcinoma" (EFVPTC) should be reported as "noninvasive follicular thyroid neoplasm with papillary-like nuclear features" (NIFTP)1,2,3. Some pathologists have begun using this new NIFTP language. Because NIFTP is a synonym for noninvasive EFVPTC, the standard setters have agreed to collect NIFTP as ICD-O-3 morphology code 8343/2. In addition, to address the confusion as to how EFVPTC is currently reported by registrars using ICD-O-3, the standard setters have agreed to collect EFVPTC specified as invasive or NOS as 8343/3 (papillary carcinoma, encapsulated) beginning with cases diagnosed in 2017. In the WHO IARC ICD-O-3 online (http://codes.iarc.fr/code/2800), there is a definition of 8343/3:

A papillary carcinoma of the thyroid gland which is encapsulated and resembles an encapsulated follicular neoplasm. Despite the complete encapsulation, metastasis can occur. The prognosis is usually similar to that of conventional papillary carcinoma. These histology codes are effective with cases diagnosed January 1, 2017 and forward. See **Appendix A** for a clear listing of codes and terms.

References:

[1]Nikiforov YE, Seethala RR, Tallini G, et al.(14 April 2016). "Nomenclature Revision for encapsulated follicular variant of papillary thyroid carcinoma: A Paradigm Shift to Reduce Overtreatment of Indolent Tumors". JAMA Oncology.

[2]Addressing Overdiagnosis in Thyroid Cancer. https://www.naaccr.org/addressing-overdiagnosis-in-thyroid-cancer/

[3]Patel KN (14 April 2016). Noninvasive Encapsulated Follicular Variant of Papillary Thyroid "Cancer" (or Not): Time for a Name Change. JAMA Oncol. http://oncology.jamanetwork.com/article.aspx?articleid=2513246#tab10

Histology coding Clarifications for Thyroid Cases Effective January 1, 2017 and forward		
Primary Site	**Description**	**Use Histology/Behavior Code**
Thyroid (C73.9)	Non-invasive follicular thyroid neoplasm with papillary like nuclear features (NIFTP)	**8343/2**
	Non-invasive encapsulated follicular variant of papillary thyroid carcinoma (non-invasive EFVPTC)	**8343/2**
	Invasive encapsulated follicular variant of papillary thyroid carcinoma (invasive EFVPTC) Encapsulated follicular variant of papillary thyroid carcinoma, NOS(EFVPTC,NOS) Synonym: Papillary carcinoma, encapsulated	

REMINDER:

Clinical and Pathologic indicators AJCC T, N, and M Values
"AJCC timing rules" state that data used for clinical staging includes any information obtained about the extent of cancer before initiation of definitive treatment (surgery, systemic or radiation therapy, active surveillance, or palliative care) or within 4 months after the date of diagnosis, whichever is shorter, as long as the cancer has not clearly progressed during that time frame; while data used for pathologic staging includes any information obtained about the extent of cancer up through completion of definitive surgery as a part of first course treatment or identified within 4 months after the date of diagnosis, whichever is longer, as long as there is no systemic or radiation therapy initiated or the cancer has not clearly progressed during that time frame. In specific instances, pathologic findings can be used when assigning clinical stage, and clinical findings can be used when assigning pathologic stage. According to the AJCC manual and trainings, this results in mixing individual clinical T, N, and M components with individual pathologic T, N, and M components to assign the clinical and/or pathologic stage group.

As part of transitioning away from Collaborative Stage towards directly-assigned TNM stage, all of the standard setting organizations have agreed to add clinical and pathologic indicators to the AJCC T, N, and M data items [940, 950, 960, 880, 890, and 900]. The indicators has been incorporated by adding the prefixes of "c" and "p" to existing valid clinical and pathologic T, N, and M codes respectively, modifying a few of the existing codes for the individual T, N, and M data items, as well as adding and deleting specific existing codes newly prefixed with a 'c' or 'p' (for example, addition of c0, c1, c1A, c1B, c1C, c1D, and c1E to the list of valid values for pathologic M data item).

Direct-Coded SEER Summary Stage is required for all cases diagnosed January 1, 2015 and forward from all facilities. Directly assigned c,pTNM is required for all cases diagnosed January 1, 2016 and forward from all facilities.

TCR CODING AND STAGING REQUIREMENT SUMMARY

Required CS Site Specific Factors

TCR requires the collection of CSv.02 data items needed to derive SEER Summary Stage, SSFs for Breast, Brain/CNS/Intracranial, and SSF 25 for applicable sites (schema discriminators). TCR requires, as available, the collection of CSv.02 data items needed to derive AJCC-7 TNM Stage. For a complete list of all TCR required Site-Specific Factors required through 2017 by primary site please see the 2017 Handbook webpage: https://www.dshs.texas.gov/tcr/training/2017-handbook.aspx.

Coding Cancer Cases

For cancer coding, the correct ICD-O version must be used for all cases according to the year in which the cancer case was diagnosed. If the diagnosis year is unknown, use the year 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 the TCR.

The *International Classification of Diseases for Oncology, 3rd Edition* (ICD-O-3) **must** be used to code the primary cancer site (topography) and the cell type (morphology, behavior, and grade, NAACCR items 522 and 523) of the tumor for all cases diagnosed/admitted on January 1, 2001 and forward. In 2010 several newly reportable conditions and new ICD-O histology terms and codes for hematopoietic and lymphoid neoplasms were added. A list of these conditions and terms can be found beginning on page 23 in the Casefinding Section. These newly reportable conditions are included in the Hematopoietic Database and Manual. Also, refer to the Multiple Primary and Histology rules for site specific histology rules.

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

Note: These cases must be converted to ICD-O-3 codes. Third party software automatically convert these codes appropriately, for Web Plus users this is a manual process.

Staging Cancer Cases

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

Table 1.4 Staging Cancer Cases

Year of Diagnosis	Stage System/Manual
Prior to 2001	SEER April 1977 Summary Staging Guide
January 1, 2001 – December 31, 2003 **January 1, 2015 and forward**	SEER Summary Staging Manual 2000 (SSSM2K)
January 1, 2004 – December 31, 2015	Collaborative Stage Data Collection System Coding Instructions, version 02.05
January 1, 2014 and forward	AJCC Cancer Staging Manual , Seventh Edition*

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

Note: "AJCC timing rules" state that data used for clinical staging includes any information obtained about the extent of cancer before initiation of definitive treatment (surgery, systemic or radiation therapy, active surveillance, or palliative care) or within 4 months after the date of diagnosis, whichever is shorter, as long as the cancer has not clearly progressed during that time frame; while data used for pathologic staging includes any information obtained about the extent of cancer through completion of definitive surgery as a part of first course treatment or identified within 4 months after the date of diagnosis, whichever is longer, as long as no systemic or radiation therapy is initiated or the cancer has not clearly progressed during that time frame. In specific instances, pathologic findings can be used when assigning clinical stage, and clinical findings can be used when assigning pathologic stage.

*Directly Coded Summary Stage 2000 and c,pTNM are required from all facilities for reporting year 2016 and forward.

TCR CODING AND STAGING MANUALS

Table 1.5 TCR Coding and Staging Requirement Summary

Coding and Staging Schema	Diagnosis Year
International Classification of Diseases for Oncology, 3rd Edition (ICD-O-3)	2001 – forward
International Classification of Diseases for Oncology, 2nd Edition (ICD-O-2)	1995 – 2000*
Collaborative Stage Data Collection System Coding Instructions, vs. 02.05	2004 – 2015
SEER Summary Staging Manual 2000 (SSSM2K)	2001 – 2003 2015 – forward
SEER April 1977 Summary Staging Guide	1995 – 2000
Multiple Primary and Histology Coding Rules (MP/H)	2007 – forward
Hematopoietic and Lymphoid Neoplasm Coding Manual	2010 – forward
AJCC Cancer Staging Manual , Seventh Edition	2014 – forward

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

ACOS FACILITY INSTRUCTION MANUALS AND DATE IMPLEMENTED

Table 1.6 ACoS Facility Instruction Manuals and Date Implemented

Manual/Guidelines	Implemented
Data Acquisition Manual (DAM)	1995
Registry Operations and Data Standards (ROADS)	1996 – 2002
Facility Oncology Registry Data Standards (FORDS)	2003
Collaborative Staging (CS)	2004 – 2017*
Multiple Primary and Histology Coding Rules (MP/H)	2007
Hematopoietic and Lymphoid Neoplasm Coding Manual	2010
AJCC Cancer Staging Manual , Seventh Edition	2014

*Specific SSFs are required for 2017 diagnosis cases.

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

COMPLIANCE

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

Table 1.7 Case Submission Requirements:

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

Small Cancer Caseload Facilities (100 or fewer):
The TCR developed the "Small Facility Casefinding and Data Collection Program" with the goal to increase and improve the reporting and data quality of cancer cases, as required by the Texas Cancer Incidence Reporting Act (Chapter 82, Texas Health and Safety Code), from Texas facilities with 100 or fewer expected cancer cases. 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.

Note: Hospital Reporting instructions, as well as reporting laws and rules can be found on the TCR website: https://www.dshs.texas.gov/tcr/

TIMELINESS OF DATA SUBMISSION

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

TIMELY REPORTING CALENDAR

Table 1.8 Timely Reporting Calendar

Cases admitted in:	Should be reported the following:
January	July
February	August
March	September
April	October
May	November
June	December
July	January
August	February
September	March
October	April
November	May
December	June

TCR Hospital Reporting webpage: https://www.dshs.texas.gov/tcr/reporting/hospitals.aspx

REGIONAL CONTACTS

Table 1.9 Regional Contacts

REGISTRY OPERATIONS MANAGERS	eREPORTING OPERATIONS MANAGER
Dwenda Smith, CTR HSR 2, 3, 4, 5, 6 Austin, TX (817) 264-4592 Dwenda.Smith@dshs.texas.gov **Miriam Robles, CTR** HSR 1, 7, 8, 9, 10, 11 Austin, TX 512-776-3609 Miriam.Robles@dshs.texas.gov	**Beatriz Gutierrez, MPH, CTR** Austin, TX 512-776-3613 Beatriz.Gutierrez@dshs.texas.gov
HEALTH SERVICE REGIONS 2, 3, 4	**HEALTH SERVICE REGIONS 5, 6**
Debra Anderson, BS, CTR Regional Program Specialist (Team Lead) Texas Department of State Health Services Texas Cancer Registry 1301 S. Bowen Rd., Ste. 200 Arlington, TX 76013 Phone: 817-264-4594 Fax: 817-264-4583 Debra.Anderson@dshs.texas.gov	**Marie Gallegos, CTR** Regional Program Specialist (Team Lead) Texas Department of State Health Services Texas Cancer Registry 5425 Polk Ave. Houston, TX 77023-1497 Phone: 713-767-3183 Fax: 713-767-3284 Marie.Gallegos@dshs.texas.gov
HEALTH SERVICE REGIONS 1, 7, 9, 11	**HEALTH SERVICE REGIONS 8, 10**
TBA Regional Program Specialist (Team Lead) Austin, TX Phone: 512-776-3080 Fax: 512-776-7681	***TBA*** Regional Program Specialist (Team Lead) Austin, TX Phone: 512-776-3080 Fax: 512-776-7681

Map of Health Service Regions: https://www.dshs.texas.gov/tcr/training/handbook/Appendix-Health-Service-Regions.pdf

Please see Contact TCR webpage for updates: https://www.dshs.texas.gov/tcr/contact.aspx#regions

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STANDARDS FOR CONFIDENTIALITY, DISCLOSURE OF DATA, AND QUALITY ASSURANCE

STANDARDS FOR CONFIDENTIALITY, DISCLOSURE OF DATA, AND QUALITY ASSURANCE

CONFIDENTIALITY

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

DISCLOSURE OF DATA

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

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

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

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

QUALITY ASSURANCE

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

INTERNAL PROCESS

Submission Review:
The TCR's data upload system currently checks all submitted abstracts for errors. The TCR uses CDC's Registry Plus Software Suite to upload submitted data. As abstracts are uploaded into the system, they are intensely scrutinized for:

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

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

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

EXTERNAL PROCESS

Facility Training:
TCR staff provides technical assistance, training, and continuing education for cancer registrars and medical records personnel on standards and procedures for reporting. Requests for training and technical assistance should be directed to the Austin Central Office Training Team. To request training please submit your training needs using the online training request forms found on the Education and Training section of the TCR website: https://www.dshs.texas.gov/tcr/training.aspx. You can also contact TCR Training staff at TCR.Training@dshs.texas.gov.

Inpatient/Outpatient Casefinding Follow-back Audit:
The TCR has implemented a new *Inpatient/Outpatient Casefinding Follow-back Audit* process effective with 2014 admission year.

This audit will ensure that complete and timely statewide cancer data is received from all Texas facilities and available for our annual Centers for Disease Control and Prevention (CDC) and North American Association of Central Cancer Registries (NAACCR) Calls for Data submissions. In addition, this data will also be available to use in cancer surveillance, program planning, and evaluation activities. The audit will be conducted on an annual basis at the end of each reporting year to identify potentially missed cases.

The TCR will use the Texas Hospital Inpatient and Outpatient Data to conduct this audit. This data will be obtained by the TCR on a yearly basis. We will use this data to perform a linkage on each individual facility to identify cases that have not been reported to the TCR. Once the linkage is complete, each facility will be provided with a listing of potentially missed cases for your review, abstraction, and submission. This process is similar to the Death Clearance Only Audit performed annually.

Exception: Currently, Reconciliation Audits do not apply to the following type of facilities: Small Casefinding and Data Collection (CFDC) participating facilities, Cancer Treatment Centers, Military, Veteran Affairs, Physician Reporting, and Pathology Labs.

Casefinding Data Quality Audits:

TCR staff or a TCR representative review casefinding sources such as disease indices, pathology reports (including cytology and autopsy reports), outpatient records, radiation therapy logs, and appropriate oncology logs for missing cases. Periodically, facilities are randomly selected for a casefinding audit. A casefinding audit is a systematic method of reviewing the facility's casefinding procedures and identifying all reportable cases in order to assess completeness and timeliness. The audit is a tool to improve a facility's casefinding process and is not a punitive measure. Sometimes chart review may be performed on records identified from the audit to determine case reportability. Casefinding procedures are located in the Casefinding Section beginning on page 24. Results from a specific facility's data quality audit are not shared with other entities without the facility's approval.

Reabstracting Data Quality Audits:

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

DEATH CLEARANCE

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

New Consolidated Facility Listing

TCR has implemented an external quality assurance process beginning with 2015 cases, that will include the Inpatient/Outpatient Casefinding Follow-back and the Death Clearance listing of patients for facilities on one report. All follow-back cases will be available for facilities on one report and will contain the casefinding source, for example: DCO or Inpatient/Outpatient. This will eliminate multiple listing requests for facilities and it will be performed annually.

Note: Small Casefinding and Data Collection (CFDC) facilities are not required to abstract and submit missed cases. Contact the Quality Assurance Death Clearance Specialist for instructions or your regional TCR representative for further details.

3

CASEFINDING FOR COMPLETENESS OF REPORTING

CASEFINDING FOR COMPLETENESS OF REPORTING

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

Casefinding is a process used to identify all eligible cases to be reported to the TCR. Casefinding sources include disease indices, pathology and laboratory reports, patient logs, and similar resources specific to each facility. Refer to the Casefinding sources list on page 27 for a more detailed list. Every inpatient and/or outpatient with active disease and/or receiving cancer-directed therapy must be reported to the TCR regardless of the patient's state or country of residence. The requirements for reporting depend on the governing agencies of the registry. For example, hospitals participating in the Approvals Program of the Commissions on Cancer (CoC) of the American College of Surgeons follow the guidelines set forth by CoC; however, they must also adhere to the TCR reporting criteria. **Remember that cases diagnosed prior to 1995 are no longer required to be reported.**

REPORTABLE CANCER CASES

Cases of cancer to be reported to the TCR include:

1. All neoplasms with a **behavior code** of /2 (in situ) or /3 (malignant) in the *International Classification of Diseases for Oncology 3rd Edition (ICD-O-3)*, with some exceptions (see pages 30-31).

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

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

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

Note: According to MP/H rules (MP/H link: https://seer.cancer.gov/tools/mphrules/download.html), the terms tumor, mass, lesion and neoplasm are interchangeable for benign and malignant brain and CNS sites. However, these terms are not to be used to determine case reportability. All diagnoses of the brain and CNS must have a morphology term and code listed in ICD-O-3 to be reportable. If there is no morphology term or code listed in the ICD-O-3 it is not reportable.

***Example*:** The terms "mass" and "lesion" do not have a morphology term and code listed in ICD-O-3. If these are the only terms mentioned in the medical record the case would not be reportable.

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

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

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

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

DIAGNOSIS PRIOR TO BIRTH

SEER reportability requirements apply to diagnoses made in utero. Diagnoses made in utero are reportable **only when the pregnancy results in a live birth**. In the absence of documentation of stillbirth, abortion or fetal death, assume there was a live birth and report the case.

Disease Regression

When a reportable diagnosis is confirmed prior to birth and disease is not evident at birth due to regression, accession the case based on the pre-birth diagnosis.

CASES DIAGNOSED CLINICALLY ARE REPORTABLE. In the absence of a histologic or cytologic confirmation of a reportable neoplasm, accession the case based on the **clinical diagnosis** (when a recognized medical practitioner states the patient has a cancer, carcinoma, malignant neoplasm, or reportable neoplasm). A clinical diagnosis may be recorded in the final diagnosis, on the face sheet, in a clinic note, or in other parts of the medical record.

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

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

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

> ***Example*:** In February 2017 a patient has a CT that shows possible lung cancer. The physician states this is probably lung cancer. A fine-needle aspiration is non-diagnostic and the physician advises the patient to have further tests. The patient refuses any further work-up or treatment. In September 2017 the physician sees the patient again and states that this is probable lung cancer based on previous x-rays, continued symptoms, and further decline in health.

CASEFINDING METHODS

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

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

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

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

Casefinding Sources

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

CASEFINDING PROCESS

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

Disease indices should be obtained after medical records are completed and coded (monthly or quarterly). The indices must include both **inpatient and outpatient** admissions **and must** be based on **year of admission.** It must be sorted **alphabetically** by last name and include the following: **last name, first name, medical record number, admission/discharge date, date of birth, social security number, all primary and secondary ICD-10* or ICD-10^ diagnosis codes and admission type.**

Attachment A (page 49) is an example of a disease index that can be modified for individual facilities. See page 34 for further instructions on disease index procedures.

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

Review the disease index for reportable cancer **ICD-10-CM^** codes to ensure the facility has reported all of its reportable cases to the TCR.

- Request a TCR Facility Data Report from your regional office when needed during the reporting year. A Facility Data Report is a complete listing of cases submitted by a facility.
- Compare the patients with reportable codes on the disease index to the TCR Facility Data Report.
- Review any patient charts with reportable codes that are missing from the TCR Facility Data Report for reportability.
- Prepare an abstract for each reportable case missing from the TCR Facility Data Report.
- If a previously reported patient is found to have a subsequent primary, assign the new primary the patient's original registry number. Change the sequence number to reflect the new primary and abstract the pertinent cancer information.

Note: If a facility uses an automated casefinding method (for example: the hospital's mainframe extracts possible reportable cases and places these into cancer registry software suspense file), a manual disease index should be run at the end of the reporting year. **Ensure that the ICD-10-CM^ codes used are the most current for the reporting year**. This disease index is then checked against the cancer registry database to ensure that all cases were either reported or clearly documented as non-reportable with the reason it is not reportable.

At the end of each reporting year, TCR requires that each facility send the **electronic** disease index, non-reportable list, and the casefinding check-list (Attachment C, page 51) to the facility's health service region. Refer to page 17 for a list of all regional offices.

REPORTABLE NEOPLASMS

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

- Malignant neoplasms *(exclusions noted on page 32)*
- Benign and borderline tumors of central nervous system (CNS) diagnosed 2004 and forward
- Pituitary adenomas diagnosed as of 2004
- *Carcinoma in-situ (*exclusions noted on page 32)*
- Carcinoid, NOS (Carcinoid NOS of the appendix is reportable as of 01/01/2015)
- Non-invasive mucinous cystic neoplasm (MCN) of the pancreas with high-grade dysplasia
- Solid pseudopapillary neoplasm of the pancreas
- Cystic pancreatic endocrine neoplasm (CPEN)
- Mature Teratoma of the testes in adults is malignant and reportable as 9080/3
- Pilocytic/juvenile astrocytoma is reportable and should be coded to 9421/3 per ICD-O-3 errata
- AIN III of the anus or anus canal (C210-C211), LIN III (laryngeal intraepithelial neoplasia) (C320-C329), SIN III (squamous intraepithelial neoplasia excluding cervix), VAIN III (C529) and VIN III (C510-C519)
- Intraepithelial neoplasia, grade 3 (including additions to the list) Lobular neoplasia grade III (LN III)/lobular intraepithelial neoplasia grade III (LIN III) breast (C500-C509) Pancreatic intraepithelial neoplasia (PanIN III), Penile intraepithelial neoplasia III (PeIN III) are reportable.

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

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

Note: Gastrointestinal stromal tumors (GIST) and thymomas are frequently non-malignant. However, for cases diagnosed January 1, 2013 or later, they must be abstracted and assigned a *Behavior* Code of *3* if they are noted to have: Multiple foci; Metastasis; Positive lymph nodes

Reportable Examples:

Example 1: Non-invasive mucinous cystic neoplasm (MCN) of the pancreas with high-grade dysplasia is reportable. For neoplasms of the pancreas, the term MCN with high-grade dysplasia replaces the term mucinous cystadenocarcinoma, non-invasive (8470/2).

Example 2: Report mature teratoma of the testis when diagnosed after puberty (malignant) and do not report when diagnosed in a child (benign). Do not report Mature Teratoma of the testis when it is not known whether the patient is prepubescent or postpubenscent. Pubescence can take place over a number of years; review physical history and do not rely only on age. For testis: Mature teratoma in adults is malignant (9080/3); therefore, is a reportable neoplasm.

Example 3: Hemangioma, NOS (9120/0) and cavernous hemangioma (9121/0) arising in the dura and parenchyma of the brain/CNS are reportable.

Example 4: Cystic pancreatic endocrine neoplasm (CPEN) is reportable. Assign 8150/3 unless specified as a neuroendocrine tumor, Grade 1 (8240/3) or neuroendocrine tumor, Grade 2 (8249/3).

Example 5: Solid pseudopapillary neoplasm of the pancreas is reportable as 8452/3

Example 6: Rathke pouch tumor (C751, 9350/1) is a reportable neoplasm for cases diagnosed 2004 and later. Rathke cleft cyst and Rathke pouch tumor are different conditions. Rathke cleft cyst is not reportable.

Example 7: "Carcinoid of the appendix found on appendectomy." Carcinoid tumor, NOS, is reportable (8240/3).

Example 8: Report liver cases with an LI-RADS category LR-5 or LR-5V based on the 2014 American College of Radiology definitions, http://nrdr.acr.org/lirads.
Use the date of the LR-5 or LR-5V scan as the date of diagnosis when it is the earliest confirmation of the malignancy. Do not report cases based **only** on an LI-RADS category of LR-4.

Example 9: "Atypical fibroxanthoma (superficial malignant fibrous histiocytoma)." The case is reportable because the information in parentheses provides more detail and confirms a reportable malignancy.

Example 10: "Positive histology from needle biopsy followed by negative resection." This case is reportable based on positive needle biopsy.

Example 11: "Biopsy-proven squamous cell carcinoma of the nipple with a subsequent areolar resection showing foreign body granulomatous reaction to suture material and no evidence of residual malignancy in the nipple epidermis." This case is reportable. The fact that no residual malignancy was found in the later specimen does not disprove the malignancy diagnosed by the biopsy.

Example 12: Final diagnosis from dermatopathologist: ulcerated histologically malignant spindle cell neoplasm, consistent with atypical fibroxanthoma.

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

Example 13: "Aggressive adult granulosa cell tumor with one of two lymph nodes positive for malignant metastatic granulosa cell tumor." This case is reportable because malignant granulosa cell tumor is reportable. The lymph node metastases prove malignancy.

Example 14: "Ovarian mucinous borderline tumor with foci of intraepithelial carcinoma." This case is reportable because there are foci of intraepithelial carcinoma (carcinoma in situ).

Example 15: Dermoid cyst of the brain is reportable.

Example 16: Tectal plate lipoma is a reportable brain tumor. It is a benign neoplasm of the mid brain (brain stem).

Example 17: Report as either 8240/3 or 8151/3 when the pathology diagnosis is a neuroendocrine tumor (/3) and the clinical diagnosis is an insulinoma (/0).

Brain or CNS Neoplasms

- A brain or a CNS neoplasm identified only by diagnostic imaging is reportable. **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

- **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

Notes:

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

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

NON-REPORTABLE NEOPLASMS
(Exclusions)

- Basal cell carcinoma (8090–8110) of the skin (C440-C449) **except genital sites**
- Basal and squamous cell carcinoma (8070–8110) of skin of anus (C445)
- Epithelial carcinomas (8010–8046) of the skin (C440-C449)
- Papillary and squamous cell carcinomas (8050–8084) of the skin (C440-C449) **except genital sites**
- Malignant neoplasms, NOS (8000–8005) of the skin (C440-C449)
- In situ neoplasms of cervix regardless of histology (behavior /2; C53_)
- SIN III of the cervix
- Intraepithelial neoplasms of the cervix (CIN) (8077/2; C530-C539) or prostate (PIN)(8148/2; C619)
- Borderline cystadenomas (8442, 8451, 8462, 8472, 8473) of the ovaries (C569) with behavior code 1 are **not** collected as of January 01, 2001
- Cases diagnosed **prior to 1995** are no longer required to be reported.
- Benign and borderline CNS cases diagnosed **prior to 2004** are no longer required
- Benign and borderline tumors of the cranial bones (C410)
- Cysts or lesions of the brain or CNS diagnosed January 01, 2004 or later which have no ICD-O-3 morphology code

Note: Do not report even if patient is receiving treatment.

Note: Cholesteatoma in the cerebral meninges is not a reportable CNS case since there is no code for cholesteatoma listed in *ICD-O-3.*

Note: Carcinoid tumorlets in the lung are not reportable.

Note: “AIN II-III,” “AIN II/III,” “VAIN II-III,” “VAIN II/III,” “VIN II-III,” “VIN II/III,” etc. are not reportable.

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

Note: Cases designated “BIRADS 4” or “BIRADS 5” without any additional information are not reportable.

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

Note: Lobular intraepithelial neoplasia grade 1 is not reportable.

Note: Subdural hygroma is not reportable – it is not a neoplasm. Subdural hygroma is a collection of cerebrospinal fluid in the sub-dural space. It may be related to a head injury.

Note: Noninvasive mucinous cystic neoplasm (MCM) of the pancreas with low or intermediate grade dysplasia is not reportable.

Note: Do not report Mature Teratoma of the testis when it is not known whether the patient is prepubescent or postpubenscent; review history and physical information and do not rely only on age. Do not report mature teratoma when it is not known whether the patient is pre or post pubescent.

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

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

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

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

Non-Reportable Examples:

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

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

Example 3: Low grade appendiceal mucinous neoplasm (LAMN) is not reportable. The WHO classification designates LAMN as /1 with uncertain malignant potential.

Example 4: Diffuse idiopathic pulmonary neuroendocrine cell hyperplasia (DIPNECH) is not reportable. It is a generalized proliferation of scattered single cells, small nodules (neuroendocrine

bodies), or linear proliferation of pulmonary neuroendocrine cells (PNCs), according to the WHO classification of lung tumors.

Example 5: Lentiginous melanocytic lesion is not reportable.

Example 6: Lobular intraepithelial neoplasia grade 1 and grade 2 are not reportable.

Example 7: Brain lesions associated with multiple sclerosis are not reportable. These brain lesions are not neoplastic; they are part of the disease process of multiple sclerosis.

Example 8: High grade squamous intraepithelial lesion (HGSIL or HSIL) of the vulva or vagina is not reportable.

Example 9: HGSIL, HSIL, carcinoma in situ (CIS), and AIN III (8077) arising in perianal skin (C445) are not reportable.

COMPREHENSIVE REPORTABLE LISTS ICD-10-CM CODES

The following comprehensive lists are intended to aid appropriate staff (for example: Information Services, Data Management) in creating the disease index (DI) with the required reportable neoplasms and ICD-10-CM codes.

Two separate DI's must be requested:
1. A DI with reportable 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 supplementary 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 2 to 3 years. However, in the event that circumstances change (for example, new coders are hired or new codes are added to the list), then the supplementary list should be reviewed sooner to ensure complete casefinding. Some facilities may find that it works best to review the supplementary codes every 3 or every 6 months.

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

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

Table 3.2 Reportable ICD-10-CM Codes

ICD-10-CM CODE (100% Review Required)	DESCRIPTION
C00._ - C43._, C4A._, C45._ - C96._	Malignant neoplasms (excluding category C44), stated or presumed to be primary (of specified site) and certain specified histologies
C49.A_	Gastrointestinal Stromal Tumors (GIST)
C80.0 - C80.2 C81._ - C96._	Malignant neoplasm without specification of site Malignant neoplasms of lymphoid, hematopoietic and related tissue
D00._ - D09._	In-situ neoplasms (*Note: Carcinoma in situ of the cervix (CIN III-8077/2) and Prostatic Intraepithelial Carcinoma (PIN III-8148/2) are not reportable*).
D18.02	Hemangioma of intracranial structures and any site
D18.1	Lymphangioma, any site (*Note: Includes Lymphangiomas of Brain, Other parts of nervus system and endocrine glands, which are reportable*)
D32._	Benign neoplasm of meninges (cerebral, spinal and unspecified)
D33._	Benign neoplasm of brain and other parts of central nervous system
D35.2 - D35.4	Benign neoplasm of pituitary gland, craniopharyngeal duct and pineal gland
D42._, D43._	Neoplasm of uncertain or unknown behavior of meninges, brain, CNS
D44.3 - D44.5	Neoplasm of uncertain or unknown behavior of pituitary gland, craniopharyngeal duct and pineal gland
D45	Polycythemia vera (9950/3)
D46._	Myelodysplastic syndromes (9980, 9982, 9983, 9985, 9986, 9989, 9991, 9992)
D47.1	Chronic myeloproliferative disease (9963/3)
D47.3	Essential (hemorrhagic) thrombocythemia (9962/3)
D47.4	Osteomyelofibrosis (9961/3)
D47.Z_	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9960/3, 9970/1, 9931/3)
D47.9	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9970/1, 9931/3)
D49.6, D49.7	Neoplasm of unspecified behavior of brain, endocrine glands and other CNS
R85.614	Cytologic evidence of malignancy on smear of anus
R87.614	Cytologic evidence of malignancy on smear of cervix
R87.624	Cytologic evidence of malignancy on smear of vagina

^International Classification of Diseases, ICD-10-CM Tabular List of Diseases and Injuries, FY 2017

Source: https://seer.cancer.gov/tools/casefinding/case2017-icd10cm.html

SUPPLEMENTARY ICD-10-CM CODES

Table 3.5 Supplementary ICD-10-CM Code List Effective 10/01/2015 Forward

ICD-10-CM CODE (5% Review Required)	DESCRIPTION
B20	Human immunodeficiency virus [HIV] disease with other diseases
B97.33, B97.34, B97.35	Human T-cell lymphotrophic virus,(type I [HTLV-1], type II [HTLV-II], type 2 [HIV 2]) as the cause of diseases classified elsewhere
B97.7	Papillomavirus as the cause of diseases classified elsewhere
D10._ - D31._, D34, D35.0, D35.1, D35.5_ D35.9, D36._	Benign neoplasms (see "must collect" list for reportable benign neoplasms) ***Note:*** *Screen for incorrectly coded malignancies or reportable by agreement tumors* ***Note****: Borderline cystadenomas M-8442, 8451, 8462, 8472, 8473, of the ovaries moved from behavior /3 (malignant) to /1 (borderline malignancy) in ICD-O-3. SEER registries are not required to collect these cases for diagnoses made 1/1/2001 and after. However, cases diagnosed prior to 1/1/2001 should still be abstracted and reported to SEER.*
D3A._	Benign carcinoid tumors
D37._ - D41._	Neoplasms of uncertain or unknown behavior (see "must collect" list for reportable neoplasms of uncertain or unknown behavior) ***Note:*** *Screen for incorrectly coded malignancies or reportable by agreement tumors*
D44.0 - D44.2, D44.6-D44.9	Neoplasm of uncertain or unknown behavior of other endocrine glands (see "must collect" list for D44.3-D44.5) ***Note:*** *Screen for incorrectly coded malignancies or reportable by agreement tumors*
D47.0	Histiocytic and mast cell tumors of uncertain behavior
D47.2	Monoclonalgammopathy ***Note:*** *Screen for incorrectly coded Waldenstrom's macroglobulinemia*
D47.Z2	Castleman disease
D48._	Neoplasm of uncertain behavior of other and unspecified sites
D49.0 - D49.9	Neoplasm of unspecified behavior (except for D49.6 and D49.7)
D61.1	Drug-induced aplastic anemia (also known as “aplastic anemia due to antineoplastic chemotherapy”) ICD-10-CM Coding instruction note: Use additional code for adverse effect, if applicable, to identify drug
D61.810	Antineoplastic chemotherapy induced pancytopenia
D61.82	Myelophthisis ICD-10-CM Coding instruction: Code first the underlying disorder, such as: malignant neoplasm of breast (C50._)
D63.0	Anemia in neoplastic disease

ICD-10-CM CODE (5% Review Required)	DESCRIPTION
D64.81	Anemia due to antineoplastic chemotherapy
D69.49, D69.59, D69.6	Other thrombocytopenia *Note: Screen for incorrectly coded thrombocythemia*
D70.1	Agranulocytosis secondary to cancer chemotherapy
D72.1	Eosinophilia (*Note: Code for eosinophilia (9964/3). Not every case of eosinophilia is a malignancy. Reportable Diagnosis is "Hypereosonophilic syndrome."*)
D75.81	Myelofibrosis (note: this is not primary myelofibrosis [9961/3] ICD-10-CM Coding instruction note: Code first the underlying disorder, such as: malignant neoplasm of breast (C50._)
D76._	Other specified diseases with participation of lymphoreticular and reticulohistiocytic tissue
D89.0, D89.1	Other disorders involving the immune mechanism, not elsewhere classified *Note: Review for miscodes*
D89.4-	Mast cell activation syndrome and related disorders *Note: Effective 10/1/2016*
E31.2-	Multiple endocrine neoplasia [MEN] syndromes *ICD-10-CM Coding instruction: Code also any associated malignancies and other conditions associated with the syndromes*
E34.0	Carcinoid syndrome
E83.52	Hypercalcemia
E88.09	Other disorders of plasma-protein metabolism, not elsewhere classified
E88.3	Tumor lysis syndrome (following antineoplastic chemotherapy)
G13.0	Paraneoplastic neuromyopathy and neuropathy ICD-10-CM Coding instruction note:: Code first underlying neoplasm (C00-D49)
G13.1	Other systemic atrophy primarily affecting central nervous system in neoplastic disease *ICD-10-CM Coding instruction note:: Code first underlying neoplasm (C00-D49)*
G32.8-	Other specified degenerative disorders of nervous system in diseases classified elsewhere ICD-10-CM Coding instruction note: Code first underlying disease, such as: cerebral degeneration (due to) neoplasm (C00-D49)
G53	Cranial nerve disorders in diseases classified elsewhere *Note: Code first underlying neoplasm (C00-D49)*
G55	Nerve root and plexus compressions in diseases classified elsewhere *ICD-10-CM Coding instruction note: code also underlying disease, such as neoplasm (C00-D49)*
G63	Polyneuropathy in diseases classified elsewhere ICD-10-CM Coding instruction note: Code first underlying disease, such as: neoplasm (C00-D49)

ICD-10-CM CODE (5% Review Required)	DESCRIPTION
G73.1	Lambert-Eaton syndrome in neoplastic disease *ICD-10-CM Coding instruction: Code first underlying neoplasm (C00-D49)*
G89.3	Neoplasm related pain (acute)(chronic)
G99.2	Myelopathy in diseases classified elsewhere *ICD-10-CM Coding instruction: Code first underlying disease, such as: neoplasm (C00-D49)*
H47.42	Disorders of optic chiasm in (due to) neoplasm ICD-10-CM Coding instruction: Code also underlying condition
H47.52-	Disorders of visual pathways in (due to) neoplasm *ICD-10-CM Coding instruction: Code also underlying condition*
H47.63-	Disorders of visual cortex in (due to) neoplasm ICD-10-CM Coding instruction: Code also underlying condition
J34.81	Nasal mucositis (ulcerative)
J91.0	Malignant pleural effusion ICD-10-CM Coding instruction: Code first underlying neoplasm
J93.12	Secondary spontaneous pneumothorax *ICD-10-CM Coding instruction: Code first underlying condition, such as:* *Malignant neoplasm of bronchus and lung (C34._)* *Secondary malignant neoplasm of lung (C78.0_)*
K12.31	Oral mucositis (ulcerative) due to antineoplastic therapy
K12.33	Oral mucositis (ulcerative) due to radiation
K22.711	Barrett's esophagus with high grade dysplasia
K62.7	Radiation proctitis
K62.82	Dysplasia of anus (AIN I and AIN II)
K92.81	Gastrointestinal mucositis (ulcerated) (due to antineoplastic therapy)
M36.0	Dermato(poly)myositis in neoplastic disease ICD-10-CM Coding instruction: Code first underlying neoplasm (C00-D49)
M36.1	Arthropathy in neoplastic disease ICD-10-CM Coding instruction: Code first underlying neoplasm, such as: Leukemia (C91-C95), malignant histiocytosis (C96.A), multiple myeloma (C90.0)
M84.5-	Pathologic fracture in neoplastic disease ICD-10-CM Coding instruction: Code also underlying neoplasm (C00-D49)
M90.6-	Osteitis deformans in neoplastic disease *ICD-10-CM Coding instruction: Code first the neoplasm (C40._, C41._)*
N42.3	Dysplasia of prostate (PIN I and PIN II)
N76.81	Mucositis (ulcerative) of vagina and vulva
N87._	Dysplasia of cervix uteri (CIN I and CIN II)

ICD-10-CM CODE (5% Review Required)	DESCRIPTION
N89.0,N89.1, N89.3	Vaginal dysplasia (VIN I and VIN II)
N90.0,N90.1, N90.3	Vulvar dysplasia (VAIN I and VAIN II)
O01.-	Hydatidiform mole *Note: Benign tumor that can become malignant. If malignant, report as Choriocarcinoma (9100/3,) malignancy code in the C00-C97 range*
O9A.1-	Malignant neoplasm complicating pregnancy, childbirth and the puerperium (conditions in C00-C96) *ICD-10-CM Coding instruction: Use additional code to identify neoplasm*
Q85.0-	Neurofibromatosis (nonmalignant) (9540/1) *Note: Neurofibromatosis is not cancer. These tumors can be precursors to acoustic neuromas, which are reportable*
R18.0	Malignant ascites *ICD-10-CM Coding instruction: Code first malignancy, such as: Malignant neoplasm of ovary (C56._), secondary malignant neoplasm of retroperitoneum and peritoneum (C78.6)*
R53.0	Neoplastic (malignant) related fatigue *ICD-10-CM Coding instruction: Code first associated neoplasm*
R59.-	Enlarged lymph nodes
R85.6-	Abnormal findings on cytological and histological examination of digestive organs. ***Note:*** *see "must collect" list for R85.614*
R87.61-, R87.62-	Abnormal findings on cytological/histological examination of female genital organs. ***Note:*** *see "must collect" list for R87.614 and R87.624*
R92.-	Abnormal findings on diagnostic imaging of breast
R97.-	Abnormal tumor markers
T38.8-, T38.9-	Poisoning by hormones and their synthetic substitutes
T45.1-	Poisoning by, adverse effect of and under dosing of antineoplastic and immunosuppressive drugs
T45.8-, T45.9-	Poisoning by primary systemic and hematological agent, unspecified
T66	Unspecified effects of radiation
T80.2-	Infections following infusion, transfusion and therapeutic injection
T80.810	Extravasation of vesicant antineoplastic chemotherapy
T80.818	Extravasation of other vesicant agent
T86.0	Complications of bone marrow transplant ICD-10-CM Coding instruction: Use addition code to identify other transplant complications, such as: malignancy associated with organ transplant (C80.2) or post-transplant lymphoproliferative disorders (PTLD) (D47.Z1)

ICD-10-CM CODE (5% Review Required)	DESCRIPTION
Y63.2	Overdose of radiation given during therapy
Y84.2	Radiological procedure and radiotherapy as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure
Z03.89	Encounter for observation for other suspected diseases and conditions ruled out
Z08	Encounter for follow-up examination after completed treatment for malignant neoplasm
Z12.-_	Encounter for screening for malignant neoplasms
Z13.0	Encounter for screening for diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
Z15.0	Genetic susceptibility to malignant neoplasm ICD-10-CM Coding instruction: Code first, if applicable, any current malignant neoplasm (C00-C75, C81-C96); Use additional code, if applicable, for any personal *history of malignant neoplasm (Z85._)*
Z17.0, Z17.1	Estrogen receptor positive and negative status
Z19.1	Hormone sensitive malignancy status
Z19.2	Hormone resistant malignancy status
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
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
Z85._	Personal history of malignant neoplasm
Z86.0_, Z86.01_, Z86.03	Personal history of in situ and benign neoplasms and neoplasms of uncertain behavior
Z92.21, Z92.23, Z92.25. Z92.3	Personal history of antineoplastic chemotherapy, estrogen therapy, immunosuppression therapy or irradiation (radiation)
Z94.81, Z94.84	Bone marrow and stem cell transplant status

^International Classification of Diseases, ICD-10-CM Tabular List of Diseases and Injuries, FY 2017

NON-REPORTABLE ICD-10-CM CODES

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

Table 3.6 Non-Reportable Codes

ICD-10-CM CODE^	DESCRIPTION
E31.21 E31.22 E31.23	Multiple endocrine neoplasia (MEN) type I, IIA and IIB (rare familial cancer syndrome) **Note**: use additional codes to identify any malignancies and other conditions associated with the syndrome.
D61.82	Myelophthisis
D63.0	Anemia in neoplastic disease **Note**: Assign also a code for the neoplasm causing the anemia Excludes: anemia due to antineoplastic chemotherapy, new code 285.3
D75.81	Myelofibrosis (NOS) **Note**: Not every case of myelofibrosis is associated with a malignancy. Review terms included in ICD-O-3 to determine if case is reportable. See the current ICD-9-CM.
G94	Cerebral degeneration in diseases classified elsewhere
G99.2	Myelopathy in other diseases classified elsewhere
G89.3	Neoplasm related pain (acute, chronic); Cancer associated pain; Pain due to malignancy (primary/secondary); Tumor associated pain
G63	Polyneuropathy in malignant disease
G73.3	Myasthenic syndromes in other diseases classified elsewhere
G73.1	Eaton-Lambert syndrome in neoplastic disease (Effective 10/1/2011)
J91.0	Malignant pleural effusion **Note**: Code first malignant neoplasm if known. If the primary site is not known, code 199.0, disseminated carcinomatosis, or code 199.1, malignancy NOS, should be assigned.
R18.0	Malignant ascites **Note**: Code first malignant neoplasm if known. If the primary site is not known, code 199.0, disseminated carcinomatosis, or code 199.1, malignancy NOS, should be assigned

^International Classification of Diseases, ICD-10-CM Tabular List of Diseases and Injuries, FY 2017

OTHER CASEFINDING METHODS

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

Pathology

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

SUSPENSE FILE

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

NON-REPORTABLE LIST

Personnel responsible for reporting should review the table of terms that indicate a diagnosis of cancer on page 28-29. Upon review of the disease index (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**.

The TCR will review the disease index and the non-reportable list when it conducts casefinding audits after facilities have completed reporting for a given year (see page 22). The non-reportable list will answer any questions TCR staff may have regarding the non-reporting of these cases. The list should include patient name, date of birth, social security number, medical record number, admission date, casefinding source, and the reason the case was not reportable.

Attachment B (page 50) is a sample form that can be used as a history file of the non-reportable cases. Non-reportable cases can also be documented on the disease index. Place the notation "NR" next to the patient information and include a justification if the case is determined not reportable. Another method would be to develop an electronic spreadsheet that can be sorted alphabetically, such as Excel or Word. An alphabetical index card file can also be used.

Note: There is 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 disease index. The non-reportable list must be submitted to TCR after reporting is complete for the year.

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

***Non-reportable examples*:**

a. The IDC-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.**

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

c. 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.**

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

***Reportable examples*:**

a. 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.**

b. A patient was diagnosed with adenocarcinoma of the stomach in 1985 with no evidence of recurrent or metastatic disease. In 2017, the patient was admitted and diagnosed with small cell carcinoma of the lung. **The lung cancer is reportable for 2017 because the patient has active lung cancer.**

c. 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.**

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

e. 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.**

f. 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.**

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

h. In 2017 a patient comes to your facility for a colonoscopy. The record states that the patient was diagnosed with breast cancer in 2013. 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 5 years, **report the case.**
- It is unknown how long ago the breast cancer was diagnosed, **report the case.**

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

i. 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.**

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

k. 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.**

Summary: If there is any indication within the medical record that the patient has evidence of disease, or is on cancer directed treatment, the case is reportable except for those morphologies listed under non-reportable neoplasms on page 29. This would include but not limited to radiology reports, pathology reports, consults, history and physicals, and clinic notes.

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

AMBIGUOUS TERMINOLOGY FOR SOLID TUMORS

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

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

Apparent(ly)	Favor(s)	Probable
Appears	Malignant appearing	Suspect(ed)
Comparable with	Most likely	Suspicious (for)
Compatible with	Presumed	Typical (of)
Consistent with		

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

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

How to use the ambiguous terminology for <u>case ascertainment</u>

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 an invasive tumor, accession the case. Please refer to page 116 for terms synonymous for in situ.

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

      ***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.

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

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

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

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

         Exception: Do not accession a case based ONLY on suspicious cytology. If cytology is reported using an ambiguous term, do not interpret this as a diagnosis of cancer. **Report the case only if a positive biopsy or a physician's clinical impression of cancer supports the cytology findings or if cancer directed therapy is administered.** Cytology is the examination of cells obtained by aspiration, washing, smear, or scraping.

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

As of January 2013, (SEER Program Coding and Staging Manual 2016, Reportability, page 5 and 11) a positive urine cytology is reportable.

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

***Examples*:**

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

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

Cytology using ambiguous terminology (only) remains not reportable.

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

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

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

   ***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 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 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.

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

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

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

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

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

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

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

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

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

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

   e. **Discrepancies**

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

         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.

Note: AJCC does **NOT** define ambiguous terminology and does **NOT** mandate how words should be interpreted. AJCC instructs registrars to review physician's statements, consider treatment choices, assess physical exam, medical history, symptoms, imaging, lab tests, diagnostic procedures and all other available information in order to decide cancer involvement, exercise critical thinking.

Ambiguous Terminology Lists: References of Last Resort

The references of last resort clarifies the use of Ambiguous Terminology as listed in FORDS: Revised for 2016 for case reportability and staging in Commission on Cancer (CoC)-accredited programs. The references of last resort is still in effect for 2017. When abstracting, registrars are to use the "Ambiguous Terms at Diagnosis" list with respect to case reportability, and the "Ambiguous Terms Describing Tumor Spread" list with respect to tumor spread for staging purposes. However, these lists need to be used correctly.

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

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

CASEFINDING INSTRUCTIONS FOR HEMATOPOIETIC & LYMPHOID NEOPLASMS

See the Reportability Instructions at https://seer.cancer.gov/seertools/hemelymph/.

As of **January 2010** (*Hematopoietic and Lymphoid Neoplasm Coding Manual*, page 23) use the ambiguous terms when screening all reports other than cytology and tumor markers.

CASEFINDING LISTS

Current and previous casefinding lists are available on the SEER website: https://seer.cancer.gov/tools/casefinding/. 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.

Definition of Casefinding (case ascertainment): Process of identifying all reportable cases through review of source documents and case listings. Casefinding covers a range of cases that need to be assessed to determine whether or not they are reportable.

ADDITIONAL GUIDELINES FOR CASE REPORTING

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

a. The clinic is owned by the facility.

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

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

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

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

- Cases diagnosed and/or treated for cancer prior to admission **should be reported** if there is evidence of **active disease**, whether or not diagnostic or therapeutic procedures were performed. **Stable disease indicates active disease.**
- Cases diagnosed at autopsy are reportable.
- Patients with active cancer coming into a facility for "consultation only" should be reported.
- Abstract cases with a reportable diagnosis using the medical record from the first admission (inpatient or outpatient) to your facility. Use information from subsequent admissions to supplement documentation and to include all first course treatment information**. Do not submit a report for each admission; submit one report per primary tumor.**
- Cases in which the disease is **no longer active** should only be reported if the patient is still receiving cancer-directed therapy. For instance, a patient with a history of leukemia in remission, but is still receiving chemotherapy.

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

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

***Examples for Determining Case Reportability*:**

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

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

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

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

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

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

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

HELPFUL HINTS TO CONDUCT CASEFINDING

- All possible sources of cancer cases in a facility should be reviewed to achieve complete and accurate casefinding.
- Review pathology reports monthly.
- Review disease index monthly.
- Review radiation oncology logs weekly.

- Have coders route medical charts to the registrar/reporter on all identified cancer patients.
- Review outpatient and emergency room visits for reportability. Arrangements can be made to have these routed to the registrar/reporter, or the registrar/reporter can physically review them in the department.
- Maintain a list of non-reportable cases or document non-reportable cases on the disease index.

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

- The **electronic** disease index (see Attachment A, page 49) along with documentation of the parameters used to generate the index.
- The **electronic** non-reportable list (see Attachment B, page 50).
- The casefinding checklist (see Attachment C, page 51).

Note: For more information on cancer reporting visit the Cancer Reporting page on the TCR website, located at https://www.dshs.texas.gov/tcr/reporting.aspx.

Contact your regional representative for an assessment of your casefinding procedures. This will better prepare you for an audit.

DETERMINING MULTIPLE PRIMARIES

Solid Tumors

Apply the general and site-specific instructions for determining multiple primaries in the *Multiple Primary and Histology Coding Rules Manual*: https://seer.cancer.gov/tools/mphrules/download.html.

Apply the site-specific multiple primary rules in the *Multiple Primary and Histology Coding Rules Manual*: https://seer.cancer.gov/tools/mphrules/download.html.

Site-specific multiple primary rules cover the following:

Primary Site	Topography Codes
Head and neck	C000-C148, C300-C329
Colon	C180-C189
Lung	C340-C349
Melanoma of the skin	C440-C449 with Histology 8720-8780
Breast	C500-C509
Kidney	C649
Renal Pelvis/ Ureter/ Bladder/ Other urinary	C659, C669, C670-C679, C680-C689
Benign Brain	C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
Malignant Brain	C700, C701, C709, C710-C719, C720-C725, C728, C729, C751-C753
Other sites	Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain

General and site-specific rules for solid tumors do not cover lymphoma and leukemia (9590-9992).

Hematopoietic and Lymphoid Neoplasms

Apply the Multiple Primary Rules in the *Hematopoietic and Lymphoid Neoplasm Coding Manual and Database*: https://seer.cancer.gov/seertools/hemelymph/.

Transplants

Transplanted organs or tissue may originate from:

a. organs or tissue from the patient's own body (called autograft) or

b. another human donor (homograft or allograft)

Accession a new primary in the transplanted organ as you would any new primary, applying the 2007 MP/H rules. Code the primary site to the location of the transplanted organ, i.e., code the malignancy where it resides/lies.

Example: Diagnosis of malignancy in transplanted section of colon serving as esophagus. Code the primary site as esophagus. Document the situation in a text field.

ATTACHMENT A, Sample Facility Disease Index

Sample Facility Disease Index
Cancer Cases with 2017 Admission Date

MR#	NAME	DOB	SS#	SEX	PT CLASS/ TYPE	ADMISSION DATE	DISCHARGE DATE	DIAGNOSIS/ DESCRIPTION
123123	Roberts, Jim	2/10/1959	455-66-9090	M	IN, MCR	05/02/17	05/03/17	C7A.010 Mal Carcinoid Tumor Duodenum
431124	Smith, Bob	6/29/1938	422-23-2323	M	IN, MCR	04/05/17	04/07/17	Z51.11 Chemo Encounter
C5412	Smith, Bob	6/29/1938	422-23-2323	M	SCD, MCR	05/11/17	05/11/17	C64.9 Mal Neo Kidney
431124	Smith, Bob	6/29/1938	422-23-2323	M	IN, MCR	09/06/17	09/14/17	C79.1 Sec Mal Neo Brain
431124	Smith, Bob	6/29/1938	422-23-2323	M	IN, MCR	10/15/17	10/22/17	C64.9 Mal Neo of Unsp Kidney
MR421	Sun, Len	11/4/1980	566-66-6666	M	IN, OTH	10/16/17	10/20/17	D63.0 Anemia in Neoplastic Disease
MR311	Timms, Emma	6/15/1959	500-00-5000	F	CLL, MCR	03/22/17	03/22/17	D24.1 Benign Neo Breast

C1234	Timms, Emma	6/15/1959	500-00-5000	F	IN, MCR	05/29/17	06/02/17	C50.419 Mal Neo Breast UOQ
C1234	Timms, Emma	6/15/1959	500-00-5000	F	IN, MCR	05/29/17	06/02/17	C77.3 Mal Neo Lymph-Axilla
MR311	Timms, Emma	6/15/1959	500-00-5000	F	RCR, MCR	07/13/17	07/23/17	Z51.0 Encounter for Antineoplastic Radiation Therapy
MR311	Timms, Emma	6/15/1959	500-00-5000	F	RCR, MCR	8/23/2017	11/13/17	D49.9 GIST

ICD-10 Codes

ATTACHMENT B, Non-Reportable List

Non-Reportable List

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

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

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

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

ATTACHMENT C, Sample Casefinding Document

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

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

4

DEMOGRAPHICS AND PATIENT INFORMATION

DEMOGRAPHICS AND PATIENT INFORMATION

Reporting Facility Number
(NAACCR Item #540)

Description
Identifies the facility or institution reporting the case.

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

Coding Instructions
1. Enter the three-digit facility number assigned by the TCR. This is a 10 digit code. The three digit facility number should be coded with 7 leading zeros.

2. If you do not know your facility number, contact your Health Service Region office or the Central Office in Austin. See page 15 for contact information.

Type of Reporting Source
(NAACCR Item #500) (SEER pgs. 26-28)

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

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

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

Table 4.1 Type of Reporting Source Codes

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

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

Definitions:

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

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

Managed health plan: Any facility where all of the diagnostic and treatment information is maintained in one unit record (all records for the patient from all departments, clinics, offices, etc. in a single file with the same medical record number). The abstractor is able to use the unit record when abstracting the case

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

Physician office: A physician office performs examinations and tests. Physician offices may perform limited surgical procedures.

Note: The category "physician's office" also includes facilities that are called surgery centers when surgical procedures under general anesthesia cannot be performed in these facilities.

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

Note: The category "physician's office" also includes facilities that are called surgery centers when surgical procedures under general anesthesia cannot be performed in these facilities.

Priority Order for Assigning Type of Reporting Source

Code the source that provided the best information used to abstract the case.

Examples:

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

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

c. The only patient record available for a physician office biopsy is the pathology report identified from a freestanding laboratory. Assign code 3 [Laboratory Only (hospital-affiliated or independent)]. Reporting source should reflect the lab where this case was identified. The MD office added nothing to the case, not even a confirmation of malignancy.

When multiple source documents are used to abstract a case, use the following priority order to assign a code for Type of Reporting Source: Codes: 1, 2, 8, 4, 3, 5, 6, 7. When multiple source documents are used to abstract a case, use the following priority order to assign a code for Type of Reporting Source: Codes: 1, 2, 8, 4, 3, 5, 6, 7.

Date of Admit/Date of First Contact

(NAACCR Item #580)

Description

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

Explanation

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

Coding Instructions

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

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

3. Date format is:

   a. YYYYMMDD

   ***Example*:** The patient is first seen at this facility on January 4, 2017 with a diagnosis of cancer. Record the date of admit: 20170104

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

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

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

Note: FORDS instructions (see FORDS pg. 118) differ from TCR instructions. FORDS requires that for analytic cases Date of First Contact is the date the patient qualifies as an analytic case Class of Case 00-22. If the patient was admitted for non-cancer-related reasons, the Date of First Contact is the date the cancer was first suspected during the hospitalization. TCR will continue to instruct that the date be recorded as the admit date if the diagnosis is made at the reporting facility. It is understood that ACoS facilities will continue to follow the rules according to FORDS.

Examples:

a. A patient is admitted to the hospital on January 31, 2017, with chest pains. On February 2, 2017, a CT scan shows that the patient has a lung mass consistent with malignancy. Record the date of first contact as 20170131.

b. A patient has a biopsy in a staff physician's office on March 17, 2017, 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, 2017, for a wide re-excision. Record the date of first contact as 20170317.

c. A patient has a lymph node biopsy at a small hospital on May 15, 2017. 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 20170515 as the date of first contact.

Registry/Accession Number

(NAACCR Item #550) (FORDS pg. 38)

Description

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

Explanation

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

Coding Instructions

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

   ***Example*:** 2017000001 would indicate the first 2017 case reported from a facility.

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

Note: Web Plus does not auto populate Accession Number.

Medical Record Number

(NAACCR Item #2300) (FORDS pg. 40)

Description

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

Explanation

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

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

2. If a number is not available (outpatient clinic charts or ER visit reports), enter OP followed by nine 0's in this field. See Table 4.2 for other optional medical record identifiers.

Table 4.2 Optional Medical Record Identifier Codes

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

Class of Case
(NAACCR Item #610) (FORDS pgs. 113-115)

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

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

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

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

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

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

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

Note: Non-analytical class of case codes 49 and 99, are to be used solely by the central registry.

Coding Instructions

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

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

3. Code 34 or 36 if the diagnosis is benign or borderline (*Behavior* 0 or 1) for any site diagnosed before 2004 **OR** for any site other than meninges (C70_), brain (C71_), spinal cord, cranial nerves, and other parts of central nervous system (C72_), pituitary gland (C751) craniopharyngeal duct (C752), and pineal gland (C753) that were diagnosed in 2004 or later.

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

4. Code 34 or 36 intraepithelial neoplasia grade III (8077/2 or 8148/2) of the cervix (CIN III), vulva (VIN III), vagina (VAIN III), and anus (AIN III).

5. A staff physician (codes 10-12, 41) is a physician who is employed by the reporting facility, under contract with it, or a physician who has routine practice privileges there. Treatment provided in a staff physician's office is provided "elsewhere". That is because care given in a physician's office is not within the hospital's realm of responsibility.

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.

Table 4.3 Class of Case Definitions

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 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 actually 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:** ACoS facilities should include cases in which patients are diagnosed at the reporting facility prior to the registry's reference date and all or part of the first course of treatment was received at the reporting facility after the registry's reference date.
Class 11	Initial diagnosis 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.

NON-ANALYTIC CASES Patient appears in person at reporting facility; both initial diagnosis and treatment elsewhere. 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***).
Class 34	Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis AND part or all of first course treatment done by reporting facility.
Class 35	Case diagnosed before program's Reference Date, AND initial diagnosis AND PART OR ALL of first course treatment by reporting facility.
Class 36	Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis elsewhere AND part or all of first course treatment by reporting facility.
Class 37	Case diagnosed before program's Reference Date, AND initial diagnosis elsewhere AND all or part of first course treatment by facility.
Class 38*	Initial diagnosis established by autopsy at the reporting facility, cancer not suspected prior to death.
PATIENT DOES NOT APPEAR IN PERSON AT REPORTING FACILITY	
Class 40	Diagnosis AND all first course treatment given at the same staff physician's office.
Class 41	Diagnosis and all first course treatment given in two or more different staff physician offices 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.**

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

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

Table 4.4 Class of Case Examples

CODE	REASON
00	Reporting facility admits patient due to dizziness and falling. The patient receives clinical workup which includes CT and MRI of the brain. The results are positive for brain metastasis. The patient is discharged to another hospital for treatment for lung cancer with brain metastasis. Leukemia was diagnosed and all care was given in a staff physician's office.
10	Patient is diagnosed with lung cancer at the reporting facility. Due to age and comorbidities the decision was made not to treat. Reporting hospital 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 then is treated with interferon at another facility. Patient was diagnosed by staff physician, received neoadjuvant radiation at another facility, and then underwent surgical resection at the reporting facility.
12	A diagnosis of prostate cancer is made in a staff physician's office. The patient receives radiation therapy at the reporting facility, and no other treatment is given.
13	A patient is diagnosed with colon cancer at the reporting facility and undergoes a hemicolectomy there. She then receives chemotherapy at an outside clinic.
14	Reporting facility admits patient with hemoptysis. Workup reveals adenocarcinoma. The patient undergoes surgery followed by radiation therapy at the reporting facility. The patient did not receive any other treatment.
20	Patient was diagnosed with primary breast cancer at another facility. The patient then comes to the reporting facility for surgery. It is unknown if she received any other treatment.
21	Patient diagnosed at another facility with breast cancer and received neo-adjuvant chemotherapy. She now presents to the reporting facility for modified radical mastectomy.
22	Patient had a biopsy at another facility and the diagnosis was breast cancer. She underwent a mastectomy at the reporting facility and did not receive any further treatment.
31	Patient receives chemotherapy while visiting relatives in the reporting hospital city, then returned to the originating hospital for subsequent treatments.
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.

Last Name

(NAACCR Item #2230) (FORDS pg. 43) (SEER pg. 31)

Description

Identifies the last name of the patient.

Explanation

This data item is used as a patient identifier.

Coding Instructions

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

   ***Examples*:**
   a. Record De Leon with a space as DE LEON.
   b. Record O'Hara with an apostrophe as O'HARA.
   c. If Janet Smith marries Fred Jones and changes her name to Smith-Jones record SMITH-JONES with the hyphen.

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

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

First Name

(NAACCR Item #2240) (FORDS pg. 43) (SEER pg. 30)

Description

Identifies the first name of the patient.

Explanation

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

Coding Instructions

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

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

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

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

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

Middle Name

(NAACCR Item #2250) (FORDS pg. 45)

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

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

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

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

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

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

Maiden Name

(NAACCR Item #2390)

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

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

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

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

Alias Name

(NAACCR Item #2280)

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

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

Coding Instructions

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

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

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

4. No other special characters are allowed.

***Examples*:**

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

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

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

Street Address

(NAACCR Item #2330) (FORDS pg. 46)

Description

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

Explanation

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

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

Coding Instructions

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

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

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

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

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

Table 4.5 Street Address Abbreviations

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

***Example*:**

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

Patients with an Unknown Address:

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

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

7. Use https://www.usps.com/ for help in completing address information.

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

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

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

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

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

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

Temporary Residents:

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

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

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

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

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

15. **Personnel Assigned to Navy, Coast Guard, and Maritime Ships-**The US Census Bureau has detailed rules for determining residency for personnel assigned to these ships. The rules refer to the ship's deployment, port of departure, destination, and its homeport. Refer to US Census Bureau Publications for detailed rules at www.census.gov.

16. Use residency information from a **death certificate** only when the residency from other sources is coded as unknown. Review each case carefully and apply the U.S. Census Bureau for determining residence. For example, the death certificate may give the person's previous home address rather than the nursing home address as the place of residence. If the person was a resident of a nursing home at diagnosis, use the nursing home address as the place of residence.

Address at Dx - Supplemental

(NAACCR Item #2335) (FORDS pg. 47)

Description

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

Explanation

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

Coding Instructions

1. Do not use this data item to record the number, street, apartment, unit, suite, room, lot, space or department number of the patient's address.

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

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

City

(NAACCR Item #70) (FORDS pg. 48)

Description

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

Explanation

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

Coding Instructions

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

2. Do not use punctuation, special characters, or numbers. The use of capital letters is preferred by the USPS; it also guarantees consistent results in queries and reporting.

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

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

State

(NAACCR Item #80) (FORDS pgs. 49) (SEER pg. 39)

Description

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

Explanation

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

Coding Instructions

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

2. If the patient is a resident of Canada, record the appropriate **two-letter abbreviation** for the country of residence at time of diagnosis/admission. If the province or territory of Canada is known, record the abbreviation. See page 74 for a list of Canadian Provinces/Territories.

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

4. If the patient has multiple primaries, the state of residence may be different for subsequent cases.

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

Table 4.6 State Codes

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

***Examples*:**

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

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

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

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

Table 4.7 Canadian Provinces/Territories

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

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

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

Table 4.9 Other US Territories

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

Zip Code

(NAACCR Item #100) (FORDS pg. 51)

Description

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

Explanation

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

Coding Instructions

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

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

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

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

Table 4.10 Zip Code

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

***Examples*:**

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

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

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

FIPS County Code at Diagnosis

(NAACCR Item #90) (FORDS pg. 53)

Description

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

Explanation

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

Coding Instructions

1. Enter the appropriate three-digit code for the county of residence. Use codes issued by the Federal Information Processing Standards (FIPS) publication, *Counties and Equivalent Entities of the United States, Its Possessions, and Associated areas*. U.S. Census Bureau's online FIPS County Code Look-up Tool: https://www.census.gov/geo/reference/codes/cou.html.

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

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

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

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

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

Table 4.11 Fips County Code at Diagnosis

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

Address at Dx - Country

(NAACCR Item #102) (FORDS pg. 52)

Description

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

Explanation

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

Coding Instructions

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

Table 4.12 Country Code Examples:

CODE	COUNTRY
USA	United States
CAN	Canada
MEX	Mexico
SLV	El Salvador
VNM	Viet Nam

Note: For other country codes please refer to the International Standards Organization (ISO) 3166-1 Country Three Character Codes: https://www.iso.org/obp/ui/#search.

Social Security Number

(NAACCR Item #2320) (FORDS pg. 42)

Description

Identifies the patient by social security number.

Explanation

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

Coding Instructions

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

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

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

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

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

Note: Social security numbers are used for Medicare benefits. Suffix A on a social security number indicates the number is the patient's Medicare number. Other suffixes identify another person's Medicare number under which the patient may be entitled to receive benefits. **Take caution to enter the patient's social security number and not the spouse's or guardian's number.**

The following are not allowed:

- First 3 digits= 000, 666, or 900-999
- Fourth and fifth digits= 00
- Last four digits= 0000
- First digit 9 (except for 9999999999)

Date of Birth

(NAACCR Item #240) (FORDS pg. 64; SEER pgs. 47-48)

Description

Identifies the patient's century, year, month, and day of birth.

Explanation

This item is used by the TCR to match records, and to calculate age at diagnosis.

Coding Instructions

1. Punctuation marks (slashes, dashes, etc.) are not allowed.
2. The patient's date of birth **must be entered.** Cases cannot be processed without the date of birth.
3. Date format is:
   a. YYYYMMDD - when the complete date is known and valid.
      ***Example*:** The patient's date of birth is June 28, 1983. Code the date of birth as 19830628.
   b. YYYYMM - when the year and month are known and valid, and the day is unknown.
      ***Example*:** The patient was born in November of 1981, but the day is unknown. Code 198111.
   c. YYYY when the year is known and valid but the month and day are unknown.
      ***Example*:** The record indicates the patient was born in 1978 but no month or day is given. Code 1978.

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

4. If only the age of the patient is known, calculate the year of birth from age and year of diagnosis and leave the day and month of birth unknown.
   ***Example*:** A 50 year old patient diagnosed in 2010 is calculated to have been born in 1960.
5. The year of birth *must* be recorded. TCR will not accept unknown year of birth. Every effort must be made to obtain this information as it is critical for analysis.
6. 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.

Table 4.13 Date of Birth Code

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

Birthplace - State
(NAACCR Item #252) (FORDS pg. 62; SEER pg. 45)

Description
Identifies the patient's state of birth.

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

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

2. Use the most specific code.

Table 4.14 Birthplace - State Examples

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

Birthplace - Country
(NAACCR Item #254) (FORDS pg. 63; SEER pg. 46)

Description
Identifies the patient's country of birth.

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

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

2. Use the most specific code.

Table 4.15 Birthplace Country Examples

CODE	COUNTRY
USA	United States
CAN	Canada
MEX	Mexico
SLV	El Salvador
ZZC	Central America NOS
VNM	Viet Nam
ZZU	Place of birth is unknown, no mention in patient record

Note: For other country codes please refer to the International Standards Organization (ISO) 3166-1 Country Three Character Codes https://www.iso.org/obp/ui/#search/code/

Race 1

(NAACCR Item #160) (FORDS pgs. 67; SEER pgs. 51-55)

Description

Identifies the primary race of the person.

Explanation

Racial origin captures information used in research and cancer control activities comparing stage at diagnosis and/or treatment by race. The full coding system should be used to allow accurate national comparisons. Race is defined by specific physical, hereditary and cultural traditions or origins, not necessarily by birthplace, place of residence, or citizenship.

Coding Instructions

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

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

3. Code race using the highest priority source available according to the list below (a is the highest and c is the lowest) when race is reported differently by two or more sources.
   a. The patient's self-declared identification
   b. Documentation in the medical record
   c. Death Certificate

4. Assign the same race code(s) for all tumors for one patient.

5. Race 1 is the field used to compare with race data on cases diagnosed prior to January 1, 2000.

6. Code as **01** (white) when
   a. The race is described as White or Caucasian regardless of place of birth.
   b. There is a statement that the patient is Hispanic or Latino(a) and no further information is available.

Example: There is a statement that Sabrina Fitzsimmons is a Latina but no further information is available. Code race as **01** (White).

Note: Persons of Spanish or Hispanic origin may be of any race, although persons of Mexican, Central American, South American, Puerto Rican, or Cuban origin are usually White.

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

8. Codes **02-32**, **96-98** take priority over code **01.**

9. Code **07** takes priority over all other codes.

   Example: Patient is described as Japanese and Hawaiian. Code Race 1 as 07 (Hawaiian), Race 2 as 05 (Japanese)

10. Code only the specific race when both a specific race code and a non-specific race code apply.
    a. Codes 04-17 take priority over code 96
    b. Codes 16-17 take priority over code 15
    c. Codes 20-32 take priority over code 97
    d. Codes 02-32 and 96-97 take priority over code 98
    e. Code 98 takes priority over code 99

11. Code race as **02** (Black) when the stated race is African-American, Black, or Negro.

12. Assign code **03** for any person stated to be
    a. Native American (Western Hemisphere) OR
    b. Indian, whether from North, Central South or Latin America.

13. Assign a specific code when a specific Asian race is stated. Do not use code 96 when a specific race is known.

14. Code the race based on birthplace information when the race is recorded as Oriental, Mongolian, or Asian and the place of birth is recorded as China, Japan, the Philippines, or another Asian nation.

    Example 1: Race is recorded as Asian and the place of birth is recorded as Japan. Code race as 05 (Japanese) because it is more specific than 96.

    Example 2: The patient describes himself as an Asian-American born in Laos. Code race as 11 (Laotian) because it is more specific than 96.

15. Do not use codes 96, 97 or 98 for "multi-racial".

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

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

18. In using the patient name to determine race:
    a. Do not code race from name alone, especially for females with no maiden name given.
    b. A Spanish name alone may not be used to determine the race code. A statement about race or place of birth must be documented.
    c. Refer to Appendix D in SEER 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 birth place is recorded. In some cases, race may be inferred from the nationality. Use Appendix D to identify nationalities from which race codes may be inferred.

       Example: Record states: "the patient was Nigerian" Code race as 02 (Black) per the Appendix.

       Exception: Code Race 1 through Race 5 as 99 (Unknown) when patient's names is incongruous with the race inferred on the basis of nationality. Do not code the inferred race when the patient's name in incongruent with the race inferred on the basis of nationality.

       Example: Patient's name is Siddharta Rao and birthplace is listed as England. Code Race 1 through Race 5 as 99 (Unknown).

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

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

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

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

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

24. Patient photographs may be used with caution to determine race in the absence of any other information. Use caution when interpreting a patient photograph to assist in determining race. Review the patient record for a statement to verify race. The use of photographs alone to determine race may lead to a misclassification of race.

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

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

Table 4.16 Race Codes 1 - 5

CODE	DESCRIPTION	CODE	DESCRIPTION
01	White	17	Pakistani
02	Black	20	Micronesian, NOS
03	American Indian, Aleutian, Eskimo (includes all indigenous populations of the Western hemisphere)	21	Chamorro/Chamoru
04	Chinese	22	Guamanian, NOS
05	Japanese	25	Polynesian, NOS
06	Filipino	26	Tahitian
07	Hawaiian	27	Samoan
08	Korean	28	Tongan
10	Vietnamese	30	Melanesian, NOS
11	Laotian	31	Fiji Islander
12	Hmong	32	New Guinean
13	Kampuchean (Cambodian)	96	Other Asian, including Asian, NOS and Oriental, NOS
14	Thai	97	Pacific Islander, NOS
15	Asian Indian or Pakistani, NOS	98	Other
16	Asian Indian	99	Unknown
88	No additional races (Race 2-Race 5)		

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

Table 4.17 Race Code 1 Examples

CODE	DESCRIPTION
01	-A patient was born in Mexico of Mexican parentage. -A patient stated to be German-Irish. -A person from Iran or Saudi Arabia. -An immigrant from Sweden.
02	A black female patient. **Note:** A specific race code (other than blank or 99) must not occur more than once. For example, do not code Black in race 1 for one parent and Black in race 2 for the other parent.
04	A patient is of Chinese and Korean ancestry. Code 04, Chinese in Race 1. Code 08, Korean, in Race 2. Patient is stated to be Chinese and black. Code Race 1 as 04 (Chinese), code Race 2 as 02 (Black).
CODE	**DESCRIPTION**
05	A patient has a Japanese father and a Caucasian mother. Code 05 Japanese in Race 1 and 01 White in Race 2.
07	A patient’s race is a combination of Hawaiian and any other race(s). Code 07, Hawaiian, in Race 1 and Race 2–Race 5 as appropriate.

11	A patient is stated to be Asian. The place of birth is Laos. Code Race 1 as 11, Laotian, because it is more specific than 96, Asian, NOS.
25	Patient states she has a Polynesian mother and Tahitian father. Code race 1 as 25 (Polynesian), race 2 as 26 (Tahitian) and Race 3-5 as 88.
99	A patient's race is unknown. Code Race 1 as Unknown, code 99. Race 2–Race 5 must also be coded 99. If a patient has a Spanish last name and she is stated to be a native of Indiana, code to 99, Unknown, because nothing is known about her race. Exception is done when Race is noted as "other" in face sheet; use code **99** for Race 1 and code 88 for Race 2-5.

Race 2, Race 3, Race 4, Race 5

(NAACCR Items #161, 162, 163, 164) (FORDS pgs. 69-72; SEER pgs. 51-55)

Description

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

Explanation

Racial origin captures information used in research and cancer control activities comparing stage at diagnosis and/or treatment by race. The full coding system should be used to allow accurate national comparisons.

Coding Instructions

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

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

3. Do not use codes 96, 97 or 98 for "multi-racial"

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

5. If more than the *Race 1* code is entered, and if any race is **99**, then all race codes (*Race 1, 2, 3, 4* and *5*) must be **99**. If more than the *Race 1* code is entered, and if any race codes (for *Race 2, 3, 4* and *5*) are **88** (no further race documented), then all **subsequent** race codes must also be **88**. The exception for this instruction when Race "other" is taken from face sheet, where Race 1 will be coded as 99 and Race 2-5 will be coded as 88.

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

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

8. Codes **02-32**, **96-98** take priority over code **01.**

9. Code **07** takes priority over all other codes.

10. Code only the specific race when both a specific race code and a non-specific race code apply.
    a. Codes 04-17 take priority over code 96
    b. Codes 16-17 take priority over code 15
    c. Codes 20-32 take priority over code 97
    d. Codes 02-32 and 96-97 take priority over code 98
    e. Code 98 takes priority over code 99

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

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

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

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

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

16. When the patient face-sheet indicates "Race Other," look for other descriptions of the patient's race. When **no further race information is available**, code race as 99 (Unknown) and document that patient face-sheet indicates "Race Other," and no further race information is available.

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

Spanish/Hispanic Origin

(NAACCR Item #190) (FORDS pg. 72; SEER pg. 59)

Description

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

Explanation

This is used to identify whether or not the person should be classified as *Hispanic* for purposes of calculating cancer rates. Hispanic populations have different patterns of occurrence of cancer from other populations that may be included in the 01 (White) category of *race.*

Coding Instructions

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

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

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

4. Portuguese, Brazilians and Filipinos are not presumed to be Spanish or non-Spanish.
   a. Assign code 7 when the patient is Portuguese, Brazilian, or Filipino and their name appears on a Hispanic surname list.

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

Note: Refer to the list of Spanish/Hispanic surnames on the TCR website at: https://www.dshs.texas.gov/tcr/training/handbook/Appendix-Spanish-Hispanic-Surnames.pdf

Table 4.18 Spanish/Hispanic Origin Codes

CODE	DESCRIPTION
0	Non-Spanish; non-Hispanic (includes Portuguese and Brazilian)
1	Mexican (includes Chicano, NOS)
2	Puerto Rican
3	Cuban
4	South or Central American (except Brazil)
5	Other specified Spanish/Hispanic (includes European; excludes Dominican Republic)
6	Spanish, NOS, Hispanic, NOS; Latino, NOS. There is evidence, other than surname or maiden name that the person is Hispanic, but he/she cannot be assigned to any category of 1–5.
7	Spanish surname only. The only evidence of the person's Hispanic origin is surname or maiden name and there is no other information the person is not Hispanic. Ordinarily for central registry use only.
8	Dominican Republic (effective with diagnosis on or after 1/1/2005)
9	Unknown whether Spanish or not; not stated in patient record

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

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

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

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

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

***Examples*:**

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

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

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

Sex

(NAACCR Item #220) (FORDS pg. 73; SEER pg. 63)

Description
Identifies the sex of the patient.

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

Coding Instructions
Code the sex (gender) of the patient.

Table 4.19 Patient Sex Codes

CODE	DESCRIPTION
1	Male
2	Female
3	Other (intersex, disorders of sexual development/DSD)
4	Transsexual, NOS
5	Transsexual, natal male
6	Transsexual, natal female
9	Not Stated/Unknown

Definitions:

Intersex: A person born with ambiguous reproductive or sexual anatomy; chromosomal genotype and sexual phenotype other than XY male and XX female.

Transsexual: A person who was assigned to one gender at birth based in physical characteristics but who self-identifies psychologically and emotionally as the other gender.

Transgender: See Transsexual.

Transgendered person: A person who identifies with or expresses a gender identity that differs from the one which corresponds to the person's sex at birth.

Hermaphrodite: A person having both male and female reproductive organs.

Coding Instructions

1. Assign code 3 for Intersexed (person with sex chromosomes abnormalities) or Hermaphrodites
2. Codes 5 and 6 maybe used for cases diagnosed prior to 2015
3. Assign code 5 for transsexuals who are natally male or transsexuals with primary site of C600-C639
4. Assign code 6 for transsexuals who are natally female or transsexuals with primary site of C510-C589
5. Assign code 4 for transsexuals with unknown natal sex and primary site is not C510-C589 or C600-C639
6. When gender is not known
   a. Assign code **1** when the primary site is C600 – C639
   b. Assign code **2** when the primary site is C510 – C589
   c. Assign code **9** for primary sites not included above

Text Usual Industry
(NAACCR Item #320)

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

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

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

Coding Instructions

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

2. Be descriptive and specific.
   Examples:
   Inadequate: "Automobile industry"
   Adequate: "Automobile manufacturing"

   Inadequate: "Mine"
   Adequate: "Copper mine"

   Inadequate: "Retail"
   Adequate: "Retail bookstore"

3. When recording government agencies record the level (federal, state, county, municipal) and the division.
   Example:
   Inadequate: "Census"
   Adequate: "U.S. Census Bureau"

4. Be complete. If the primary activity of the industry is unknown, record the name of the company (with city or town) in which the patient worked the most number of years before diagnosis.
   Example:
   Inadequate: "ABC, Inc."
   Adequate: "ABC, Inc., Kyle, TX"

5. If the patient's usual industry is not available or is unknown, but the patient's current or most recent occupation is recorded, the information for industry should be based upon the information in occupation. Therefore, if current or most recent occupation rather than usual occupation was recorded, record the patient's current or most recent business/industry. If no information is available regarding patient's industry, document "Unknown" in the text field. This should be used only as a last resort.

Text Usual Occupation

(NAACCR Item #310)

Description

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

Explanation

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

Definition

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

Exception

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

Coding Instructions

1. Document the patient's usual occupation, the kind of work performed during most of the patient's working life before diagnosis of this tumor, to the extent that the information is available in the medical record. Make sure the recorded usual occupation matches the recorded industry. Do not record "retired."

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

   Examples:

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

   Inadequate: "Laborer"
   Adequate: "Residential bricklayer"

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

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

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

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

Description

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

Explanation

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

Physician Follow Up

(NAACCR Item #2470)

Description

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

Explanation

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

Coding Instructions

1. Record the state license number of the physician currently responsible for the patient's care. Physician license numbers for Texas can be found at the following website: http://www.tmb.state.tx.us/page/look-up-a-license.

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

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

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

Sequence Number

(NAACCR Item #560) (FORDS pgs. 39)

Description

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

Explanation

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

Coding Instructions

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

2. Code 00 if the patient has a single reportable primary. If the patient develops a subsequent reportable primary, notify the Texas Cancer Registry. The TCR will change the code for the first primary from 00 to 01, and number subsequent primaries sequentially.

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

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

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

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

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

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

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

Table 4.20 Sequence Number: Malignant Neoplasms

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

Table 4.21 Sequence Number: Non-Malignant Neoplasms

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

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

***Examples*:**

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

b. A person was diagnosed with lung cancer in 2001. A colon cancer is diagnosed in 2017. Code the sequence number of the colon cancer to 02 and change the sequence number of the lung cancer to 01.

c. A person was diagnosed with breast cancer in April 2010 and metastasis to the lungs in June 2017. Since the lung is a metastatic site and not a second primary, it would not be abstracted. Code the sequence number of the breast cancer to 00.

d. A person was diagnosed with signet ring cell carcinoma of the bladder in 2004. In 2017, this person developed a benign meningioma in the temporal area of the brain. Code the bladder to sequence number 00, and code the brain to sequence number 60.

e. A person was diagnosed with carcinoma of the stomach in 2003, squamous cell carcinoma of the left forearm (a non-reportable neoplasm) in 2005, and non-Hodgkin's lymphoma in 2017. Code the sequence number of the stomach to 01. The sequence number of the left forearm would not be sequenced, abstracted or reported. Code the sequence number of the lymphoma to 02.

f. A person was diagnosed with a benign meningioma in June 2007. MRI at your facility in 2017 shows no change. Code the sequence number to 60 for the benign meningioma.

Other Primary Tumors

(Site, Morphology, Date) (NAACCR Item #2220)

Description

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

Explanation

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

Coding Instructions

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

   ***Examples*:**

   a. The patient had a history of duct cell carcinoma of the left breast in 2005 and is admitted in 2017 for adenocarcinoma of the lung. Complete an abstract on the lung tumor, and document duct cell carcinoma of left breast in 2005 in this field.

   b. The patient has a history of prostate cancer, no date or specific morphology is given. Patient is admitted in 2017 with a malignant melanoma of left leg. Document: history of prostate cancer, unknown date.

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

Primary Payer At Diagnosis

(NAACCR Item #630) (FORDS pgs. 74) (SEER pgs. 65-66)

Description

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

Explanation

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

Coding Instructions

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

2. Code the **first** insurance mentioned when multiple insurance carriers are listed in one admission record.

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

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

5. Code the type of the insurance reported **closest to the date of diagnosis** when there are multiple insurance carriers reported from multiple admissions and/or multiple physician encounters.

Note: Codes 21 and 65-68 are to be used for patients diagnosed on or after January 1, 2006.

Table 4.22 Primary Payer at Diagnosis Codes

CODE	LABEL	DESCRIPTION
01	Not insured	Patient has no insurance and is declared a charity write-off
02	Not insured, self-pay	Patient has no insurance and is declared responsible for charges
10	Insurance, NOS	Type of insurance unknown or other than types listed in codes 20, 21, 31, 35, 60-68
20	Private Insurance: Managed Care, HMO, or PPO	An organized system of prepaid care for a group of enrollees usually within a defined geographic area. Generally formed as one of four types: a group model, an independent physician association (IPA), a network, or a staff model. "Gate-keeper model" is another term for describing this type of insurance.
21	Private Insurance: Fee-for-Service	An insurance plan that does not have negotiated fee structure with the participating hospital. Type of insurance plan not coded as 20.
31	Medicaid	State government administered insurance for persons who are uninsured, below the poverty level, or covered under entitlement programs. Medicaid other than Medicaid described in code 35.
35	Medicaid-Administered through a Managed Care plan	Patient is enrolled in **Medicaid** through a Managed Care program (e.g. HMO or PPO). The managed care plan pays for all incurred costs.
60	Medicare without supplement, Medicare, NOS	Federal government funded insurance for persons who are 65 years of age or older, or are chronically disabled (Social Security insurance eligible). Not described in codes 61, 62, or 63.
61	Medicare with supplement, NOS	Patient has Medicare and another type of unspecified insurance to pay costs not covered by Medicare.
62	Medicare-Administered through a Managed Care plan	Patient is enrolled in **Medicare** through a Managed Care plan (e.g. HMO or PPO). The Managed Care plan pays for all incurred costs.
63	Medicare with private supplement	Patient has Medicare and private insurance to pay costs not covered by Medicare.
64	Medicare with Medicaid eligibility	Federal government Medicare insurance with State Medicaid administered supplement.

CODE	LABEL	DESCRIPTION
65	TRICARE	Department of Defense program providing supplementary civilian-sector hospital and medical services beyond a military treatment facility to military dependents, retirees, and their dependents. Formally known as CHAMPUS (Civilian Health and Medical Program of the Uniformed Services)
66	Military	Military personnel or their dependents treated at a military facility
67	Veterans Affairs	Veterans treated in Veterans Affairs facilities
68	Indian/Public Health Services	Patient who receives care at an Indian Health Services facility or at another facility and medical costs are reimbursed by the Indian Health Service. Patient receives care at a Public Health Service facility or at another facility, and medical costs are reimbursed by the Public Health Service
99	Insurance status unknown	It is unknown from the patient's medical record whether or not the patient is insured.

***Examples*:**

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

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

c. A 65-year old male patient is admitted for treatment and the patient admission page states the patient is covered by Medicare with additional insurance coverage from a PPO. Code the *Primary Payer at Diagnosis* as 62.

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

Secondary Diagnosis #1 - #10

(NAACCR Item #3780, 3782, 3784, 3786, 3788, 3790, 3792, 3794, 3796, and 3798) (FORDS pgs 88-106)

Description

Records the patient's preexisting medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-10-CM codes. Both are considered secondary diagnoses

Explanation

Preexisting medical conditions, factors influencing health status, and/or complications may affect treatment decisions and influence patient outcomes. Information on comorbidities is used to adjust outcome statistics when evaluating patient survival and other outcomes. Complications may be related to the quality of care.

ICD-10-CM codes are 7 characters long, where each character represents an aspect of the condition or procedure: the 7 characters indicate 'section', 'body system', 'root operation', 'body part', 'approach', 'device', and 'qualifier', respectively (see ICD-10-PCS Reference Manual for additional information).

Coding Instructions

1. Use only ICD-10-CM codes. Note that although this is a 7 character field, only the actual ICD-10-CM code is to be entered, leaving blanks beyond those characters. Be sure to omit decimal points.

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

3. Code the secondary diagnoses in the sequence in which they appear on the discharge abstract or are recorded by the billing department at your facility.

4. Report the secondary diagnoses for this cancer using the following priority rules:
   a. Surgically treated patients:
      - Following the most definitive surgery of the primary site
      - Following other non-primary site surgeries

   b. Non-surgically treated patients:
      - Following the first treatment encounter/episode

   c. In cases of non-treatment:
      - Following the last diagnostic/evaluative encounter

5. If there was a re-admission to the same facility within 30 days following surgical discharge, check for an ICD-10-CM code and record, space allowing, as additional *Secondary Diagnosis.*

6. If no secondary diagnoses were documented, then code 0000000 in the first data item, and leave the remaining *Secondary Diagnosis* data items blank. **Do not leave the first data item blank.**

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

8. For non-analytic cases code the first data item 0000000 and leave the remaining data items blank.

9. Do not code those fields from just a description such as Diabetes, SOB and others. Use the codes from the Dischage Abstract or Coding Sumnmary, or from the biling department.

Table 4.23 Secondary Diagnosis Codes

ICD-10-CM	CODE	DESCRIPTION, SPECIFIC INSTRUCTIONS
	0000000	No Secondary Diagnosis. Code only the first field and leave the remaining fields blank.
ICD-10-CM	All values beginning with A-B, E, G-P, R-S	Comorbid conditions: Omit the decimal point.
ICD-10-CM	T36-T50996ZZ, Y62-Y849ZZZ,	Complications: Omit the decimal point.
ICD-10-CM	Z1401-Z229ZZZ, Z681-Z6854ZZ, Z80-Z809ZZZ, Z8500-Z9989ZZ	Factors affecting health status: Omit the decimal point.

Table 4.24 Secondary Diagnosis Code Examples

CODE	DESCRIPTION (ICD-10-CM)
J449	COPD (ICD-10-CM code J44.9)
E109	Type 1 diabetes mellitus (ICD-10-CM code E10.9)
Y632	The patient was inadvertently exposed to an overdose of external beam radiation (ICD-10-CM code Y63.2)
Z853	The patient has a personal history of breast cancer (ICD-10-CM code Z85.3)

Source Comorbidity/Source Secondary Diagnosis

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

Description

This data item records the data source from which secondary diagnosis NAACCR Data Items (#3780, 3782, 3784, 3786, 3788, 3790, 3792, 3794, 3796, and 3798) (FORDS pgs. 87-106) were collected.

Coding Instructions

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

Table 4.25 Source Comorbidity Codes

CODE	DESCRIPTION
0	No comorbid condition or complication identified/Not Applicable
1	Collected from facility face sheet
2	Linkage to facility/hospital discharge data set
3	Linkage to Medicare/Medicaid data set
4	Linkage with another claims data set
5	Combination of two or more sources above
9	Other source

Height

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

Description

Height is required for all sites/hsitologies when chemotherapy and/or other drugs are given.

Coding Instructions

1. Different tumors for the same patient may have different values.
2. Height should be collected from source records once for each cancer.
3. Height should be taken from the Nursing Interview Guide, Flow Chart, or Vital Stats section from the patient's hospital medical record or physician office record.
4. The height entered should be that listed at or around the time of diagnosis. If no height was listed on the date of diagnosis, use the height recorded on the date closest to the date of diagnosis and before treatment was started.
5. Enter height as a 2 digit number measured in inches. Round all inches values to the nearest whole number; values with decimal place x.5 and greater should be rounded up (code 62.5 inches as 63 inches).
6. Do not leave this field blank. If the information is not available use code 99 (Unknown)

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

Table 4.26 Height Codes

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

Weight

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

Description

Weight is required for all sites/histologies when chemotherapy and/or other drugs are given.

Coding Instructions

1. Different tumors for the same patient may have different values.
2. Weight should be collected from source records once for each cancer.
3. Weight should be taken from the Nursing Interview Guide, Flow Chart, or Vital Stats section from the patient's medical record or physician office record.
4. The weight entered should be that listed on the date of diagnosis. If no weight was listed on the date of diagnosis, please use the weight recorded on the date closest to the date of diagnosis and before treatment was started.

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

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

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

Table 4.27 Weight Codes

CODE	DESCRIPTION
XXX	Exact weight in pounds
999	Unknown weight

Tobacco Use Cigarettes

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

Description

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

Coding Instructions

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

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

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

Table 4.28 Tobacco Use Cigarettes Codes

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

Tobacco Use Other Smoke

(Non-NAACCR Standard Data Item 9966) (Source CDC/NPCR-CER)

Description

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

Assessment Section, or other available source from the patient's hospital medical record or physician office record.

Coding Instructions

1. If the medical record only indicates "No," use code 9 (Unknown/not stated/no smoking specifics provided) rather than code 0 (Never used).
2. If the medical record indicates "None," use 0 (Never used).
3. Do not leave this field blank. If there is no information use code 9 (Unknown).

Table 4.29 Tobacco Use Other Smoke Codes

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

Tobacco Use Smokeless

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

Description

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

Coding Instructions

1. If the medical record only indicates "No," use code 9 (Unknown/not stated/no smoking specifics provided) rather than code 0 (Never used).
2. If the medical record indicates "None," use 0 (Never used).
3. Do not leave this field blank. If there is no information use code 9 (Unknown).

Table 4.30 Tobacco Use Smokeless Codes

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

Tobacco Use NOS

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

Description

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

Coding Instructions

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

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

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

Table 4.31 Tobacco Use NOS Codes

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

5

CANCER INFORMATION

CANCER INFORMATION

Date of Initial Diagnosis

(NAACCR Item #390) (FORDS pg. 120; SEER pgs. 68-72)

Description

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

Explanation

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

Coding Instructions

1. Date format is:

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

      ***Example*:** The patient has a CT on March 25, 2017 and the diagnosis is lung cancer. Code the diagnosis date as 20170325.

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

      ***Example*:** A mammogram done in January 2017 shows that the patient has a malignancy in the upper outer quadrant of the right breast, but the day is unknown. Code the diagnosis date as 201701.

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

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

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

4. Refer to the *List of Ambiguous Terms* on page 43 for language that represents a diagnosis of cancer. When the first diagnosis includes reportable ambiguous terminology, record the date of that diagnosis.

   Example: Area of microcalcifications in breast suspicious for malignancy on 2/13/17. Biopsy positive for ductal carcinoma on 2/28/17. The date of diagnosis 2/13/17.

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

Examples:

a. The patient has an excision of a benign fibrous histiocytoma on January 3, 2017. Six months later, a wide re-excision was positive for malignant fibrous histiocytoma. The pathologist reviews the original slides and documents that the previous tumor (benign fibrous histiocytoma) was malignant. Code the diagnosis date as 20170103.

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

b. The patient had a total hysterectomy and bilateral salpingo-oophorectomy (BSO) in June 2017 with pathologic diagnosis of papillary cystadenoma of the ovaries. On December 6, 2017 the patient is diagnosed with widespread metastatic papillary cystadenocarcinoma. The slides from June 2017 are not reviewed and there is no physician statement saying the previous tumor was malignant. The date of initial diagnosis should be coded 20171206.

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

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

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

> ***Example*:** An ultrasound done on 2/2/2017 to determine expected date of birth shows an unborn baby has a brain tumor. After the baby is born on 4/12/2017, resection shows malignant teratoma. Code the date of diagnosis 20170202.

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

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

> ***Example***: The patient has an elevated PSA and the physical examination is negative. The physician documents only that the patient is referred for a needle biopsy of the prostate. The biopsy is positive for adenocarcinoma. The date of diagnosis is the date of the biopsy (do not code the date of the PSA or the date the procedure was dictated or transcribed).

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

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

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

12. Code the year and month of admission when there is no basis for estimation and document "Date of DX unknown" in the *Summary Stage Documentation* text field. *This should be used only as a last resort.*

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

***Example*:**

Patient admitted to your facility on April 26, 2017 with recurrent melanoma but the original date of diagnosis is unknown. Code the date of diagnosis as 201704. Record in the *Summary Stage Documentation* text field "Date of DX Unknown."

Table 5.1 Date of Initial Diagnosis – Date Estimates

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

Examples:

a. A patient was admitted to your facility on March 15, 2017. The History and Physical states the patient has prostate carcinoma diagnosed about two months ago. Record the date of diagnosis as 201701.

b. A patient was admitted to your facility on September 10, 2017. The History and Physical

states the patient has bone and brain metastasis from malignant melanoma diagnosed in the spring. Record the date of diagnosis as 201704.

c. On March 12, 2017, a mammogram reveals a mass in the upper outer quadrant of the patient's right breast. The radiologist's impression states: compatible with carcinoma. On March 20, 2017, the patient has an excisional breast biopsy that confirms infiltrating ductal carcinoma. Record the date of diagnosis as 20170312.

Note: For users of Web Plus always press the calculator icon in order to calculate age at diagnosis.

Morphology ICD-O-2: Type and Behavior

(NAACCR Item #420, 430)

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

Morphology ICD-O-3: Type and Behavior

(NAACCR Item #522, #523) (FORDS pgs. 123-125] (SEER pgs. 89-93)

Description

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

Explanation

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

Coding Instructions for Solid Tumors:

Morphology

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

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

2. Follow the coding rules outlined on pages 20–40 of ICD-O-3.
3. The term [obs] in ICD-O-3 indicates a diagnosis for which a better diagnostic term(s) is available, but which may still be used to code the cancer in certain circumstances. Obsolete terms are retained in ICD-O-3 for historical reference.
4. Adequate text documentation must be provided to support coding. Auto coding of the ICD-O-3 code description is not considered adequate text documentation.

Solid tumor histology can be coded only after the determination of single vs. multiple primaries has been made. Refer to Multiple Primary and Histology (MP/H) rules to determine the number of primaries for solid tumors.

Note: There is an update to the ICD-O-3, "Guidelines for ICD-O-3 Update Implementation", effective January 1, 2014. This document also contains changes effective January 1, 2015. Print and add the document to your ICD-O-3 book. Follow the link to download the guidelines. https://20tqtx36s1la18rvn82wcmpn-wpengine.netdna-ssl.com/wp-content/uploads/2016/11/ICD-O-3-Implementation-Guide-FINAL.pdf

ICD-O-3 CHANGES EFFECTIVE FOR JANUARY 1, 2015

The discontinuation of Collaborative Staging has delayed the use of new malignant codes until **2017**, with the exception of **Serrated Adenocarcinoma (8213/3)** and **Malignant Glucagonomas (8152/3)**, these new codes can be used effective 2015.

- Effective 2015 pancreatic tumors, **malignant enteroglucagonomas** (8157/3) must be recoded as **malignant glucagonomas** (8152/3). Code 8157 is obsolete effective in 2015.

Table 5.2 ICD-O-3 Changes Effective for January 1, 2015

ICD-O-3 change	New code in ICD-O-3	Description	Comment	Use this code in 2015 and 2016
New term and code	8163/3	Pancreatobiliary-type carcinoma (C24.1)	DO NOT use new code until 2017	8255/3
New synonym	8163/3	Adenocarcinoma, pancreatobiliary-type (C24.1)	DO NOT use new code until 2017	8255/3
New term	8213/3	Serrated adenocarcinoma	**Use new code**	8213/3*
New term and code	8265/3	Micropapillary carcinoma, NOS (C18._, C19.9, C20.9)	DO NOT use new code until 2017	8507/3*
New term and code	8552/3	Mixed acinar ductal carcinoma	DO NOT use new code until 2017	8523/3
New term and code	9395/3	Papillary tumor of the pineal region	DO NOT use new code until 2017	9361/3*
New term and code	9425/3	Pilomyxoid astrocytoma	DO NOT use new code until 2017	9421/3
New term and code	8152/3	Malignant Glucagonomas	**Use new code**	8152/3

** ICD-O-3 rule F applies (code the behavior stated by the pathologist). If necessary, over-ride any advisory messages.*

For your convenience, we have also included this document as **Appendix K.**

2017 ICD-O-3 Update: Standard setters agreed to postpone the implementation of new histology terms and codes for ICD-O-3. See the NAACCR Guidelines for ICD-O-3 Update Implementation for the appropriate ICD-O-3 histology codes to assign for new terms.
MP/H Histology Coding Rules General Information

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

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

3. The histology coding rules are available in the SEER website: https://seer.cancer.gov/tools/mphrules/download.html. Apply the site-specific histologic coding rules. These rules cover the following:

Head and neck	C000-C148, C300-C329
Colon	C180-C189
Lung	C340-C349
Melanoma	C440-C449 With Histology 8720-8780
Breast	C500-C509
Kidney	C649
Ureter/Renal pelvis/Bladder	C659, C669, C670-C679, C680-C689
Benign brain	C700, C701, C709,C710-C719, C720-C725, C728, C729,C751-C753
Malignant brain	C700, C701, C709,C710-C719, C720-C725, C728, C729,C751-C753
Other sites	Excludes Head and Neck, Colon, Lung, Melanoma of Skin, Breast, Kidney, Renal Pelvis, Ureter, Bladder, Brain

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

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

Note: For cases diagnosed prior to January 1, 2007 refer to Appendix D located on the TCR website: http://www.dshs.state.tx.us/tcr/2009crhb.shtm. under Appendices Available Only on Line at the end of the page.

Table 5.3 Behavior Codes

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

Note: Gastrointestinal stromal tumors (GIST) and thymomas are frequently non-malignant. However, for cases diagnosed January 1, 2013 or later, they must be abstracted and assigned a *Behavior* Code of *3* if they are noted to have: Multiple foci; Metastasis; Positive lymph nodes.

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

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

Behavior Coding Instructions

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

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

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

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

4. Re-code the behavior as malignant (/3) when metastases are attributed to a tumor originally thought to be in situ (See page 92 of SEER Coding and Staging Manual 2016).

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

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

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

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

Table 5.4 Behavior Codes Examples

CODE	FIFTH DIGIT TERM	DESCRPIPTION
2	In situ and/or carcinoma in situ	Adenocarcinoma in an adenomatous polyp with no invasion of stalk
		Bowen disease (not reportable for C440–C449)
		Clark's Level I for melanoma (limited to epithelium)
		Comedocarcinoma, noninfiltrating (C50_)
2	Terms synonymous with in situ	Confined to epithelium
		AIN III (C211)
		Behavior code /2
		Hutchinson's melanotic freckle, NOS (C44_)
		Intracystic, non-infiltrating (carcinoma)
		Intraductal (carcinoma)
		Intraepidermal, NOS (carcinoma)
		Intraepithelial, NOS (carcinoma)
		Involvement up to, but not including the basement membrane
		Lentigo maligna (C44_)
		LIN III (C320-C329)
		Lobular, noninfiltrating(C50_) (carcinoma)
		Noninfiltrating (carcinoma)
		Noninvasive (carcinoma only)
		No stromal invasion/involvement
		Papillary, non-infiltrating or intraductal (carcinoma)
		Precancerous melanosis (C44_) Preinvasive
		Queyrat's erythroplasia (C60_)
		SIN III
		Stage 0 (except Paget's disease (8540/3) of breast and colon or rectal tumors confined to the lamina propria)
		VAIN III (C529)
		VIN III (C51_)
3	Invasive	Invasive or microinvasive

Coding Instructions for Hematopoietic and Lymphoid Neoplasms (9590/3-9992/3):

For hematopoietic and lymphoid diseases code histology after the Hematopoietic and Lymphoid Neoplasm Database has been searched for reportability at http://seer.cancer.gov/seertools/hemelymph/

Use the *Hematopoietic and Lymphoid Neoplasm Database (Heme DB)* at http://seer.cancer.gov/seertools/hemelymph/ for coding primary site, histology, grade, and to determine the number of primaries for morphology codes 9590-9992. Follow the steps in priority order for using the *Hematopoietic and Lymphoid Neoplasm Database* and Coding Manual.

For cases diagnosed prior to 2010 use the link to the table "Definitions of Single and Subsequent Primaries for Hematologic Malignancies" found in the Heme DB once you select the diagnosis year from the diagnosis year dropdown menu.

Note: If the patient has a hematopoietic or lymphoid neoplasm diagnosed prior to 2010 and a new one diagnosed January 1, 2010 or later, use the *Hematopoietic and Lymphoid Neoplasm Database and Manual*.

Primary Site

(NAACCR Item #400) (FORDS pg. 121; SEER pgs. 78-81)

Description
Identifies the primary site of the cancer.

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

Refer to the Multiple Primary/Histology (MP/H) rules at https://seer.cancer.gov/tools/mphrules/download.html to determine the number of primaries for solid tumors. Use all of the available information to code the site.

Refer to the Hematopoietic and Lymphoid Neoplasm Database and Coding Manual at https://seer.cancer.gov/seertools/hemelymph/ for hematopoietic and lymphoid neoplasms to determine multiple primaries and histology.

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

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

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

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

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

Coding Instructions for Solid Tumors:

1. Unless otherwise instructed, use all available information in the medical record to code the site.

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

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

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

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

   d. The patient had a total hysterectomy with a bilateral salpingo-oophorectomy ten years ago for non- cancer reasons. She now has widespread cystadenocarcinoma in the peritoneum. Code the primary site to peritoneum, NOS (C482). (The chart may or may not state that the patient has extra-ovarian or primary peritoneal carcinoma).

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

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

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

   b. Overlapping lesion of oropharynx. Code overlapping lesion when a large tumor involves both the lateral wall of the oropharynx (C10.2) and the posterior wall of the oropharynx (C10.3) and the point of origin is not stated.

c. Overlapping lesion of bladder. Code overlapping lesion of the bladder when a single lesion involves the dome (C67.1) and the lateral wall (C67.2) and the point of origin is not stated.

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

4. Code the site of the **invasive** tumor when there is an invasive tumor and an in situ tumor in different subsites of the same anatomic site.

   ***Example*:** Patient has an invasive breast tumor in the upper-outer quadrant of the left breast and in situ tumor in multiple quadrants of the left breast. Code the primary site to C504 (upper outer quadrant of breast).

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

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

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

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

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

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

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

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

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

Note: Use the site code suggested by ICD-O-3 when there is no information available indicating a different primary site.

Example: Biopsy of lymph node diagnosed as metastatic non-small cell carcinoma. Patient expired and there is no information available about the primary site. Assign C349 based on the site code suggested in ICD-O-3.

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

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

8. See the site-specific Coding Guidelines in Appendix A for primary site coding guidelines for the following sites:

Bladder	Kaposi Sarcoma
Breast	Lung
Colon	Rectosigmoid
Esophagus	Skin - Melanoma

9. See below for primary site coding guidelines for Sarcoma.

10. Angiosarcoma:

    a. Code C422 (Spleen) as the primary site for angiosarcoma of spleen with mets to bone marrow.

    b. Code C50._ (Breast) for angiosarcoma of breast. Although angiosarcoma actually originates in the lining of the blood vessels, an angiosarcoma originating in the breast has a poorer prognosis than many other breast tumors.

11. Gastrointestinal Stromal Tumors (GIST): code the primary site to the location where the malignant GIST originated.

12. Transplants

    a. Code the primary site to the location of the transplanted organ when a malignancy arises in a transplanted organ, i.e., code the primary site to where the malignancy resides or lies.

       Example: There is a diagnosis of malignancy in transplanted section of colon serving as esophagus. Code the primary site as esophagus. Document the situation in a text field.

    b. For information about organ or tissue transplants, see the section Determining Multiple Primaries.

    c. For additional information about hematopoietic-related transplants, refer to the Hematopoietic and Lymphoid Neoplasm Coding Manual and Database.

13. In the ***absence of any additional information***, assign the codes listed for these primary sites:

Primary Site	Code
Anal margin	C445
Angle of the stomach	C162
Book-leaf lesion (mouth)	C068
Colored/lipstick portion of the upper lip	C000
Cutaneous leiomyosarcoma	C44_
Distal conus	C720

Edge of tongue	C021
Frontoparietal (brain)	C718
Gastric angular notch	C163
Glossotonsillar sulcus	C109
Infrahilar area of lung	C349
Leptomeninges	C709
Masticatory space	C069
Melanoma, NOS	C449
Nail bed thumb	C446
Pancreatobiliary	C269
Parapharyngeal space	C490
Perihilar bile duct	C240

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

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

    b. Use Table 5.5 when the described histologies appear only with an ill-defined site description (such as “abdominal” or “arm”). Code to the tissue in which such tumors arise rather than the ill-defined region (C76_) of the body, which contains multiple tissues.

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

    d. Code unknown primary in the absence of any information when the physician documents an unknown primary.

    e. Assign the NOS code for the body system when there are two or more possible primary sites documented and all are within the same system.

       Example: Two possible sites are documented in the GI system such as colon and small intestine; code to the GI tract, NOS (C269). Document the possible primary sites in the appropiate text field.

    f. Assign C148 when there is an unknown head and neck primary

       Example: Lymph node biopsy with diagnosis of squamous cell carcinoma deemed to be a head and neck primary and no specific head and neck primary site identified.

       Assignment of C148 is based on a note in ICD-O-3 indicating it should be used when a code between C000 and C142 cannot be assigned. This code is more specific than C760.

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

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

Table 5.5 Primary Site Codes

HISTOLOGY	DESCRIPTION	CODE TO THIS SITE
8720-8790	Melanoma	C44_, Skin
8800-8811, 8813-8830, 8840-8921, 9040-9044	Sarcoma except periosteal fibrosarcoma and dermatofibrosarcoma	C49_, Connective, Subcutaneous and Other Soft Tissues
8990-8991	Mesenchymoma	C49_, Connective, Subcutaneous, and Other Soft Tissues
9120-9170	Blood vessel tumors, lymphatic vessel tumors	C49_, Connective, Subcutaneous, and Other Soft Tissues
9580-9582	Granular cell tumor and alveolar soft part sarcoma	C49_, Connective, Subcutaneous and Other Soft Tissues
9240-9252	Mesenchymal chondrosarcoma and giant cell tumors	C40_, C41_ for Bone and Cartilage C49_, Connective, Subcutaneous and Other Soft Tissues
8940-8941	Mixed tumor, salivary gland type	C07_ for Parotid Gland C08_ for Other and Unspecified Major Salivary Glands

Common Metastatic Sites

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

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

Sarcoma Coding Instructions

The majority of sarcomas arise in mesenchymal or connective tissues that are located in the musculoskeletal system. The musculoskeletal system includes the fat, muscles, blood vessels, deep skin tissues, nerves, bones and cartilage. The default code for sarcomas of unknown primary site is **C49.9, soft tissue, NOS,** rather than C80.9. Sarcomas may also arise in the walls of hollow organs and in the viscera covering an organ. Code the primary site to the organ of origin.

Example:
The pathology identifies a leiomyosarcoma of the uterus. Code the site to uterus, NOS (C55.9).

For Bone Sarcomas (C40._, C41._) do not use C76._ codes (Other and Ill-defined Sites) such as “arm”, “leg”, “trunk”.

For Soft tissue sarcomas (C49._, C47._, C48._, C38.1-C38.3), do not use C76._ codes (Other and Ill-defined Sites) such as “arm”, “leg”, “trunk”.

Kaposi Sarcoma Coding Instructions:

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

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

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

3. If the primary site is unknown or cannot be determined, code skin, NOS (C44.9)**.**

Melanoma Coding Instructions:

Code to Skin, NOS (C44.9) if a patient is diagnosed with metastatic melanoma and the primary site is not identified.

Additional Guidelines for Coding Primary Site:
A subareolar/retroareolar carcinoma is coded to the central portion of the breast (C50.1), which indicates that the tumor arose in the breast tissue beneath the nipple, not the nipple itself.

Mycosis Fungoides is coded to skin (C44_).

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

Coding Instructions for Hematopoietic and Lymphoid Neoplasms Guidelines:

Refer to Hematopoietic and Lymphoid Neoplasms (9590-9992)
Heme DB at https://seer.cancer.gov/seertools/hemelymph/

Coding tips:
1. **Always** code leukemia primaries to bone marrow (C421); blood cells originate in the bone marrow.

2. Waldenstrom macroglobulinemia (9761/3) is the **only** histology where primary site is blood (C420).

3. Do **not** use ambiguous terms to code a specific histology.

Grade of Tumor

(NAACCR Item #440) (FORDS pgs. 126-127; SEER pgs. 94-101)

Grade differentiation (Codes 1, 2, 3, 4, 9).
Cell Lineage Indicator (Codes 5, 6, 7, 8, 9).
Note: these coding instructions are for cases diagnosed January 1, 2014 and forward.

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

Description-Cell Indicator
Describes the lineage or phenotype of the cell. Codes 5, 6, 7, and 8 are used only for hematopoietic and lymphoid neoplasms. Code 9 indicates cell type not determined, not stated, or not applicable.

Explanation
Solid tumors grade is a system used to classify cancer cells in terms of how abnormal they look and how quickly they are likely to grow and metastasize. Pathologists describe the tumor grade using three system or formats:

1. Two levels of similarity; also called a two-grade system

2. Three levels of similarity; also called a three-grade system (code according to "Coding for solid tumors."
   a. Grade I, well
   b. Grade II, moderately
   c. Grade III, poorly (undifferentiated carcinoma is usually separated from this system, since "poorly" bears some, albeit little, similarity to the host tissue, while "undifferentiated" has none, e.g. Undifferentiated carcinoma).

3. Four levels of similarity; also called a four-grade system. The four-grade system describes the tumor as
   a. Grade I; also called well-differentiated
   b. Grade II; also called moderately differentiated
   c. Grade III; also called poorly differentiated
   d. Grade IV; also called undifferentiated or anaplastic

Breast and prostate grades may convert differently than other sites.

Coding Grade for Hematopoietic and Lymphoid Neoplasms:

a. Determine the histology based on the Hematopoietic and Lymphoid Neoplasms Manual

b. Determine the cell indicator by applying the "Grade of Tumor Rules" within the Hematopoietic and Lymphoid Neoplasms Manual

Table 5.6 Grade codes for hematopoietic and lymphoid neoplasms

TERMINOLOGY	GRADE CODE
T-cell; T-precursor	5
B-Cell; Pre-B; B-precursor	6
Null Cell; Non T-non B	**7**
NK Cell (natural Killer cell)	8
Grade unknown, not stated, or not applicable	9

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

Coding Instructions for Solid Tumors:
(Codes 1, 2, 3, 4, 9)

There are 9 different rules for coding grade for solid tumors.

Rule 1. Code grade based on information ***prior to neoadjuvant therapy*** even if that grade is unknown.

***Example*:** 2/11/2017 Rectal Bx: Poorly differentiated adenocarcinoma. Patient received pre-operative radiation to shrink tumor; 4/21/2017 Low anterior resection: moderately differentiated adenocarcinoma. Code as: 8140/33 poorly differentiated adenocarcinoma.

Rule 2. Code grade from the primary tumor only.

a. Do not code grade based on metastatic tumor or recurrence.
b. If primary site is unknown, code grade to 9.
c. In the rare instance that tumor tissue extends contiguously to an adjacent site and tissue from the primary site is not available, code grade from the contiguous site.

Rule 3. Code the grade shown below (6th digit) for specific histologies that imply a grade.

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

8020/3**4** Carcinoma, undifferentiated
8021/3**4** Carcinoma, anaplastic
8331/3**1** Follicular adenocarcinoma, well differentiated
8332/3**2** Follicular adenocarcinoma, moderately differentiated
8585/3**1** Thymic carcinoma, well differentiated
8631/3**3** Sertoli-Leydig cell tumor, poorly differentiated
8634/3**3** Sertoli-Leydig cell tumor with heterologous elements, poorly differentiated
8805/3**4** Undifferentiated sarcoma
8851/3**1** Liposarcoma, well differentiated
9062/3**4** Seminoma, anaplastic
9082/3**4** Malignant teratoma, undifferentiated

9082/3**4** Malignant teratoma, anaplastic
9083/3**2** Malignant teratoma, intermediate type
9187/3**1** Intraosseous osteosarcoma, well differentiated
9362/3**2** Pineal parenchymal tumor of intermediate differentiation
9382/3**4** Oligoastrocytoma, anaplastic
9390/3**4** Choroid plexus papilloma, anaplastic (synonym of malignant)
9392/3**4** Ependymoma, anaplastic
9401/3**4** Astrocytoma, anaplastic
9451/3**4** Oligodendroglioma, anaplastic
9505/3**4** Ganglioglioma, anaplastic
9511/3**1** Retinoblastoma, differentiated
9512/3**4** Retinoblastoma, undifferentiated

Rule 4. In situ and/or combined in situ/invasive components:

a. If a grade is given for an in situ tumor, code it. **DO NOT** code grade for dysplasia such as high grade dysplasia.
b. If there are both in situ and invasive components, code only the grade for the invasive portion even if its grade is unknown.

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

Reminder: Code the grade based on highest grade prior to any neoadjuvant therapy.

Code grade in the following priority order using the first applicable system

a. Special grade systems for (Rule 6)
   - Breast (Bloom Richardson/Nottingham) Score/Grade
   - Prostate (Gleason-Clinical)
   - Kidney (Fuhrman)
   - Heart, Mediastinum, Peritoneum, Retroperitoneum, Soft Tissue (Grade for Sarcomas)

b. Differentiation (2-, 3-, or 4- grade system) (Rule 7)

c. Nuclear Grade (2-, 3-, or 4- grade system) (Rule 7)

d. If it isn't clear whether it is a differentiation or nuclear grade and a 2-, 3-, or 4- grade system was used, code it

e. Terminology (wording) (Rule 8)

Rule 6. Use the information from the special grade systems first. If no special grade can be coded, continue with Coding for Solid Tumors #7-9.

Special Grade Systems for Solid Tumors

Grade information based on CS Site-specific factors for breast, prostate, heart, mediastinum, peritoneum, retroperitoneum, soft tissue, and kidney parenchyma is used to code grade.

Table 5.7 Special Grade Systems

SCHEMA	SPECIAL GRADE SYSTEM
Breast	Nottingham or Bloom-Richardson (BR) Score/Grade (SSF7)
Prostate	Gleason's Score on Needle Core Biopsy/Transurethral Resection of Prostate (TURP) (SSF 8)
Prostate	Gleason's Score on Prostatectomy/Autopsy (SSF 10)
Heart, Mediastinum	Grade for Sarcomas (SSF 1)
Peritoneum	Grade for Sarcomas (SSF 1)
Retroperitoneum	Grade for Sarcomas (SSF 1)
Soft Tissue	Grade for Sarcomas (SSF 1)
Kidney Parenchyma	Fuhrman Nuclear Grade (SSF 6)

Note: *Do not use these tables to code grade for any other groups including WHO (CNS tumors), WHO/ISUP (bladder, renal pelvis), or FIGO (female gynecologic sites) grades.*

Breast: (excluding lymphomas)

Use Bloom Richardson (BR) or Nottingham score/grade based on site-specific factor 7. BR could also be referred to as: Bloom-Richardson modified Bloom-Richardson, BR, BR grading, Scarff-Bloom-Richardson, SBR grading, Elston-Ellis modification of Bloom-Richardson score, Nottingham modification of Bloom-Richardson, Nottingham-Tenovus grade, or Nottingham grade.

Code the tumor grade using the following priority order

a. BR scores 3-9
b. BR grade (low, intermediate, high)

BR score may be expressed as a range, 3-9. The score is based on three morphologic features: degree of tubule formation/histologic grade, mitotic activity, nuclear pleomorphism/nuclear grade of tumor cells. If a report uses words such as low, intermediate, or high rather than numbers, use Table 5.7 to code grade.

Note: If only a grade of 1 through 4 is given with no information on the score and it is unclear if it is a Nottingham or BR Grade, do not use Table 5.8, use the Two-, Three- or Four grade system information.

Code the highest score if multiple scores are reported (exclude scores from tests after neoadjuvant therapy began). Examples: different scores may be reported on multiple pathology reports for the same primary cancer; different scores may be reported for multiple tumors assigned to the same primary cancer.

Table 5.8 Nottingham or Bloom-Richardson (BR) Score/Grade

DESCRIPTION	GRADE CODE
Score of 3	1
Score of 4	1
Score of 5	1
Score of 6	2
Score of 7	2
Score of 8	3
Score of 9	3
Low Grade, well differentiated, Bloom-Richardson (BR) grade 1, score not given	1
Medium (intermediate) Grade, moderately differentiated, BR grade 2, score not given	2
High Grade, poorly differentiated, BR Grade 3, score not given	3

Please be aware that TCR doesn't collect SS7. Grade needs to be coded using conversion table.

Kidney Parenchyma (excluding lymphomas; schema: Kidney Parenchyma): Fuhrman Nuclear Grade

The Fuhrman Nuclear Grade should be used to code grade for kidney parenchyma only based on site-specific factor 6. Do not use for kidney renal pelvis.

TCR doesn't collect SS6 and grade needs to be coded using conversion table.

Table 5.9 Kidney Parenchyma Fuhrman Nuclear Grade

DESCRIPTION	GRADE CODE
Grade 1	1
Grade 2	2
Grade 3	3
Grade 4	4

Soft Tissue (sites excluding lymphomas: soft tissue, heart, mediastinum, peritoneum, and retroperitoneum; Grade for Sarcomas)

The Grade for Sarcomas should be used to code grade based on site-specific factor 1. The grading system of the French Federation of Cancer Centers Sarcoma Group (FNCLCC) is the preferred system. This system predicts likelihood of distant metastasis and overall survival. Record the grade from any three-grade sarcoma grading system the pathologist uses. In some cases, especially for needle biopsies, grade may be specified only as "low grade" or "high grade." The numeric grade takes precedence over "low grade" or "high grade.

Table 5.10 Grade for Sarcomas

DESCRIPTION	CS CODE	GRADE CODE
Specified as Grade 1 [of 3]	010	2
Specified as Grade 2 [of 3]	020	3
Specified as Grade 3 [of 3]	030	4
Grade stated as low grade, NOS	100	2
Grade stated as high grade, NOS	200	4

Prostate (excluding lymphomas; schema: prostate)

Use the highest Gleason score from the biopsy/TURP or prostatectomy/autopsy. Use a known value over an unknown value. Exclude results from tests performed after neoadjuvant therapy began. This information is collected in Site-Specific factor 8 (Gleason score from biopsy/TURP) and site-specific factor 10 (Gleason score from prostatectomy/autopsy).

Table 5.11 Prostate Gleason Score Grade

DESCRIPTION	GRADE CODE
Gleason score 2	1
Gleason score 3	1
Gleason Score 4	1
Gleason Score 5	1
Gleason Score 6	1
Gleason Score 7	2
Gleason Score 8	3
Gleason Score 9	3
Gleason Score 10	3

Rule 7. Use the Two-, Three- or Four-grade system information.

A. Two-Grade System

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

Sites using Two-Grade System:

Colon-rectosigmoid-rectum
Heart
Bladder (papillary urothelial carcinoma)
Low grade transitional cell carcinoma -2
High grade transitional cell carcinoma -4
Endometrial stromal sarcoma
Salivary glands
Bone-osteosarcoma
Skin-angiosarcoma

Table 5.12 Two-Grade System Conversion Table

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

In transitional cell carcinoma for bladder, the terminology high grade TCC and low grade TCC are coded in the two-grade system.

B. Three-Grade System

There are several sites for which a three-grade system is used:

Oral cavity, larynx, hypopharynx-squamous
Endometrium
Lung-adenocarcinoma, neuroendocrine ca
Peritoneum
Soft tissue sarcoma
Chondrosarcoma
Brain and spinal chord
Prostate
Bladder
Salivary gland-mucoepidermoid, adenoid cystic, adenocarcinoma
Stomach-adenocarcinoma
Esophagus- squamous, adenocarcinoma
Hepatocellular carcinoma
Cholangiocarcinoma
Breast (SBR/EE)
Vulva (Invasive)
Cervix (Invasive)
Ovary (FIGO)
Fallopian Tube

The patterns of cell growth are measured on a scale of 1, 2, and 3 (also referred to as low, medium, and high grade). This system measures the proportion of cancer cells that are growing and making new cells and how closely they resemble the cells of the host tissue. Thus, it is similar to a four-grade system, but simply divides the spectrum into 3 rather than 4 categories (*see Three-Grade Conversion Table*). The expected outcome is more favorable for lower grades.

If a grade is written as 2/3 that means this is a grade 2 of a three-grade system. Do not simply code the numerator. Use table 5.13 to convert the grade to SEER codes.

Table 5.13 Three-Grade System Conversion Table

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

C. Four-grade system: Any four-grade system including Edmondson and Steiner grade for liver. There are several sites for which a four-grade system is used:

Lung-squamous carcinoma
Colorectal-adenocarcinoma
Pancreas-adenocarcinoma
Kidney-renal cell carcinoma (Fuhrman)
Hepatocellular carcinoma (Endmonson-Steiner)
CNS (WHO)
Bone (Mayo)

Table 5.14 Four Grade System

	DESCRIPTION	GRADE CODE
1/4	Grade I; Well differentiated	1
2/4	Grade II; Moderately Differentiated	2
3/4	Grade III; Poorly differentiated	3
4/4	Grade IV; Undifferentiated	4

Rule 8. Terminology: use the 'Description' column or the 'Grade' column to code grade. Breast and Prostate use the same grade code with a few noted exceptions.

Table 5.15 Terminology Conversion Table

DESCRIPTION	GRADE	ICD-O-3 MORPHOLOGY 6TH DIGIT CODE	BREAST AND PROSTATE EXCEPTIONS
Differentiated, NOS	I	1	
Well differentiated	I	1	
Stated as "Grade I" **only** * new for 2014	I	1	
Fairly well differentiated	II	2	
Intermediate differentiation	II	2	
Generally well Differentitaed	II	2	
Grade I-II or 1-2	I-II	2	
Low grade	I–II	2	1
Mid differentiated	II	2	
Moderately differentiated	II	2	
Moderately well differentiated	II	2	
Partially differentiated	II	2	
Partially well differentiated	I–II	2	1
Relatively well differentiated	II	2	
Stated as "Grade II" **only** * new for 2014	II	2	
Medium grade, intermediate grade	II–III	3	2
Grade II-III or 2-3	II-III	3	
Moderately poorly differentiated	III	3	
Moderately undifferentiated	III	3	
Poorly differentiated	III	3	
Relatively poorly differentiated	III	3	
Relatively undifferentiated	III	3	

DESCRIPTION	GRADE	ICD-O-3 MORPHOLOGY 6TH DIGIT CODE	BREAST AND PROSTATE EXCEPTIONS
Slightly differentiated	III	3	
Dedifferentiated	III	3	
Stated as "Grade III" **only** * new for 2014	III	3	
High grade	III–IV	4	3
Grade III-IV	III-IV	4	
Undifferentiated, anaplastic, not differentiated	IV	4	
Stated as "Grade IV" **only** * new for 2014	IV	4	
Non-high grade; not applicable; unknown; not stated		9	

Rule 9. If no description fits or grade is unknown prior to neoadjuvant therapy, code as a 9 (unknown).

Sites/Histologies Not Graded
Use code 9 for:

- Breast- LCIS
- Ovary- germ cell tumors except dysgerminoma (all others are high grade)
- Testis- all histologies
- Thyroid tumors
- Pituitary tumors
- Parathyroid tumors
- Pheochromocytoma
- Pancreas- endocrine/islet cell tumors
- Skin- basal cell carcinoma

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

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

For cases without pathology or cytology confirmation, code the grade of tumor stated on a Magnetic Resonance Imaging (MRI) or Positron Emission Tomography (PET) report if there is no tissue diagnosis (pathology or cytology report).

For more information regarding the grading rules for cases diagnosed 1/1/2014 and forward please go to http://seer.cancer.gov/tools/grade/

WHEN CODING GRADE FOR HEMATOPOIETIC AND LYMPHOID NEOPLASMS REMEMBER TO FOLLOW THE INSTRUCTIONS GIVEN AT THE CURRENT HEMATOPOIETIC AND LYMPHOID NEOPLASM MANUAL.
https://seer.cancer.gov/tools/heme/Hematopoietic_Instructions_and_Rules/

Laterality

(NAACCR Item #410) (FORDS pg. 122; SEER pgs. 82-84)

Description

Identifies the side of a paired organ or the side of the body where the tumor originated.

Explanation

Aids in staging and extent of disease information, and may indicate the number of primaries.

Coding Instructions

1. Starting with cases diagnosed January 1, 2004 and later, laterality is coded for specified invasive, benign, and borderline primary intracranial and CNS tumors. See Paired Organ Sites Table beginning on page 12.

2. Non-paired sites are coded to 0.

3. Unknown (C809) and Ill-defined (C760–C768) sites are coded to 0.

4. Assign code 9 when the disease originated in a paired site, but the laterality is unknown **AND** there is no statement that only one side of the paired organ is involved.

   ***Example*:** Admitting history says patient was diagnosed with lung cancer based on positive sputum cytology. Patient is treated for painful bony metastases. There is no information about laterality in the diagnosis of this lung cancer. Assign code 9.

5. **Do not** code metastatic sites as bilateral involvement.

   ***Example*:** Patient is diagnosed with adenocarcinoma of the left lung and the physician states patient has metastasis to the right lung. Assign laterality code 2, left origin of primary.

6. For primaries of in situ behavior, if laterality is not known, code to 3 (only one side involved, right or left origin of primary not indicated). Laterality for in situ behavior cannot be coded to 9 or 4.

7. Assign code 3 if laterality is unknown but the tumor is confined to a single side of a paired organ.

   ***Example*:** Pathology report: Patient has a 2 cm carcinoma in the upper pole of the kidney. Code laterality as 3 because there is documentation that the disease exists in only one kidney, but it is unknown if the disease originated in the right or left kidney.

8. Assign code 5 for a midline tumor of a paired site. (C700, C710-C714, C722-C725, C443, C445).

Note: Midline for code 5 refers to the point where the right and left sides of paired organs come into direct contact and a tumor forms at that point such as skin of trunk (C445). Most paired sites cannot develop midline tumors. **Do not** assign code 5 to sites not previously listed above.

   ***Example*:** A melanoma of the skin of back is described as midline. Record laterality as 5. Non-paired sites may be coded right or left, if appropriate. Otherwise, code non-paired sites 0.

9. Document the laterality in a text field.

Table 5.16 Laterality Codes

CODE	DESCRIPTION
0	Not a paired site
1	Right origin of primary
2	Left origin of primary
3	Only one side involved, right or left origin of primary not indicated
4	Bilateral involvement at time of diagnosis, lateral origin unknown for a single primary; or: • Both ovaries simultaneously involved with a single histology • Bilateral retinoblastomas • Bilateral Wilms' tumors **Note**: If both lungs have nodules or tumors and the lung of origin is not known, assign code 4
5	Paired site: midline tumor
9	Unknown site; paired site, lateral origin unknown

Bilateral Sites

Laterality must be recorded for the following bilateral sites. Only major headings are listed. Laterality should be recorded for all anatomic sub-sites included in *ICD-O-3* unless specifically excluded. Such exclusions are coded 0.

Code laterality using codes 1–5 or 9 for all of the sites listed in the following table:

Table 5.17 Bilateral Site Codes

PAIRED ORGAN SITES - ALPHABETIC ORDER	
PRIMARY SITE	**ICD-O-3 CODE**
Acoustic nerve	C724
Adrenal gland [cortex, medulla]	C740–C749
Breast	C500–C509
Carotid body	C754
Cerebral meninges, NOS	C700
Cerebrum	C710
Conjunctiva, lacrimal gland, orbit, cornea, retina, choroid, ciliary body, iris, sclera, lens, eyeball	C690
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

PAIRED ORGAN SITES - ALPHABETIC ORDER	
PRIMARY SITE	**ICD-O-3 CODE**
Maxillary sinus [antrum]	C310
Middle ear [tympanic cavity]	C301
Nasal cavity [excluding nasal cartilage and nasal septum code 0]	C300
Occipital lobe	C714
Olfactory nerve	C722
Optic nerve	C723
Ovary	C569
Overlapping lesion of the eye and adnexa; Eye, NOS; Eye and lacrimal Gland	C690–C699
Parietal lobe	C713
Parotid gland	C079
Pelvic Bones and associated joints [excluding sacrum, coccyx and symphysis pubis - code 0]	C414
Peripheral nerves and autonomic nervous system of lower limb and Hip	C472
Peripheral nerves and autonomic nervous system of upper limb and shoulder	C471
Pleura	C384
Renal pelvis	C659
Rib, clavicle, and associated joints [excluding sternum - code 0]	C413
Short bones of upper limb and associated joints	C401
Short bones of lower limb and associated joints	C403
Skin of external ear	C442
Skin of eyelid	C441
Skin of other and unspecified parts of face [midline code 5]	C443
Skin of upper limb and shoulder	C446
Skin of lower limb and hip	C447
Skin of trunk [midline code 5]	C445
Spermatic cord	C631
Sublingual gland	C081
Submandibular gland	C080
Temporal lobe	C712
Testis	C620–C629
Tonsil, NOS and Overlapping lesion of Tonsil	C098–C099
Tonsillar fossa	C090
Tonsillar pillar	C091
Ureter	C669

Table 5.18 Bilateral Site Codes

PAIRED ORGAN SITES - NUMERICAL ORDER	
ICD-O-3 CODE	**PRIMARY SITE**
C079	Parotid gland
C080	Submandibular gland
C081	Sublingual gland
C090	Tonsillar fossa
C091	Tonsillar pillar

PAIRED ORGAN SITES - NUMERICAL ORDER	
ICD-O-3 CODE	**PRIMARY SITE**
C098	Overlapping lesion of tonsil
C099	Tonsil, NOS
C300	Nasal cavity [excluding nasal cartilage and nasal septum code 0]
C301	Middle ear [tympanic cavity]
C310	Maxillary sinus [antrum]
C312	Frontal sinus
C340	Main bronchus [excluding carina]
C341–C349	Lung
C384	Pleura
C400	Long bones of upper limb, scapula, and associated joints
C401	Short bones of upper limb and associated joints
C402	Long bones of lower limb and associated joints
C403	Short bones of lower limb and associated joints
C413	Rib and clavicle [excluding sternum code 0]
C414	Pelvic bones [excluding sacrum, coccyx, and symphysis pubis code 0]
C441	Skin of eyelid
C442	Skin of external ear
C443	Skin of other and unspecified parts of face [midline code 5]
C445	Skin of trunk [midline code 5]
C446	Skin of upper limb and shoulder
C447	Skin of lower limb and hip
C471	Peripheral nerves and autonomic nervous system of upper limb and shoulder
C472	Peripheral nerves and autonomic nervous system of lower limb and hip
C491	Connective, subcutaneous, and other soft tissues of upper limb and shoulder
C492	Connective, subcutaneous, and other soft tissues of lower limb and hip
C500–C509	Breast
C569	Ovary
C570	Fallopian tube
C620–C629	Testis
C630	Epididymis
C631	Spermatic cord
C649	Kidney, NOS
C659	Renal pelvis
C669	Ureter
C690–C699	Eye and adnexa
C700	Cerebral meninges , NOS
C710	Cerebrum [effective with cases diagnosed 01/01/2004]
C711	Frontal lobe [effective with cases diagnosed 01/01/2004]
C712	Temporal lobe [effective with cases diagnosed 01/01/2004]
C713	Parietal lobe [effective with cases diagnosed 01/01/2004]
C714	Occipital lobe [effective with cases diagnosed 01/01/2004]
C722	Olfactory nerve [effective with cases diagnosed 01/01/2004]
C723	Optic nerve [effective with cases diagnosed 01/01/2004]

PAIRED ORGAN SITES - NUMERICAL ORDER	
ICD-O-3 CODE	**PRIMARY SITE**
C724	Acoustic nerve [effective with cases diagnosed 01/01/2004]
C725	Cranial nerve, NOS [effective with cases diagnosed 01/01/2004]
C740–C749	Adrenal gland [cortex, medulla]
C754	Carotid body

Notes:

a. A laterality code of 1–5 or 9 **must** be assigned for the above sites except as noted. If the site is not listed on the table, assign code 0 for laterality.

b. Never use code 4 for bilateral primaries for which separate abstracts are prepared, or when the side of origin is **known** and the tumor has spread to the other side. Code 4 is seldom used EXCEPT for the following diseases:
   - Both ovaries involved simultaneously, single histology
   - Bilateral retinoblastoma
   - Bilateral Wilms tumors

   Example: A left breast primary with metastasis to the right breast is coded to 2 (left). This would not be coded to 4 (bilateral).

Note: Sometimes the physician may describe the site of the tumor in an organ as right or left. This is a descriptive term and does not refer to a bilateral site or organ.

***Example*:** Patient admitted for surgical resection of tumor in right colon. Code to 0, not a paired site. Do not code to 1. Right colon refers to the ascending colon. The colon is not a paired site.

Final Diagnosis - Morphology/Behavior, Grade, Primary Site, and Laterality Documentation
(NAACCR Items #2580 [Final Diagnosis (Primary, Laterality)], #2590 [Final Diagnosis (Morphology, Behavior, Grade)]

Text to support morphology/behavior, grade, primary site, and laterality codes **must** be provided.

Documenting Instructions

1. Record the morphology/behavior, grade, primary site, and laterality descriptions.
2. Do not use the generic ICD-9-CM code statement found on the face sheet.

***Examples*:**

a. **Morphology:** Moderately well differentiated mucin-producing adenocarcinoma
   Primary Site: Colon, ascending

b. **Morphology:** Grade 3, infiltrating ductal and lobular carcinoma
   Primary Site: Right breast, upper outer quadrant

c. **Morphology:** Anaplastic astrocytoma
   Primary Site: Brain, frontal-parietal lobe

d. **Morphology: Intermediate grade large cell carcinoma**
   Primary Site: Left lung lower lobe

Lymph - Vascular Invasion

(NAACCR Item #1182) (FORDS pg 128)

Description

Indicates the presence or absence of tumor cells in lymphatic channels (not lymph nodes) or blood vessels within the primary tumor as noted microscopically by the pathologist.

Explanation

Lymph-vascular invasion is an indicator of prognosis.

Note: TCR collects this data item only for Penis (C60) and Testis (C62)

Coding Instructions

1. Code from pathology report(s). Code the absence or presence of lymph-vascular invasion as described in the medical record.

    a. The primary sources of information about lymph-vascular invasion are the pathology check lists (synoptic reports) developed by the College of American Pathologists. If the case does not have a checklist or synoptic report, code from the pathology report or a physician's statement, in that order.

    b. Do not code perineural invasion in this field.

    c. Information to code this field can be taken from any specimen from the primary tumor.

    d. If lymph-vascular invasion is identified anywhere in the resected specimen, it should be coded as present/identified.

2. Use of codes:

    a. Use code 0 when the pathology report indicates that there is no lymph-vascular invasion. This includes cases of purely in situ carcinoma, which biologically have no access to lymphatic or vascular channels below the basement membrane.

    b. Use code 1 when the pathology report or a physician's statement indicates that lymph-vascular invasion (or one of its synonyms) is present in the specimen.

    Note: Synonyms for lymph-vascular invasion include LVI, lymphovascular invasion, vascular invasion, blood vessel invasion, and lymphatic invasion. Lymph node involvement is **not** the same as lymph-vascular invasion.

    c. Use code 9 when:

    - There is no microscopic examination of a primary tissue specimen.
    - The primary site specimen is cytology only or a fine needle aspiration.
    - The biopsy is only a very small tissue sample.
    - It is not possible to determine whether lymph-vascular invasion is present.
    - The pathologist indicates the specimen is insufficient to determine lymph-vascular invasion.
    - Lymph-vascular invasion is not mentioned in the pathology report.

Table 5.19 Lymph-Vascular Invasion Codes

CODE	DESCRIPTION
0	Lymph-vascular invasion not present (absent)/Not identified
1	Lymph-vascular invasion present/Identified
8	Not applicable
9	Unknown if lymph-vascular invasion present ; Indeterminate

Diagnostic Confirmation

(NAACCR Item #490); (FORDS pg. 129-131; SEER pgs. 85-87)

Description

Records the best method of diagnostic confirmation of the cancer being reported at any time in the patient's history.

Explanation

This item is an indicator of the precision of diagnosis. The percentage of solid tumors that are clinically diagnosed only is an indication of whether casefinding includes sources beyond pathology reports. Complete casefinding must include both clinically and pathologically confirmed cases.

Coding Instructions for Solid Tumors

1. The codes are in **priority order**; code 1 has the highest priority. Always code the procedure with the lower numeric value when presence of cancer is confirmed with multiple diagnostic methods.

2. Change to a lower code if at ANY TIME during the course of disease the patient has a diagnostic confirmation that has a higher priority. There is no time limit for this field.

3. If diagnosed elsewhere, copies of the previous pathology or radiology reports included in the medical record may be used to code this field.

4. All diagnostic reports in the medical record must be reviewed to determine the most definitive method used to confirm the diagnosis of cancer. This review must cover the entire medical history in regard to the primary tumor. If diagnosed prior to admission to the reporting facility, review the history section of the record to identify information regarding previous diagnostic tests and treatments.

5. If the information in the medical record indicates a biopsy or resection of the tumor has been performed, assume the diagnostic confirmation is histological even if the pathology report is not available.

   ***Example*:** A patient comes in for a bone scan for staging of a known prostate cancer. It is noted in the record that the patient had a prostate biopsy two weeks prior. Use diagnostic confirmation code 1, positive histology.

6. Assign **code 1** when the microscopic diagnosis is based on:

   a. Tissue specimens from biopsy, surgery, autopsy or Dilatation & Curettage

   b. Bone marrow specimens (aspiration and biopsy)

7. Assign **code 2** when the microscopic diagnosis is based on:
   a. Examination of cells (rather than tissue) including but not limited to: sputum smears, bronchial brushings, bronchial washings, prostatic secretions, breast secretions, gastric fluid, spinal fluid, peritoneal fluid, pleural fluid, urinary sediment, cervical smears and vaginal smears.
   b. Paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid.
8. Assign **code 4** when there is information that the diagnosis of cancer was microscopically confirmed, but the type of confirmation is unknown.
9. Assign **code 5** when the diagnosis of cancer is based on laboratory tests or marker studies **with** a clinical diagnosis for that specific cancer.

   ***Examples*:**
   a. The patient has elevated alpha-fetoprotein **with** a clinical diagnosis of liver cancer.
   b. The workup for a prostate cancer patient is limited to a highly elevated PSA and the physician diagnoses and/or treats the patient based only on that PSA.
10. Assign **code 6** when the diagnosis is based only on:
    a. The surgeon's operative report from a surgical exploration or endoscopy such as colonoscopy, mediastinoscopy, or peritoneoscopy and no tissue was examined.
    b. Gross autopsy findings (no tissue or cytologic confirmation).
11. Assign **code 7** when the only confirmation of malignancy was diagnostic imaging such as computerized axial tomography (CT scans), magnetic resonance imaging (MRI scans), or ultrasounds/sonography.
12. Assign **code 8** when the case was diagnosed by any clinical method not mentioned in preceding codes.
13. Assign **code 9** when it is unknown how the diagnosis was confirmed. Death certificate only cases will be assigned **code 9**.

Note: The diagnostic code must be changed to the lower (more specific) code if a more definitive code confirms the diagnosis during the course of the disease, **regardless of time frame**.

Examples:
a. Mammography indicates a lesion suspicious for cancer. The diagnostic confirmation code is 7. Two weeks later a biopsy confirms infiltrating ductal carcinoma. **The correct diagnostic confirmation code is 1.**
b. MRI originally diagnosed a patient with a glioblastoma. The diagnostic confirmation code is 7. A year later a surgical biopsy is obtained**. The diagnostic confirmation code would be changed to 1.**
c. A thoracentesis is performed for a patient who is found to have a large pleural effusion. Cytology reveals malignant cells consistent with adenocarcinoma. **The diagnostic confirmation code is 2.**

d. CAT scan of abdomen reveals metastatic deposits in the liver and a large lesion in the ascending colon. Biopsy and later resection of the colon lesion revealed mucin-producing adenocarcinoma. **The diagnostic confirmation code is 1.**

e. Fine needle aspiration (FNA) is positive for malignant cells. **The diagnostic confirmation code is 2.**

Table 5.20 Diagnostic Confirmation Codes for Solid Tumors

CODE	DESCRIPTION	DEFINITION
MICROSCOPICALLY CONFIRMED		
1	Positive histology	Histological confirmation (tissue microscopically examined). In situ behavior must be microscopically confirmed.
2	Positive cytology	Cytological confirmation (no tissue microscopically examined; fluid cells microscopically examined). Includes pap smears, bronchial brushings, FNA and peritoneal fluid, cervical and vaginal smears, diagnoses based on paraffin block specimens from concentrated spinal, pleural or peritoneal fluid.
4	Positive microscopic confirmation, method not specified	Microscopic confirmation is all that is known. It is unknown if the cells were from histology or cytology.
NOT MICROSCOPICALLY CONFIRMED		
5	Positive laboratory test/marker study	A clinical diagnosis of cancer is based on laboratory tests/marker studies that are clinically diagnostic for cancer but there is no histologic confirmation. This includes alpha-fetoprotein for liver cancer. Elevated PSA is non-diagnostic of cancer. However if the physician uses the PSA as a basis for diagnosing prostate cancer with no other work-up, code to 5. (FORDS Manual page 130).
6	Direct visualization without microscopic confirmation	The tumor was visualized during a surgical/endoscopic procedure only with no tissue resected for microscopic exam.
7	Radiography and other imaging techniques without microscopic confirmation	The malignancy was reported by the physician from an imaging technique report only.
8	Clinical diagnosis only (other than 5, 6, or 7)	The physician documented the tumor in the medical record. **Note:** Refer to the *Ambiguous Terminology List* in the MP/H Rules for cases diagnosed on or after 1/1/2007.
CONFIRMATION UNKNOWN		
9	Unknown whether or not microscopically confirmed	There is a statement of tumor in the medical record, but there is no indication of how it was diagnosed. Includes death certificate only cases.

Instructions for Coding Diagnostic Confirmation of Hematopoietic or Lymphoid Tumors (9590-9992)

Note 1. There is no priority hierarchy for coding *Diagnostic Confirmation* for hematopoietic and lymphoid tumors. Usually the specific histologic type is diagnosed by immunophenotyping or genetic testing. For cases diagnosed January 1, 2010 and later see the *Hematopoietic and Lymphoid Neoplasm Database and Coding Manual* at http://seer.cancer.gov/seertools/hemelymph/ for information on the definitive diagnostic confirmation code for specific types of neoplasm.

Note 2. Use **Code 1** when **ONLY** the tissue, bone marrow, or blood was used to diagnose the specific histology. Do **not** use code 1 if the provisional diagnosis was based on tissue, bone marrow, or blood **and** the immunophenotyping or genetic testing on that same tissue, bone marrow, or blood identified the specific disease (See code 3).

Note 3.If a neoplasm is originally confirmed by histology (code 1), and later has immunophenotyping, genetic testing or JAK2 which confirms a more specific neoplasm and there is no evidence of transformation, change the histology code to the more specific neoplasm and change the diagnostic confirmation to code 3. Do **not** use diagnostic confirmation code 3 for cases diagnosed prior to January 1, 2010.

1. **Code 1 Positive histology**: Tissue from lymph node(s), organ(s) or other tissue specimens from biopsy, frozen section, surgery or autopsy; Bone marrow specimens (aspiration and biopsy). Assign **code 1** when the neoplasm is microscopically confirmed **AND**
   a. Immunophenotyping, genetic testing, or JAK2 **not** done **OR**
   b. Immunophenotyping, genetic testing, or JAK2 done but **negative** (non-diagnostic) for the neoplasm being abstracted **OR**
   c. Immunophenotyping, genetic testing, or JAK2 done but **not listed** in the Definitive Diagnostic Methods in the Hematopoietic Database

Note:In situations like this, the immunophenotyping, genetic testing, or JAK2 may have been done to rule out other neoplasms that are clonally similar to the neoplasm being abstracted. Usually the provisional diagnosis will include two or more neoplasms.

> ***Example***: Bone marrow positive for myeloproliferative neoplasm, probable essential thrombocythemia. JAK2 done and is negative. The JAK2 did not confirm the essential thrombocythemia. Code the myeloproliferative neoplasm (9975/3) with diagnostic confirmation code 1 (positive bone marrow biopsy only)

Note: For leukemia only, assign **code 1** when the diagnosis is based only on the complete blood count (CBC), white blood count (WBC) or peripheral blood smear. Do not use code 1 if the diagnosis was based on immunophenotyping or genetic testing using tissue, bone marrow, or blood.

2. **Code 2 Positive cytology**: Assign **code 2** when the microscopic diagnosis is based on cytologic examination of *cells* (rather than tissue) including but not limited to spinal fluid, peritoneal fluid, pleural fluid, urinary sediment, cervical smears and vaginal smears, or from paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid. These methods are rarely used for hematopoietic or lymphoid tumors.

3. **Code 3 Positive histology PLUS positive immunophenotyping or genetic testing**: Assign **code 3** when there is a histology positive for cancer AND positive immunophenotyping and/or positive genetic testing results. Do not use code 3 for neoplasms diagnosed prior to January 1, 2010.

   ***Example*:** Bone marrow examination is positive for acute myeloid leukemia (9861/3). Genetic testing shows AML with inv (16) (p13.1q22) (9871/3). Code the Diagnostic Confirmation 3, positive histology and positive genetic testing.

Note: Assign **code 3** when the bone marrow or tissue biopsy, CBC or peripheral smear is positive for neoplasm being abstracted (including acceptable ambiguous terminology and provisional diagnosis) **AND** Immunophenotyping, genetic testing or JAK2 is listed in the Definitive Diagnostics Methods in the Hematopoietic Database and the neoplasm is confirmed **OR** a more specific histology is identified.

4. **Code 4 Positive microscopic confirmation, method not specified**: Assign code 4 when there is information that the diagnosis of cancer was microscopically confirmed but the type of confirmation is unknown. This code is rarely used for hematopoietic and lymphoid neoplasms.

5. **Code 5 Positive laboratory test/marker study**: Assign **code 5** when the diagnosis of cancer is based on laboratory tests or marker studies which are clinically diagnostic for that specific cancer, but there is no positive histologic confirmation.

6. **Code 6 Direct visualization without microscopic confirmation**: Assign **code 6** when the diagnosis is based only on the surgeon's report from a surgical exploration or endoscopy or from gross autopsy findings without tissue or cytological findings.

7. **Code 7 Radiology and other imaging techniques without microscopic confirmation**: This code is rarely used for hematopoietic and lymphoid neoplasms. An example of when this code would be assigned is: a terminally ill patient has CT scan with the impression: suspicious for lymphoma but the patient refused further workup.

8. **Code 8 Clinical diagnosis only**: Assign **code 8** when the case was diagnosed by any clinical method that cannot be coded as 5, 6 or 7. A number of hematopoietic and lymphoid neoplasms are diagnosed by tests of exclusion where the tests for the disease are equivocal and the physician makes a clinical diagnosis based on the information from the equivocal tests and the patient's clinical presentation.

9. **Code 9 Unknown whether or not microscopically confirmed; death certificate only**: Assign **code 9** when it is unknown if the diagnosis was confirmed microscopically or for death certificate only (DCO) cases.

Table 5.21 Diagnostic Confirmation Codes for Hematopoietic or Lymphoid Tumors (9590-9992)

CODE	DESCRIPTION	DEFINITION
MICROSCOPICALLY CONFIRMED		
1	Positive histology	Tissue from lymph node(s), organ(s) or other tissue specimens from biopsy, frozen section, surgery or autopsy; Bone marrow specimens (aspiration and biopsy); Peripheral blood smear can be used as histological diagnoses for all hematopoietic histologies (9590/3-9992/3) For **leukemia** only (9800/3-9948/3), positive histology also includes • Complete blood count (CBC) • White blood count (WBC) Neoplasm microscopically confirmed **AND** • Immunophenotyping, genetic testing or JAK2 **not** done **OR** • Immunophenotyping, genetic testing or JAK2 done but **negative** (non-diagnostic) for the neoplasm being abstracted **OR** • Immunophenotyping, genetic testing or JAK2 done but **not listed** in the Definitive Diagnostic Methods in the Heme DB ○ In situations like this, the immunophenotyping, genetic testing, or JAK2 may have been done to **rule out** other neoplasms that are clonally similar to the neoplasm being abstracted. Usually the provisional diagnosis will include two or more neoplasms **Example**: Bone marrow positive for myeloproliferative neoplasm, probable essential thrombocythemia. JAK2 done and is negative. The JAK2 did not confirm the essential thrombocythemia. Code the myeloproliferative neoplasm (9975/3) with diagnostic confirmation code 1 (positive bone marrow biopsy only). **Example:** Acute Myeolomonocytic Leukemia (9867/3) CD 10 (+). CD 10 (+) is not listed under Immunophenotyping for this histology, diagnostic confirmation shlud be 1 Use for historical cases not already in the database if information states that there was histologic confirmation.
2	Positive cytology, no positive histology	This code is rarely used for Hematopoietic and Lymphoid neoplasms. This code includes examination of fluid such as spinal fluid, peritoneal fluid, or pleural fluid. This code also includes paraffin block specimens from concentrated spinal fluid, peritoneal fluid, or pleural fluid. When a small-gauge needle (fine needle aspirations or FNA), or other method is used to obtain a specimen and there is not enough tissue to do a histologic examination the report will be a cytology report rather than a pathology report.

CODE	DESCRIPTION	DEFINITION
3	Positive histology PLUS: • Positive immunophenotyping AND/OR • Positive genetic studies (**Effective for cases diagnosed 1/1/2010 and later**)	This code can only be used when there is histologic confirmation (including ambiguous terminology and provisional diagnosis) (Code 1) **and** • Immunophenotyping, genetic testing, or JAK2 is listed in the **Definitive Diagnostic Methods** in the Heme DB **AND** a) Immunophenotyping, genetic testing, or JAK2 is **positive** for the neoplasm being abstracted (***confirms disease***) **OR** b) Immunophenotyping, genetic testing, or JAK2 identified a ***more specific histology*** (not preceded by ambiguous terminology) **Note:** ***Do not use*** code 3 for positive immunophenotyping or genetic testing identifying a more specific histology when preceded by ambiguous terminology. ***Example (identifying a more specific histology:*** Bone Marrow biopsy (+) for Acute Myeloid Leukemia (9861/3). Genetic testing (+) for AML with inv (16) (p13.1q22) (9871/3) code diagnostic confirmation code 3, positive histology and positive genetic testing.
4	Positive microscopic confirmation, method not specified	This code is rarely used for Hematopoietic Lymphoid neoplasms The diagnosis is stated to be microscopically confirmed but the method is not specified or unknown.
NOT MICROSCOPICALLY CONFIRMED		
5	Positive laboratory test/marker study	This code is rarely used for Hematopoietic and Lymphoid neoplasms. If there no provisional diagnosis or clinical suspicion of cancer, immunophenotyping or genetic testing would not be done. **Example**: CT scan consistent with multiple myeloma (9732/3). Twenty-four hour urine protein elevated with the presence of Bence-Jones kappa. Code 5 for diagnosis based on the positive Bence-Jones, which is listed as one of the diagnostic confirmation methods in the Heme DB and is also a lab test. Code 1 and 3 do not apply because there is no histologic confirmation and positive immunophenotyping and or genetic studies in this example.
6	Direct visualization without microscopic confirmation	This code is rarely used for hematopoietic and lymphoid neoplasms. The operative report may state that the patient had lymphoma but no biopsy or cytology was done or the the diagnosis is determined by gross autopsy findings (no tissue or cytologic confirmation).

CODE	DESCRIPTION	DEFINITION
7	Radiography and other imaging techniques without microscopic confirmation	This code is rarely used for Hematopoietic and Lymphoid neoplasms. Assign code 7 when the diagnosis is confirmed by radiology or other imaging techniques only.
8	Clinical diagnosis only (other than 5, 6, or 7)	While clinical diagnosis is seldom used for solid tumors, it is a valid diagnostic method for certain hematopoietic neoplasms. The Heme DB will list Clinical Diagnosis as the definitive diagnostic method for certain hematopoietic neoplasms. For these neoplasms, the biopsy, immunophenotyping, and genetic testing do not confirm the neoplasm. The diagnosis is determined based on the physician's clinical expertise, combined with the information from the biopsy, equivocal or negative tests, and the clinical symptoms. This is called a "diagnosis of exclusion" because the physician's judgment and the work-up literally exclude all other possible diagnoses, leaving one diagnosis. **Example**: Bone marrow biopsy shows anemia NOS; physician notes states the patient's overall clinical presentation of hypercalcemia, fever, and anemia is consistent with Myelodysplastic Syndrome, NOS (9989/3). Code Diagnostic Confirmation 8, clinical diagnosis only.
CONFIRMATION UNKNOWN		
9	Unknown whether or not microscopically confirmed	There is a statement of tumor in the medical record, but there is no indication of how it was diagnosed. Includes death certificate only cases.

Changing Abstract Information

There are some circumstances under which the information originally coded in the abstract should be updated.

1. To correct coding or abstracting errors when identified.

2. When better information is available at a later date.

- Earlier or more specific diagnosis date
- Better histology or grade
- More specific primary site
- Lower diagnostic confirmation code

> ***Example*:** At the time of diagnosis a patient is diagnosed with liver metastasis but primary site cannot be determined and the abstract is submitted as an unknown primary. At a later date the physician determines that the patient has a colon primary. Change the primary site from unknown to colon. Be sure to make any necessary changes in *Collaborative Stage* and *Surgery Codes*. Document the new information in the appropriate text fields.
>
> ***Example*:** A patient is diagnosed with lung cancer by CT exam alone. An abstract is submitted with the histology of cancer (8000/3) and diagnostic confirmation code 7. At a later admit the H&P states that the patient has squamous cell carcinoma of the lung diagnosed by fine needle aspiration. The *Histology* should be changed from cancer to squamous cell carcinoma (8070/3), and the *Diagnostic Confirmation* should be changed to 2, cytology. These findings should also be documented in the text fields.

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

6

STAGING

STAGING

SUMMARY STAGE DOCUMENTATION

Please, DO NOT enter text in any text fields when treatment is either not done, or unknown if done. This information is conveyed by the treatment flags.

Summary Stage Documentation
(NAACCR Item #2600)

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

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

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values. Staging should include all information available through completion of surgery(ies) in the first course of treatment or within 4 months of diagnosis in the absence of disease progression, whichever is longer.

Coding Instructions
1. Prioritize entered information in the order of the fields listed below.
2. Text automatically generated from coded data is not acceptable.
3. NAACCR-approved abbreviations should be utilized.
4. Do not repeat information from other text fields.
5. Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
6. If information is missing from the record, state that it is missing.
7. Do not include irrelevant information.
8. Do not include information that the registry is not authorized to collect.

Suggestions for text:
- Date(s) of procedure(s), including clinical procedures, which provided information for assigning stage; Organs involved by direct extension.
- Size of tumor, status of margins.
- Number and sites of positive lymph nodes.
- Site(s) of distant metastasis.
- Physician‘s specialty and comments.

Summary Stage Documentation - PE

(NAACCR Item #2520)

Description

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

Explanation

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

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values.

Coding Instructions

1. Prioritize entered information in the order of the fields listed below.
2. Text automatically generated from coded data is not acceptable.
3. NAACCR-approved abbreviations should be utilized
4. Do not repeat information from other text fields.
5. Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
6. If information is missing from the record, state that it is missing.
7. Do not include irrelevant information.
8. Do not include information that the registry is not authorized to collect.

Suggestions for text:

- Date of physical exam.
- Age, sex, race/ethnicity.
- History that relates to cancer diagnosis.
- Primary site.
- Histology (if diagnosis prior to this admission).
- Tumor location.
- Tumor size.
- Palpable lymph nodes.
- Record positive and negative clinical findings. Record positive results first.
- Impression (when stated and pertains to cancer diagnosis).
- Treatment plan.

Summary Stage Documentation - Xray/Scan

(NAACCR #2530)

Description

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

Explanation

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

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values.

Coding Instructions

1. Prioritize entered information in the order of the fields listed below.
2. Text automatically generated from coded data is not acceptable.
3. NAACCR-approved abbreviations should be utilized.
4. Do not repeat information from other text fields.
5. Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
6. If information is missing from the record, state that it is missing.
7. Do not include irrelevant information.
8. Do not include information that the registry is not authorized to collect.

Suggestions for text:

- Date(s) and type(s) of X-ray/Scan(s).
- Primary site.
- Histology (if given).
- Tumor location.
- Tumor size.
- Lymph nodes.
- Record positive and negative clinical findings. Record positive results first.
- Distant disease or metastasis

Summary Stage Documentation - Scopes

(NAACCR Item #2540)

Description

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

Explanation

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

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values.

Coding Instructions

1. Prioritize entered information in the order of the fields listed below.
2. Text automatically generated from coded data is not acceptable.
3. NAACCR-approved abbreviations should be utilized.
4. Do not repeat information from other text fields.
5. Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
6. If information is missing from the record, state that it is missing.
7. Do not include irrelevant information.
8. Do not include information that the registry is not authorized to collect.

Suggestions for text:

- Date(s) of endoscopic exam(s).
- Primary site.
- Histology (if given).
- Tumor location.
- Tumor size.
- Record site and type of endoscopic biopsy.
- Record positive and negative clinical findings. Record positive results first.

Summary Stage Documentation - Lab tests
(NAACCR Item # 2550)

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

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

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values.

Coding Instructions
1. Prioritize entered information in the order of the fields listed below.
2. Text automatically generated from coded data is not acceptable.
3. NAACCR-approved abbreviations should be utilized.
4. Do not repeat information from other text fields.
5. Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
6. If information is missing from the record, state that it is missing.
7. Do not include irrelevant information.
8. Do not include information that the registry is not authorized to collect.

Suggestions for text:
- Type of lab test/tissue specimen(s).
- Record both positive and negative findings. Record positive test results first.
- Information can include tumor markers, serum and urine electrophoresis, special studies, etc.
- Date(s) of lab test(s).
- Tumor markers included, but are not limited to:
    - Breast Cancer – Estrogen Receptor Assay (ERA), Progesterone Receptor Assay (PRA), Her2/neu.
    - Prostate Cancer – Prostatic Specific Antigen (PSA).
    - Testicular Cancer – Human Chorionic Gonadotropin (hCG), Alpha Fetoprotein (AFP), Lactate Dehydrogenase (LDH).

Summary Stage Documentation - OP

(NAACCR Item # 2560)

Description

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

Explanation

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

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values.

Coding Instructions

1. Prioritize entered information in the order of the fields listed below.
2. Text automatically generated from coded data is not acceptable.
3. NAACCR-approved abbreviations should be utilized.
4. Do not repeat information from other text fields.
5. Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
6. If information is missing from the record, state that it is missing.
7. Do not include irrelevant information.
8. Do not include information that the registry is not authorized to collect.

Suggestions for text:

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

Summary Stage Documentation - Path

(NAACCR Item # 2570)

Description

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

Explanation

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

The text field must contain a description that has been entered by the abstractor independently from the code(s). If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values. Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values.

Coding Instructions

1. Prioritize entered information in the order of the fields listed below.
2. Text automatically generated from coded data is not acceptable.
3. NAACCR-approved abbreviations should be utilized.
4. Do not repeat information from other text fields.
5. Additional comments can be continued in empty text fields, including Remarks. For text documentation that is continued from one text field to another, use asterisks or other symbols to indicate the connection with preceding text.
6. If information is missing from the record, state that it is missing.
7. Do not include irrelevant information.
8. Do not include information that the registry is not authorized to collect.

Suggestions for text:

- Date(s) of procedure(s).
- Anatomic source of specimen.
- Type of tissue specimen(s).
- Tumor type and grade (include all modifying adjectives, i.e., predominantly, with features of, with foci of, elements of, etc.).
- Gross tumor size.
- Extent of tumor spread.
- Involvement of resection margins.
- Number of lymph nodes involved and examined.
- Record both positive and negative findings. Record positive test results first.

Note if pathology report is a slide review or a second opinion from an outside source, i.e., AFIP, Mayo. Record any additional comments from the pathologist, including differential diagnoses considered and any ruled out or favored.

STAGE PROGNOSTIC FACTORS

Tumor Size Summary

(NAACCR Item #756) (FORDS pg. 142-144) (SEER revised coding instructions pg. 11-14)

Description

This data item records the most accurate measurement of a solid primary tumor, usually measured on the surgical resection specimen.

Explanation

Tumor size is one indication of the extent of disease. As such, it is used by both clinicians and researchers. Tumor size that is independent of stage is also useful for quality assurance efforts.

Table 6.1 Tumor Size Summary

Code	Description
000	No mass/tumor found
001	1 mm or described as less than 1 mm (0.1 cm or less than 0.1 cm)
002-988	Exact size in millimeters (2 mm to 988 mm) (0.2 cm to 98.8cm)
989	989 millimeters or larger (98.9 cm or larger)
990	Microscopic focus or foci only and no size of focus is given
998	SITE-SPECIFIC CODES Alternate descriptions of tumor size for specific sites: Familial/multiple polyposis • Rectosigmoid and rectum (C19.9, C20.9) • Colon (C18.0, C18.2-C18.9) **If no size is documented**: Circumferential: • Esophagus (C15.0-C15.5, C15.8-C15.9) Diffuse; widespread: 3/4s or more; linitis plastica: • Stomach and Esophagus GE Junction (C16.0-C16.6, C16.8-C16.9) Diffuse, entire lung or NOS: • Lung and main stem bronchus (C34.0-C34.3, C34.8-C34.9) Diffuse: • Breast (C50.0-C50.6, C50.8-C50.9)
999	Unknown; size not stated Not documented in patient record Size of tumor cannot be assessed No excisional biopsy or tumor resection done The only measurement(s) describes pieces or chips Not applicable

Instructions for coding

***Note**: All measurements should be in millimeters (mm). Here is a link to one of the websites to convert cms to mms:*
http://www.rapidtables.com/convert/length/cm-to-mm.htm

Record size in specified order:

1. Size measured on the surgical resection specimen, when **surgery is administered as the first definitive treatment, i.e., no pre-surgical treatment administered.**

    a. If there is a discrepencey among tumor size measurements in the various sections of the pathology report, code the size from the synoptic report (also known as CAP protocol or pathology report checklist). If only a text report is available, use: final diagnosis, microscopic, or gross examination, in that order.

    Example: chest X-ray shows 3.5 cm mass; the pathology report from the surgery states that the same mass is malignant and measures 2.8 cm. Record tumor size as 028 (28 mm).

    Example: Pathology report states lung carcinoma is 2.1 cm x3.2 cm x 1.4 cm. Record tumor size as 032 (32mm).

2. If neoadjuvant therapy followed by surgery, do not record the size of the pathologic specimen. Code the largest size of tumor prior to neoadjuvant treatment; if unknown code size 999.

    Example: Patient has a 2.2 cm mass in the oropharynx; fine needle aspiration of mass confirms squamous cell carcinoma. Patient receives a course of neoadjuvant combination chemotherapy. Pathologic size after total resection is 2.8 cm. Record tumor size as 022 (22mm).

3. If no surgical resection, then the largest measurement of the tumor from physical exam, imaging, or other diagnostic procedures priotr to any other form of treatment (See coding rules below)

4. If 1, 2, and 3 do not apply, the largest size from all information available within four months of the date of diagnosis, in the absence of disease progression.

Coding Instructions

1. Tumor size is the **diameter** of the tumor, **not the depth or thickness** of the tumor.

2. Recording ‘less than’/ ‘greater than’ Tumor Size

    a. If tumor size is reported as less than x mm or less than x cm, the reported tumor size should be 1 mm less; for example if size is < 10 mm, code size as 009. Often these are given in cm such as < 1 cm, which is coded as 009; < 2 cm is coded as 019; < 3 cm is coded as 029; < 4 cm is coded as 039; < 5 cm is coded as 049. If stated as less than 1 mm, use code 001.

    b. If tumor size is reported as more than x mm or more than x cm, code size as 1 mm more; for example if size is > 10 mm, size should be coded as 011. Often these are given in cm such as

> 1 cm, which is coded as 011; > 2 cm is coded as 021; > 3 cm is coded as 031; > 4 cm is coded as 041; > 5 cm is coded as 051. If described as anything greater than 989 mm (98.9 cm), code as 989.

c. If tumor size is reported to be between two sizes, record tumor size as the midpoint between the two: i.e., add the two sizes together and then divide by two ("between 2 and 3 cm" is coded as 025).

3. **Rounding**: Round the tumor size only if it is described in fractions of millimeters. If the largest dimension of a tumor is less than 1 millimeter (between 0.1 and 0.9 mm), record size as 001 (do not round down to 000). If tumor size is greater than 1 millimeter, round tenths of millimeters in the 1- 4 range down to the nearest whole millimeter, and round tenths of millimeters in the 5-9 range up to the nearest whole millimeter. Do not round tumor size expressed in centimeters to the nearest whole centimeter (rather, move the decimal point one space to the right, converting the measurement to millimeters).

   Examples:

   Breast cancer described as 6.5 millimeters in size. Round up Tumor Size as 007.

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

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

   5.2 mm breast cancer. Round down to 5 mm and code as 005.

4. **Priority of imaging/radiographic techniques**: Information on size from imaging/radiographic techniques can be used to code size when there is no more specific size information from a pathology or operative report, but it should be taken as low priority, over a physical exam.

5. **Tumor size discrepancies among imaging and radiographic reports**: If there is a difference in reported tumor size among imaging and radiographic techniques, unless the physician specifies which imaging is most accurate, record the largest size in the record, regardless of which imaging technique reports it.

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

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

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

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

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

Example 1: A breast tumor with infiltrating duct carcinoma with extensive in situ component; total size 2.3 cm. Record tumor size as 023 (23 mm).

Example 2: Duct carcinoma in situ measuring 1.9 cm with an area of invasive ductal carcinoma. Record tumor size as 019 (19 mm).

8. **Record the largest dimension or diameter of tumor, whether it is from an excisional biopsy specimen or the complete resection of the primary tumor.**

   Example: Tumor is described as 2.4 x 5.1 x 1.8 cm in size. Record tumor size as 051 (51 mm).

9. **Record the size as stated for purely in situ lesions.**

10. **Disregard microscopic residual or positive surgical margins when coding tumor size**. Microscopic residual tumor does not affect overall tumor size. The status of primary tumor margins may be recorded in a separate data field.

11. **Do not add the size of pieces or chips together to create a whole**. They may not be from the same location, or they may represent only a very small portion of a large tumor. However, if the pathologist states an aggregate or composite size (determined by fitting the tumor pieces together and measuring the total size), record that size. If the only measurement describes pieces or chips, record tumor size as 999.

12. **Multifocal/multicentric tumors**: If the tumor is multi-focal or if multiple tumors are reported as a single primary, code the size of the largest invasive tumor or if all of the tumors are in situ, code the size of the largest in situ tumor.

13. **Tumor size code 999 is used when size is unknown or not applicable**. Sites/morphologies where tumor size is not applicable are listed here.

    Hematopoietic, Reticuloendothelial, and and Myeloproliferative neoplasms: (histology codes 9590- 9992)
    Kaposi Sarcoma
    Melanoma Choroid
    Melanoma Ciliary Body
    Melanoma Iris
    Unknown Primary Site

14. Document the information to support coded tumor size in the appropriate text field of the abstract.

Regional Lymph Nodes Positive

(NAACCR item # 820) (FORDS pg. 133) (SEER 93-96) Section V: Stage of Disease at Diagnosis

Description

Records the exact number of regional lymph nodes examined by the pathologist and found to contain metastases. Beginning with cases diagnosed on or after January 1, 2004, this item became a component of the Collaborative Staging System (CS). In 2016 use of CS was discontinued, however this data item continued to be required.

Rationale

This data item is necessary for pathologic staging, and it serves as a quality measure for pathology reports and the extent of the surgical evaluation and treatment of the patient.

Table 6.2 Regional Nodes Positive

Codes	Description
00	All nodes examined are negative
01-89	1-89 nodes are positive (code exact number of nodes positive
90	90 or more nodes positive
95	Positive aspiration or core biopsy of lymph node (s) was performed
97	Positive nodes are documented, but the number is unspecified
98	No nodes were examined
99	It is unknown whether nodes are positive; not applicable; not stated in patient record

Instructions for Coding

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.

1. Regional lymph nodes only. Record information only about regional lymph nodes in this field. Involved distant lymph nodes should be coded in the M (distant metastasis) field and not counted as positive regional nodes.

    a. For Kaposi sarcoma, retinoblastoma, and lymphoma ocular adnexa, while all lymph node involvement (regional and distant) is coded in N, only count positive regional lymph nodes and not the distant N1 nodes in this field.

2. **This field is based on pathologic information only**. This field is to be recorded regardless of whether the patient received neoadjuvant (preoperative) treatment.

3. True **in situ cases** cannot have positive lymph nodes, so the only allowable codes are 00 (negative) or 98 (not examined). Codes 01-97 and 99 are not allowed.

4. **Nodes positive is cumulative**. Record the total number of regional lymph nodes removed and found to be positive by pathologic examination.

    a. The number of regional nodes positive is cumulative from all procedures that remove lymph nodes through the completion of surgeries in the first course of treatment.

b. Do not count a positive aspiration or core biopsy of a lymph node in the same lymph node chain removed at surgery as an additional node in Regional Nodes Positive when there are positive nodes in the resection. In other words, if there are positive regional lymph nodes in a lymph node dissection, do not count the core needle biopsy or the fine needle aspiration if it is in the same chain. See also Use of Code 95 below.

   Example 1: Lung cancer patient has a mediastinoscopy and positive core biopsy of hilar lymph node. Patient then undergoes right upper lobectomy that yields 3 hilar and 2 mediastinal nodes positive out of 11 nodes dissected. **Code Regional Nodes Positive as 05 and Regional Nodes Examined as 11 because the core biopsy was of a lymph node in the same chain as the nodes dissected.**

   Example 2: Positive right cervical lymph node aspiration followed by right cervical lymph node dissection showing 1 of 6 nodes positive. **Code Regional Nodes Positive as 01 and Regional Nodes Examined as 06.**

c. If the positive aspiration or core biopsy is from a node in a different node region, include the node in the count of Regional Nodes Positive.

   Example: Breast cancer patient has a positive core biopsy of a supraclavicular node and an axillary dissection showing 3 of 8 nodes positive. **Code Regional Nodes Positive as 04 and Regional Nodes Examined as 09 because the supraclavicular lymph node is in a different, but still regional, lymph node chain.**

d. If the location of the lymph node that is core-biopsied or aspirated is not known, assume it is part of the lymph node chain surgically removed, and do not include it in the count of Regional Nodes Positive.

   Example: Patient record states that lymph node core biopsy was performed at another facility and 7/14 regional lymph nodes were positive at the time of resection. **Code Regional Nodes Positive as 07 and Regional Nodes Examined as 14.**

5. **Priority of lymph node counts**. If there is a discrepancy regarding the number of positive lymph nodes, use information in the following priority: final diagnosis, synoptic report (also known as CAP protocol or pathology report checklist), microscopic description, gross description.

6. **Positive Nodes in Multiple Primaries in Same Organ**. If there are multiple primary cancers with different histologic types in the same organ and the pathology report just states the number of nodes positive, the registrar should first try to determine the histology of the metastases in the nodes and code the nodes as positive for the primary with that histology. If no further information is available, code the nodes as positive for all primaries.

   Example: A breast case is two separate primaries as determined by the SEER multiple primary rules. The pathology report states "3 of 11 lymph nodes positive for metastasis" with no further information available. **Code Regional Nodes Positive as 03 and Regional Nodes Examined as 11 for both primaries**

7. **Isolated Tumor Cells (ITCs)** in lymph nodes. For all primary sites except cutaneous melanoma and Merkel cell carcinoma of skin, count only lymph nodes that contain micrometastases or larger (metastases greater than 0.2 millimeters in size). Do not include in the count of lymph nodes positive any nodes that are identified as containing isolated tumor cells (ITCs). If the path report indicates that nodes are positive but the size of metastasis is not stated, assume the metastases are larger than 0.2 mm and count the lymph node(s) as positive.

   a. For cutaneous melanoma and Merkel cell carcinoma, count nodes with ITCs as positive lymph nodes.

8. **Code 95.** Use code 95 when the only procedure for regional lymph nodes is a needle aspiration (cytology) or core biopsy (tissue).

   a. Use code 95 when a positive lymph node is aspirated and there are no surgically resected lymph nodes.

      Example: Patient with esophageal cancer. Enlarged mid-esophageal node found on CT scan, which is aspirated and found to be positive. Patient undergoes radiation therapy and no surgery. **Code Regional Nodes Positive as 95 and Regional Nodes Examined as 95.**

   b. Use code 95 when a positive lymph node is aspirated and surgically resected lymph nodes are negative.

      Example: Lung cancer patient has aspiration of suspicious hilar mass, which shows metastatic squamous carcinoma in lymph node tissue. Patient undergoes neoadjuvant (preoperative) radiation therapy followed by lobectomy showing 6 negative hilar lymph nodes. **Code Regional Nodes Positive as 95 and Regional Nodes Examined as the 06 nodes surgically resected.**

9. **Code 97**. Use code 97 for any combination of positive aspirated, biopsied, sampled or dissected lymph nodes if the number of involved nodes cannot be determined on the basis of cytology or histology. Code 97 includes positive lymph nodes diagnosed by either cytology or histology.

   Example: Patient with carcinoma of the pyriform sinus has a mass in the mid neck. Fine needle aspiration (FNA) of one node is positive. The patient has neoadjuvant (preoperative) chemotherapy, then resection of the primary tumor and a radical neck dissection. In the radical neck dissection "several" of 10 nodes are positive; the remainder of the nodes showchemotherapy effect. **Code Regional Nodes Positive as 97 because the total number of positive nodes biopsied and removed is unknown, and code Regional Nodes Examined as 10.**

   Note 1: For primary sites where the number of involved nodes must be known in order to map to N1, N2, etc., code 97 maps to N1 and therefore should be avoided, even if this means slightly undercounting the number of nodes positive.

   Note 2: If the aspirated node is the only one that is microscopically positive, use code 95.

   Note 3: Avoid using Regional Nodes Positive code 97 if possible, even if this means slightly undercounting the number of nodes positive.

10. **Code 98** may be used in several situations:

    a. When the assessment of lymph nodes is clinical only.

    b. When no lymph nodes are removed and examined.

    c. When a “dissection” of a lymph node drainage area is found to contain no lymph nodes at the time of pathologic examination.

    d. If Regional Nodes Positive is coded as 98, Regional Nodes Examined is usually coded 00.

11. **Code 99**. If it is unknown whether regional lymph nodes are positive.

    For the following schemas, the Regional Nodes Positive field is always coded as 99:

    i. Brain
    ii. CNS Other
    iii. Heme Retic
    iv. Ill-Defined Other (includes unknown primary [C809])
    v. Intracranial Gland
    vi. Lymphoma (excluding Mycosis Fungoides [9700/3] and Sezary Syndrome [9701/3])
    vii. Myeloma Plasma Cell Disorder
    viii. Placenta

Regional Lymph Nodes Examined
(NAACCR item # 830) (FORDS pg. 132) (SEER pg. 97- 99)

Description
Records the total number of regional lymph nodes that were removed and examined by by the pathologist. Beginning with cases diagnosed on or after January 1, 2014, this item became a component of the Collaborative Staging System (CS). In 2016 use of CS was discontinued, however this data item continued to be required.

Rationale
This data item serves as a quality measure of the pathologic and surgical evaluation and treatment of the patient.

Table 6.3 Regional Nodes Examined

Code	Description
00	No nodes were examined
01-89	1-89 nodes are examined (code exact number of nodes examined)
90	90 or more nodes were examined
95	No regional nodes were removed, but aspiration OR core biopsy regional nodes was performed
96	Regional lymph node removal was documented as a sampling, and the number of nodes is unknown/not stated
97	Regional lymph node removal was documented as a dissection, and the number of nodes is unknown/not stated
98	Regional lymph nodes were surgically removed, but the number of lymph nodes is unknown/not stated and not documented as a sampling or dissection; nodes were examined, but the number is unknown
99	It is unknown whether nodes are examined; not applicable; not stated in patient record

Instructions for coding

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

1. **Regional lymph nodes only**. Record information only about regional lymph nodes in this field. Involved distant lymph nodes should be coded in the M (distant metastasis) field and not counted as positive regional nodes.

    a. For Kaposi sarcoma, retinoblastoma, and lymphoma ocular adnexa, while all lymph node involvement (regional and distant) is coded in N, only count positive regional lymph nodes and not the distant N1 nodes in this field.

2. **This field is based on pathologic information only**. This field is to be recorded regardless of whether the patient received neoadjuvant (preoperative) treatment.

3. Code **00** may be used in several situations

   a. When the assessment of lymph nodes is clinical.

   b. When no lymph nodes are removed and examined.

   c. When a "dissection" of a lymph node drainage area is found to contain no lymph nodes at the time of pathologic examination.

   d. If Regional Nodes Examined is coded 00, Regional Nodes Positive is coded as **98**.

4. Nodes removed and examined is cumulative. Record the total number of regional lymph nodes removed and examined by the pathologist.

   a. The number of regional lymph nodes examined is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment.

   b. Do not count a positive aspiration or core biopsy of a lymph node in the same lymph node chain removed at surgery as an additional node in Regional Nodes Examined.

      Example: Lung cancer patient has a mediastinoscopy and positive core biopsy of a hilar lymph node. Patient then undergoes right upper lobectomy that yields 3 hilar and 2 mediastinal nodes positive out of 11 nodes dissected. **Code Regional Nodes Positive as 05 and Regional Nodes Examined as 11 because the core biopsy was of a lymph node in the same chain as the nodes dissected.**

   c. If the positive aspiration or core biopsy is from a node in a different node region, include the node in the count of Regional Nodes Examined.

      Example: Breast cancer patient has a positive core biopsy of a supraclavicular node and an axillary dissection showing 3 of 8 nodes positive. Code Regional Nodes Positive as 04 and Regional Nodes Examined as 09 because the supraclavicular lymph node is in a different, but still regional, lymph node chain.

   d. If the location of the lymph node that is aspirated or core-biopsied is not known, assume it is part of the lymph node chain surgically removed, and do not include it in the count of Regional Nodes Examined.

      ***Example*:** Patient record states that lymph node core biopsy was performed at another facility and 7/14 regional lymph nodes were positive at the time of resection. Code Regional Nodes Positive as 07 and Regional Nodes Examined as 14.

5. **Priority of lymph node counts**. If there is a discrepancy regarding the number of lymph nodes examined, use information in the following priority: final diagnosis, synoptic report (also known as CAP protocol or pathology report checklist), microscopic description, gross description.

6. **Code 95.** Use code 95 when the only procedure for regional lymph nodes is a needle aspiration (cytology) or core biopsy (tissue).

Example: Patient with esophageal cancer. Enlarged mid-esophageal node found on CT scan, which is aspirated and found to be positive. Patient undergoes radiation therapy and no surgery. **Code Regional Nodes Positive as 95 and Regional Nodes Examined as 95.**

7. **Lymph node excision biopsy**. If a lymph node excision biopsy was performed, code the number of nodes removed, if known.

8. Definition of **"sampling" (code 96).** A lymph node "sampling" is removal of a limited number of lymph nodes. Other terms for removal of a limited number of nodes include lymph node biopsy, berry picking, sentinel lymph node procedure, sentinel node biopsy and, selective dissection. Use code 96 when a limited number of nodes are removed but the number is unknown.

9. Definition of **"dissection" (code 97).** A lymph node "dissection" is removal of most or all of the nodes in the lymph node chain(s) that drain the area around the primary tumor. Other terms include lymphadenectomy, radical node dissection, and lymph node stripping. Use code 97 when more than a limited number of lymph nodes are removed and the number is unknown.

10. **Multiple lymph node procedures**. If both a lymph node sampling and a lymph node dissection are performed and the total number of lymph nodes examined is unknown, use code 97.

11. When neither the type of lymph node removal procedure nor the number of lymph nodes examined is known, use **code 98.**

12. **Code 99**. If it is unknown whether nodes were removed or examined, code as 99.

    a. Primary sites always coded 99. For the following schemas, the Regional Nodes Examined field is always coded as 99.

        i. Brain
        ii. CNS Other
        iii. Heme Retic
        iv. Ill-Defined Other (includes unknown primary [C809])
        v. Intracranial Gland
        vi. Lymphoma (excluding Mycosis Fungoides [9700/3] and Sezary Syndrome [9701/3])
        vii. Myeloma Plasma Cell Disorder
        viii. Placenta

COLLABORATIVE STAGE - SFFs

To access the Coding Instructions for CS v02.05, go to the link below and follow the installation instructions. The Coding Instructions must be downloaded to your computer.

The CSv02.05 Cancer Schemas can be accessed directly from this website.

Collaborative Stage Version 2, Site Specific Schema:

Release Notes: https://cancerstaging.org/cstage/coding/Documents/ReleaseNotesv0205.pdf

The following link includes the Site Specific Factors required by the Texas Cancer Registry.

COLLABORATIVE STAGE SITE SPECIFIC FACTORS FOR 2017

2010-2017 SSFs Required by TCR:
https://www.dshs.texas.gov/tcr/training/handbook/TCR-SSFs-2010-2017.pdf

Refer to Tables 1.1 and 1.2 (page 8) for SSFs required by TCR.

SEER STAGING

SEER Summary Stage 1977
(NAACCR Item #760)

Description
Code for summary stage at the initial diagnosis or treatment of the reportable tumor. This has traditionally been used by central registries to monitor time trends. For hospital registries, CoC requires its use in the absence of defined AJCC classification. For site-specific definitions of categories, see the SEER Summary Staging Guide.

SEER Summary Stage 1977 is limited to information available within 2 months of the date of diagnosis. NAACCR approved extension of this time period to 4 months for prostate tumors diagnosed beginning January 1, 1995.

Explanation
Stage information is important when evaluating the effects of cancer control programs. It is crucial for understanding whether changes over time in incidence rates or outcomes are due to earlier detection of the cancers. In addition, cancer treatment cannot be studied without knowing the stage at diagnosis.

To study historical trends in stage, the coding system must be relatively unchanged (stable) over time. AJCC's TNM system is updated periodically to maintain clinical relevance with changes in diagnosis and treatment. The surveillance registries often rely on the Summary Stage, which they consider to be more stable. Summary Stage has been in widespread use, either as the primary staging scheme or a secondary scheme, in most central and hospital registries since 1977.

Table 6.1 SEER Summary Stage 1977 Codes

CODE	DESCRIPTION
0	In situ
1	Localized
2	Regional, direct extension only
3	Regional, regional lymph nodes only
4	Regional, direct extension and regional lymph nodes
5	Regional, NOS
7	Distant
8	Not applicable
9	Unstaged

Note*:* Code 8 was added in Version 10.1 to be used when there is not an applicable code to reflect stage (e.g., benign brain).

Note: Summary stage is required. The correct data item to use (and corresponding code manual) is determined by the year in which the cancer was diagnosed. Tumors diagnosed on or after January 1, 2004, should be assigned a summary stage based upon the Collaborative Stage data item algorithms and retained in Derived SS2000 [3020].Tumors diagnosed on or after January 1, 2001, should be assigned a summary stage according to the SEER *Summary Staging Manual 2000*, and the code should be reported in SEER Summary Stage 2000 [759]. Tumors diagnosed before January 1, 2001, should be assigned a summary stage according to *SEER Summary Stage Guide 1977*, and the code should be reported in SEER Summary Stage 1977 [760]. https://seer.cancer.gov/archive/manuals/historic/ssm_1977.pdf

SEER Summary Stage 2000

(NAACCR Item #759)

Direct coding of this data item is required for all cases diagnosed January 1, 2015 and forward.

Description

Code summary stage at the initial diagnosis or treatment of the reportable tumor. For hospital registries, CoC requires its use in the absence of a defined AJCC classification. Note that Texas Cancer Registry requires directly coded SEER Summary Stage 2000 from all facilities for all sites/histologies. For site-specific definitions of categories, see SEER *Summary Staging Manual 2000* *https://seer.cancer.gov/tools/ssm/* .

Summary staging is the most basic way of categorizing how far a cancer has spread from its point of origin. The 2000 version of Summary Stage applies to every anatomic sites, including the lymphoma and leukemias. Summary staging uses all information in the medical record. It is a combination of the most precise clinical and pathological documentation of the extent of disease.

Summary stage should include all information available through completion of surgery(ies) in the first course of treatment or within 4 months of diagnosis in the absence of disease progression, whichever is longer.

Explanation

Stage information is important when evaluating the effects of cancer control programs. It is crucial in understanding whether changes over time in incidence rates or outcomes are due to earlier detection of the cancers. In addition, cancer treatment cannot be studied without knowing the stage at diagnosis.

Table 6.2 SEER Summary Stage 2000 Codes

CODE	DESCRIPTION
0	In situ
1	Localized
2	Regional by direct extension only
3	Regional, regional lymph nodes only
4	Regional by both, direct extension and regional lymph nodes
5	Regional, NOS
7	Distant site(s)/node(s) are involved
8	Not applicable
9	Unstaged, unknown if extension or metastasis, unspecified, DCO

Note*:* Code 8 was added in Version 10.1 to be used when there is not an applicable code to reflect stage (e.g., benign brain, borderline ovarian).

Note: Direct-Coded Summary stage is required for all cases diagnosed January 1, 2015 and forward from all facilities. The correct data item to use (and corresponding code manual) is determined by the year in which the cancer was diagnosed. Tumors diagnosed on or after January 1, 2004, should be assigned a summary stage based upon the Collaborative Stage data item algorithms and retained in Derived SS2000 [3020].Tumors diagnosed on or after January 1, 2001, should be assigned a summary stage according to the SEER *Summary Staging Manual 2000*, and the code should be reported in SEER Summary Stage 2000 [759]. Tumors diagnosed before January 1, 2001, should be assigned a summary stage according to *SEER Summary Stage Guide 1977*, and the code should be reported in SEER Summary Stage 1977 [760].

AJCC TNM STAGING SYSTEM

From 2004 through 2015 AJCC TNM was derived based on Collaborative Staging. Beginning with cases diagnosed January 1, 2015 directly coded AJCC TNM fields are requested as available. Beginning with cases diagnosed January 1, 2016 and forward, directly coded AJCC TNM fields are required from ALL facilities.

AJCC TNM is a system to describe the amount and spread of cancer in a patient's body.

T describes the size of the tumor and any spread of cancer into nearby tissue.
N describes spread of cancer to nearby lymph nodes.
M describes metastasis (spread of cancer to other parts of the body).

This system was created and is updated by the American Joint Committee on Cancer (AJCC) and the International Union Against Cancer (UICC). The AJCC staging system is used to describe most types of cancer.

Schemas for which TNM is Not Defined

The table below shows the schemas (based on primary site/histology combinations) for which TNM is not defined (i.e., not applicable).

Note: SEER Summary Stage 2000 is collected for all schemas, including schemas listed in the table.

List of Cancer Schemas Not Defined in TNM

Adnexa Uterine Other
Biliary Other
Brain
CNS Other
Digestive Other
Endocrine Other
Eye Other
Genital Female Other
Male Genital Other
Heme Retic
Ill Defined Other
Intracranial Gland
Kaposi Sarcoma
Lacrimal Sac
Melanoma Eye Other
Melanoma Sinus Other
Middle Ear
Myeloma Plasma Cell Disorder
Pharynx Other
Respiratory Other
Sinus Other
Trachea
Urinary Other

Code 88 for the data items indicated below for the schemas listed above.

- Clinical T
- Pathologic T
- Clinical N
- Pathologic N
- Clinical M
- Pathologic M

Code 88 for the staging group for the schemas listed above.

Primary Site/Histologies with Partial TNM Definitions

TNM is partially defined for the following schemas:

- Placenta (Gestational Trophoblastic Tumors): N is not defined
  - Code 88 for clinical and pathologic N
- Lymphoma: T, N, and M are not defined (Ann Arbor Stage used)
  - Code 88 for clinical and pathologic T, N, and M
  - Stage Group is defined; clinical and pathologic stage group data elements must be assigned manually
    - Assign 99 if stage group is unknown
- For the following schemas, T, N, and M are defined; however, stage group is not defined. Code 88 for the stage group.
  - Conjunctiva
  - Lacrimal Gland
  - Melanoma Conjunctiva
  - Orbit
  - Retinoblastoma
- Lymphoma Ocular Adnexa
  - Lymphomas of the ocular adnexa are included in the UICC Hodgkin & non-Hodgkin Lymphoma chapter
  - For 2016, SEER registries are required to collect Clinical Stage Group and Pathologic Stage Group for lymphomas of the ocular adnexa using the Hodgkin & non-Hodgkin Lymphoma Stage Group definitions.
    - Code 88 for clinical and pathologic T, N, and M
    - Stage Group is defined; clinical and pathologic stage group data elements must be assigned manually
    - Assign 99 if stage group is unknown

Schemas Where T is (In Situ) Not Defined

Per TNM, in situ is a very rare diagnosis for the following schemas and is not allowed in the T category definition.

Adrenal Gland
Carcinoid Appendix
Corpus Adenosarcoma
Corpus Sarcoma
GIST Appendix
GIST Colon
GIST Esophagus
GIST Peritoneum
GIST Rectum
GIST Small Intestine
GIST Stomach
Kidney Parenchyma
Lacrimal Gland
Liver
Melanoma Buccal Mucosa
Melanoma Choroid
Melanoma Ciliary Body
Melanoma Epiglottis Anterior
Melanoma Floor Mouth
Melanoma Gum Lower
Melanoma Gum Other
Melanoma Gum Upper
Melanoma Hypopharynx
Melanoma Iris
Melanoma Larynx Glottic
Melanoma Larynx Other
Melanoma Larynx Subglottic
Melanoma Larynx Supraglottic
Melanoma Lip Lower
Melanoma Lip Other
Melanoma Lip Upper
Melanoma Mouth Other
Melanoma Nasal Cavity
Melanoma Nasopharynx
Melanoma Oropharynx
Melanoma Palate Hard
Melanoma Palate Soft
Melanoma Pharynx Other
Melanoma Sinus Ethmoid
Melanoma Sinus Max
Melanoma Tongue Ant
Mycosis Fungoides
NET Ampulla
NET Colon
NET Rectum
NET Small Intestine
Orbit
Ovary
Parotid Gland
Placenta
Prostate
Salivary Gland Other
Submandibular Gland
Thyroid

Code 88 for the data items indicated below for an in situ diagnosis for the schemas listed above.

- Clinical T
- Pathologic T
- Clinical N
- Pathologic N
- Clinical M
- Pathologic M

Assigning Stage when only information available is Stage Group

Assignment of T, N, and M data items when the ONLY information available is stage group, i.e. no other information on extent of disease or T, N, or M.

1. Determine whether the stage group is pathologic or clinical
   a. When clinical or pathologic is not known
      i. Assume the stage group is clinical when
         a) patient is presenting for neoadjuvant therapy
         b) patient is coming in for surgery
      ii. Assume the stage group is pathologic when
         a) patient is post-surgery
         b) patient is coming in for ADJUVANT therapy, assume there was surgery
      iii. Assume the stage group is clinical when there is no basis to assume as instructed above

2. Assign the given clinical or pathologic stage group and leave the corresponding T, N, and M components blank.

3. FIGO Stages: Assign the applicable clinical or pathologic stage group and leave the corresponding T, N, and M components blank for the following FIGO stages only.

Schema	**FIGO Stage**
Cervix	IIIB
Vulva	III [NOS], IIIA, IIIB, IIIC, IVA
Vagina	III
Corpus Carcinoma	III [NOS], IIIC [NOS], IIIC1, IIIC2
Corpus Adenosarcoma	IIIC
Corpus Sarcoma	IIIC
Ovary	IIIC
Peritoneum Female Gen	IIIC
Fallopian Tube	III [NOS], IIIC
Placenta	All stages can have T and M assigned

Examples of Stage Group Only Cases

Example 1: Patient presents for neoadjuvant therapy for Stage IIC rectal tumor.
Assign Clinical Stage group IIC. Leave the clinical T, N, and M data items as blank.

Example 2: Patient presents for adjuvant therapy, post mastectomy for Stage IIB breast tumor. No other information available.
Assign Pathologic Stage group IIB. Leave pathologic T, N, and M data items blank. The documented stage group is pathologic (post mastectomy).

Example 3: Patient presents for chemotherapy for Stage IVA liver tumor.
Assign Clinical Stage group IVA. Leave clinical T, N, and M data items blank.

Example 4: Physician documents Breast tumor, Stage IIIC. No other information available.
Assign Clinical Stage group IIIC. Leave clinical T, N, and M data items blank. Default to clinical when unable to determine if clinical or pathologic.

Example 5: Patient with Stage IV Merkel cell carcinoma presents for treatment.
Assign Clinical Stage group IV. Leave clinical T, N, and M data items blank.

Example 6: Patient presents for adjuvant therapy, post-surgical resection for Stage IIIA melanoma. No other information available.
Assign Pathologic Stage group IIIA. Leave pathologic T, N, and M data items blank.

Example 7: Patient with Stage II bladder tumor, post-cystectomy with lymph node dissection, presents for chemotherapy.
Assign Pathologic Stage group II. Leave pathologic T, N, and M data items blank.

Example 8: Patient with Stage IA breast cancer presents for follow up exam.
Assign Clinical Stage group IA. Leave clinical T, N, and M data items blank.

TNM Clin T

(NAACCR Item #940) (FORDS pg. 157; SEER pg. 28-31 from Section V: Stage of Disease at Diagnosis)

Description

Detailed site-specific codes for the clinical tumor (T) as defined by AJCC and recorded by the physician. This field is manually coded.

Explanation

Clinical T reflects the tumor size and/or extension of the primary tumor prior to the start of treatment.

Codes (in addition to those published in the ***AJCC Cancer Staging Manual)***

AJCC Value*	AJCC site-specific value for clinical T staging
88	Not applicable, no code assigned for this case in the current AJCC Staging Manual
Blank	No information at all is available to code item. Indicates registrar could not find information in chart.
X	Indicates not assessed

*See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups.

Coding Instructions

1. Refer to the most recent *AJCC Cancer Staging Manual* staging rules and coding values as there are site-specific rules that may apply in addition to the general rules.

2. Code as documented by the first treating physician or managing physician per the medical record where possible; otherwise, use available information to code the clinical T.

3. Code the value only and not the 'T' component and convert lower case to upper case; for example, T3b is recorded as 3B.

4. The code for occult carcinoma of the lung is TX; record X.

Note: See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the FORDS manual for specifications for codes and data entry rules.

TNM Clin N

(NAACCR Item #950) (FORDS pg. 159; SEER pg. 32-37 from Section V: Stage of Disease at Diagnosis)

Description

Detailed site-specific codes for the clinical tumor (N) as defined by AJCC and recorded by the physician. This field is manually coded.

Explanation

Clinical N indicates the presence or absence of regional lymph node metastasis prior to the start of treatment.

Codes (in addition to those published in the ***AJCC Cancer Staging Manual)***

AJCC Value*	AJCC site-specific value for clinical N staging
88	Not applicable, no code assigned for this case in the current AJCC Staging Manual
Blank	No information at all is available to code item. Indicates registrar could not find information in chart.
X	Indicates not assessed

*See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups.

Coding Instructions

1. Refer to the most recent *AJCC Cancer Staging Manual* for staging rules and coding values as there are site-specific rules that may apply in addition to the general rules.

2. Code as documented by the first treating physician or managing physician per the medical record where possible; otherwise, use available information to code the clinical N.

3. Code the value only and not the 'N' component and convert lower case to upper case; for example, N2c is recorded as 2C.

***Note**:* See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the FORDS manual for specifications for codes and data entry rules.

TNM Clin M

(NAACCR Item #960) (FORDS pg. 160; SEER pg. 38-40 from Section V:Stage of Disease at Diagnosis)

Description

Detailed site-specific codes for the clinical tumor (M) as defined by AJCC and recorded by the physician. This field is manually coded.

Rationale

Beginning in 2016, new T, N, M categories were implemented in the AJCC TNM data items (940, 950, 960, 880, 890 and 900). These new categories have been generated by adding the prefixes of "c" and "p" to existing valid clinical and pathologic TNM categories respectively, and modifying, adding and deleting specific categories. The new categories enable registrars to comply with AJCC clinical and pathologic staging/classification timeframe rules while abstracting. Additional TNM categories will be added and use of existing categories will be expanded with the implementation of the AJCC 8th edition Manual.

Explanation

Clinical M indicates the presence or absence of distant metastasis prior to the start of treatment.

Codes (in addition to those published in the ***AJCC Cancer Staging Manual)***

AJCC Value*	AJCC site-specific value for clinical M staging
88	Not applicable, no code assigned for this case in the current AJCC Staging Manual
Blank	No information is available to code item. Indicates registrar could not find information in chart.
Code	Definition
< BLANK >	Not recorded
c0	cM0
c0I+	cM0(i+)
c1	cM1
c1A	cM1a
c1B	cM1b
c1C	cM1c
c1D	cM1d
c1E	cM1e
p1	pM1
p1A	pM1a
p1B	pM1b
p1C	pM1c
p1D	pM1d
p1E	pM1e

*See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups.

Coding Instructions

1. Refer to the most recent *AJCC Cancer Staging Manual* for staging rules and coding values as there are site-specific rules that may apply in addition to the general rules.
2. Code as documented by the first treating physician or managing physician per the medical record where possible; otherwise, use available information to code the clinical M.
3. Code the value only and not the 'M' component and convert lower case to upper case; for example, M1a is recorded as 1A.

***Note**:* See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the FORDS manual for specifications for codes and data entry rules.

TNM Clinical Stage (Prefix/Suffix) Descriptor
(NAACCR Item #980) (FORDS pg. 162; SEER pg. 43 from Section V:Stage of Disease at Diagnosis)

Description
Clinical Stage (Prefix/Suffix) Descriptor is the prefix or suffix used in conjunction with AJCC clinical TNM fields. This field is manually coded.

Explanation
The prefix/suffix denotes special circumstances that may affect the staging and analysis of the data and is based on the clinical T, N, and M values prior to treatment. The descriptors are adjuncts to and do not change the stage group.

Code	Description	Description
0	None	There are no prefix or suffix descriptors that would be used for this case
1	E (Extranodal, lymphomas only)	A lymphoma case involving an extranodal site
2	S (Spleen, lymphomas only)	A lymphoma case involving the spleen
3	M (Multiple primary tumors in a single site)	This is one primary with multiple tumors in the primary site at the time of diagnosis
5	E & S (Extranodal and spleen, lymphoma	A lymphoma case with involvement of both an extranodal site and the spleen
9	Unknown, not stated in patient record	A prefix or suffix would describe this stage, but it is not known which would be correct

Coding Instructions

1. Code the descriptor as documented by the first treating physician or managing physician per the medical record where possible; otherwise, use available information to code the clinical stage descriptor.

TNM Clinical Stage Group

(NAACCR Item #970) (FORDS pg. 161; SEER pg. 41-42 from Section V:Stage of Disease at Diagnosis)

Description

Clinical Stage Group is the detailed site-specific field used to code the clinical stage group as defined by AJCC. This field is manually coded. The standard setters require a non-BLANK value for the Pathologic Stage Group.

Explanation

Clinical stage group identifies the extent of disease based on the clinical T, N, and M values prior to the start of treatment. This data item cannot be blank.

Codes (in addition to those published in the ***AJCC Cancer Staging Manual)***

AJCC Value*	AJCC site-specific value for clinical stage group
88	Not applicable, no code assigned for this case in the current AJCC Staging Manual
99	Unknown, not staged
OC	Occult (Lung)

*See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups.

Coding Instructions

1. Refer to the most recent *AJCC Cancer Staging Manual* for staging rules and coding values as there are site-specific rules that may apply in addition to the general rules.
2. Code as documented by the first treating physician or managing physician per the medical record where possible; otherwise, use available information to code the clinical stage group.
3. Code the value only and not the 'Stage' component (do not include the word 'Stage'); convert Roman numerals to Arabic numerals and lower case to upper case; for example, Stage IIA2 is recorded as 2A2.
4. If stage group cannot be determined from the TNM components, then record it as unknown, code 99.
5. If pediatric staging is used and not AJCC staging, use code 88 for clinical and pathologic T, N, M, and Stage Group. If AJCC staging is used for pediatric staging, code using the appropriate AJCC values.

Note: See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the FORDS manual for specifications for codes and data entry rules.

TNM Path T

(NAACCR Item #880) (FORDS pg. 165; SEER pg. 50-54 from Section V:Stage of Disease at Diagnosis)

Description

Detailed site-specific codes for the pathologic tumor (T) as defined by AJCC and recorded by the physician. This field is manually coded.

Explanation

Pathologic T reflects the tumor size and/or extension of the primary tumor after completion of surgical treatment.

Codes (in addition to those published in the ***AJCC Cancer Staging Manual)***

AJCC Value*	AJCC site-specific value for pathological T staging
88	Not applicable, no code assigned for this case in the current AJCC Staging Manual
Blank	No information at all is available to code item. Indicates registrar could not find information in chart.
X	Indicates not assessed

*See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups.

Coding Instructions

1. Refer to the most recent *AJCC Cancer Staging Manual* for staging rules and coding values as there are site-specific rules that may apply in addition to the general rules.
2. Code as documented by the treating physician(s) or managing physician per the medical record where possible; otherwise, use available information to code the pathologic T.
3. Code the value only and not the 'T' component and convert lower case to upper case; for example, T3b is recorded as 3B.
4. The code for occult carcinoma of the lung is TX; record X.

Note: See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the FORDS manual for specifications for codes and data entry rules.

TNM Path N

(NAACCR Item #890) (FORDS pg. 167; SEER pg. 55-61 from Section V:Stage of Disease at Diagnosis)

Description

Detailed site-specific codes for the pathologic tumor (N) as defined by AJCC and recorded by the physician. This field is manually coded.

Explanation

Pathologic N indicates the presence or absence of regional lymph node metastasis and the extent of metastasis after completion of surgical treatment.

Codes (in addition to those published in the ***AJCC Cancer Staging Manual)***

AJCC Value*	AJCC site-specific value for pathological N staging
88	Not applicable, no code assigned for this case in the current AJCC Staging Manual
Blank	No information at all is available to code item. Indicates registrar could not find information in chart.
X	Indicates not assessed

*See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups.

Coding Instructions

1. Refer to the most recent *AJCC Cancer Staging Manual* for staging rules and coding values as there are site-specific rules that may apply in addition to the general rules.
2. Code as documented by the treating physician(s) or managing physician per the medical record where possible; otherwise, use available information to code the pathologic N.
3. Code the value only and not the 'N' component and convert lower case to upper case; for example, N2c is recorded as 2C.

Note: See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the FORDS manual for specifications for codes and data entry rules.

TNM Path M

(NAACCR Item #900) (FORDS pg. 168; SEER pg. 62-64 from Section V:Stage of Disease at Diagnosis)

Description

Detailed site-specific codes for the pathologic metastases (M) as defined by AJCC and recorded by the physician. This field is manually coded.

Explanation

Pathologic M indicates the presence or absence of distant metastasis after completion of surgical treatment.

Codes (in addition to those published in the ***AJCC Cancer Staging Manual)***

AJCC Value*	AJCC site-specific value for pathological M staging
88	Not applicable, no code assigned for this case in the current AJCC Staging Manual
Blank	No information at all is available to code item.

*See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups.

Coding Instructions

1. Refer to the most recent *AJCC Cancer Staging Manual* for staging rules and coding values as there are site-specific rules that may apply in addition to the general rules.
2. Code as documented by the treating physician(s) or managing physician per the medical record where possible; otherwise, use available information to code the pathologic M.
3. Code the value only and not the 'M' component and convert lower case to upper case; for example, M1c is recorded as 1C.

***Note**:* See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the FORDS manual for specifications for codes and data entry rules.

TNM Pathologic Stage (Prefix/Suffix) Descriptor

(NAACCR Item #920) (FORDS pg. 170; SEER pg. 68 from Section V:Stage of Disease at Diagnosis)

Description

Pathologic Stage (Prefix/Suffix) Descriptor is the prefix or suffix used in conjunction with AJCC pathologic TNM fields. This field is manually coded.

Explanation

The prefix/suffix denotes special circumstances that may affect the staging and analysis of the data and is based on the pathologic T, N, and M values after completion of surgical treatment. The descriptors are adjuncts to and do not change the stage group.

Code	Description	Description
0	None	There are no prefix or suffix descriptors that would be used for this case
1	E (Extranodal, lymphomas only)	A lymphoma case involving an extranodal site
2	S (Spleen, lymphomas only)	A lymphoma case involving the spleen
3	M (Multiple primary tumors in a single site)	This is one primary with multiple tumors in the organ of origin at the time of diagnosis
4	Y (Classification after intial multimodality therapy)	Neoadjuvant treatment given before staging
5	E & S (Extranodal and spleen, lymphoma	A lymphoma case with involvement of both an extranodal site and the spleen
9	Unknown, not stated in patient record	A prefix or suffix would describe this stage, but it is not known which would be correct

Coding Instructions

1. Code the descriptor as documented by the treating physician(s) or managing physician per the medical record where possible; otherwise, use available information to code the pathologic stage descriptor.

***Note**:* See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the FORDS manual for specifications for codes and data entry rules.

TNM Pathologic Stage Group

(NAACCR Item #910) (FORDS pg. 169; SEER pg. 65-67 from Section V:Stage of Disease at Diagnosis)

Description

Pathologic Stage Group is the detailed site-specific field used to code the pathologic stage group as defined by AJCC. This field is manually coded. The standard setters require a non-BLANK value for the Pathologic Stage Group.

Explanation

Pathologic stage group identifies the extent of disease based on the pathologic T, N, and M values after completion of surgical treatment.

Codes (in addition to those published in the ***AJCC Cancer Staging Manual)***

AJCC Value*	AJCC site-specific value for pathological stage group
88	Not applicable, no code assigned for this case in the current AJCC Staging Manual
99	Unknown, not staged
OC	Occult (Lung)

*See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups.

Coding Instructions

1. Refer to the most recent *AJCC Cancer Staging Manual* for staging rules and coding values as there are site-specific rules that may apply in addition to the general rules.
2. Code as documented by the treating physician(s) or managing physician per the medical record where possible; otherwise, use available information to code the pathologic stage group.
3. If pathologic M is blank and clinical M is coded as 0, 1, 1A, 1B, or 1C, then pT, pN, and cM may be used to stage the case. If stage group cannot be determined from the TNM components, then record it as unknown. The standard setters require a non-BLANK value for the Pathologic Stage Group.
4. If the value is less than 4 characters, record the value to the left and leave the rest of the spaces blank.
5. If pediatric staging is used and not AJCC staging, use code 88 for clinical and pathologic T, N, M, and Stage Group. If AJCC staging is used for pediatric staging, code using the appropriate AJCC values.

Note: See the *AJCC Cancer Staging Manual* current edition for site-specific categories for the TNM elements and stage groups. See the FORDS manual for specifications for codes and data entry rules.

7

TREATMENT INFORMATION

TREATMENT INFORMATION

First Course of Treatment

The first course of treatment includes all methods of treatment recorded in the treatment plan and administered to the patient before disease progression or recurrence. "Active surveillance" is a form of planned treatment for some patients; its use is coded in the *RX Summ--Treatment Status* item. "No therapy" is a treatment option that occurs if the patient refuses treatment, the family or guardian refuses treatment, the patient dies before treatment starts, or the physician recommends no treatment be given. If the patient refuses all treatment, code "patient refused" (code 7 or 87) for all treatment modalities. Maintenance treatment given as part of the first course of planned care (for example, for leukemia) is first course treatment, and cases receiving that treatment are analytic.

All Diseases (including benign and borderline malignancy intracranial & CNS tumors) Except Leukemia and Hematopoietic Diseases

Definitions:

Active Surveillance: See Watchful Waiting

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.

> ***Example***: chemotherapy and radiation therapy

Disease recurrence: For solid tumors, see the *2007 Multiple Primary and Histology Coding Rules Manual* and for hematopoietic and lymphoid neoplasms see the *Hematopoietic Manual* and the hematopoietic database to determine disease recurrence.

First course of therapy: All treatments administered to the patient after the original diagnosis of cancer in an attempt to destroy or modify the cancer tissue. See below for detailed information on timing and treatment plan documentation requirements.

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

Palliative treatment: The World Health Organization describes palliative care as 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. Palliative therapy may also be part of the first course of therapy if it destroys proliferating 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, or Surgery of Other Regional or Distant Sites.

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: A treatment option for patients with slow, indolent diseases, such as prostate cancer. The physician closely monitors the patient and delays treatment until the patient becomes symptomatic or exhibits other signs of disease progression, such as rising PSA. Also referred to as Active Surveillance.

Treatment Timing

Use the following **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).

   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 agreement with the treatment plan and the treatment plan was not changed as a result 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 below).

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

1. Code all treatment fields to 00 (Not done) when physician decides to do **watchful waiting/active surveillance** for a patient who has prostate cancer. The first course of therapy is no treatment. When the disease progresses or the patient becomes symptomatic, any prescribed treatment is second course.

2. Code the treatment as first course of therapy if the patient refuses treatment but changes his/her mind and the prescribed treatment is implemented less than one year from the date of diagnosis, AND there is no evidence of disease progression.

3. The first course of therapy is **no treatmen**t when the patient **refuses** treatment. Code the treatment fields to Refused.

   a. Keep the refused code even if the patient later changes his/her mind and decides to have the prescribed treatment

      i. more than one year after diagnosis
      OR
      ii. when there is evidence of disease progression before treatment is implemented

4. Code all treatment that was started and administered, whether completed or not.

   Example: The patient completed only the first dose of a planned 30-day chemotherapy regimen. Code chemotherapy as administered.

5. Code the treatment on both abstracts when a patient has multiple primaries and the treatment given for one primary also affects/treats the other primary.

   Example 1: The patient had prostate and bladder cancer. The bladder cancer was treated with a TURB. The prostate cancer was treated with radiation to the prostate and pelvis. The pelvic radiation includes the regional lymph nodes for the bladder. Code the radiation as treatment for both the bladder and prostate cases.

   Example 2: The patient had a hysterectomy for ovarian cancer. The pathology report reveals a previously unsuspected microinvasive cancer of the cervix. Code the hysterectomy as surgical treatment for both the ovarian and cervix primaries.

6. Code the treatments only for the site that is affected when a patient has multiple primaries and the treatment affects only one of the primaries.

   Example: The patient has colon and tonsil primaries. The colon cancer is treated with a hemicolectomy and the tonsil primary is treated with radiation to the tonsil and regional nodes. Do not code the radiation for the colon. Do not code the hemicolectomy for the tonsil.

7. Code the treatment given as first course even if the correct primary is identified later when a patient is diagnosed with an unknown primary.

   Example: The patient is diagnosed with metastatic carcinoma, unknown primary site. After a full course of chemotherapy, the primary site is identified as prostate. Code the chemotherapy as first course of treatment.

   a. Do not code treatment as first course when added to the plan after the primary site is discovered. This is a change in the treatment plan.

      Example: The patient is diagnosed with metastatic carcinoma, unknown primary site. After a full course of chemotherapy, the primary site is identified as prostate. Hormonal treatment is started. Code the chemotherapy as first course of treatment. The hormone therapy is second course because it was not part of the initial treatment plan.

Note: The first course of treatment includes all treatment planned and administered by the physician(s) from the initial diagnosis of cancer. Treatment can include multiple methods and may last a year or more. Any treatment delivered after the first course is considered subsequent treatment.

Note: Should there be a change of therapy due to apparent failure of the originally delivered treatment or because of the progression of the disease, the later therapy is not considered first course.

First Course Treatment for Leukemia and Hematopoietic Diseases

Refer to the Hematopoietic and Lymphoid Neoplasm Database to determine the correct coding of treatment for hematopoietic diseases.

Leukemia:
Leukemia is grouped or typed by how quickly the disease develops and gets worse. Chronic leukemia gets worse slowly. Acute leukemia gets worse quickly. Leukemias are also grouped by the type of white blood cells affected. There are lymphoid and myeloid leukemias.

Generally, treatment for leukemias is divided into three phases:

1. Remission induction (chemotherapy and/or biological response modifiers)
2. CNS prophylaxis or consolidation (irradiation to brain, chemotherapy)
3. Remission continuation or maintenance (chemotherapy or bone marrow transplants)

Definitions:

Induction: Initial intensive course of chemotherapy.

Consolidation: Repetitive cycles of chemotherapy given immediately after remission.

Maintenance: Chemotherapy given for a period of months or years to maintain remission.

Remission: the bone marrow is normocellular with less than 5% blasts, there are no signs or symptoms of the disease, no signs or symptoms of central nervous system leukemia or other extramedullary infiltration, and all of the following laboratory values are within normal limits: white blood count and differential, hematocrit/hemoglobin level, and platelet count.

Coding Guidelines for First Course Therapy for Leukemia and Hematopoietic Diseases:

1. If a patient has a partial or complete remission during the first course therapy:

    a. Code and document all therapy that is "remission-inducing" as first course.

    b. Code and document all therapy that is "consolidation" as first course.

    c. Code and document all therapy that is "remission-maintaining" as first course.

Note: Do not code the treatment given after the patient relapses (is no longer in remission).

2. Some patients do not have a remission. A change in the treatment plan indicates a failure to induce remission. If the patient does not have a remission:

    a. Code and document the treatment given in an attempt to induce a remission.

    b. Do **not** record treatment administered after the change in treatment plan.

Other Treatment for Hematopoietic Diseases:

1. Record all treatment as described above. The following treatments are coded as "other" in Other Treatment even though they do not "modify, control, or destroy proliferating cancer tissue."

    a. Collect phlebotomy for polycythemia vera ONLY. Phlebotomy also may be referred to as blood removal, bloodletting or venisection.

    b. Collect blood thinners, and/or anticlotting agents for:

        - 9740/3 Mast cell sarcoma
        - 9741/3 Systemic mastocytosis
        - 9742/3 Mast cell leukemia
        - 9875/3 Chronic myelogenous leukemia BCR/ABL1 positive

- 9950/3 Polycythemia vera
- 9961/3 Primary myelofibrosis
- 9962/3 Essential thrombocythemia
- 9963/3 Chronic neutrophilic leukemia
- 9975/3 Myelodysplastic/myeloproliferative neoplasm, unclassifiable

Note: Blood Thinners/Anticoagulants/Anticlotting Drugs examples:

Aggrenox (Dipyridamole)
Aggrastat (Tirofiban)
Agrylin (Anagrelide Hcl)
Arixtra (Fondaparinox)
Brilinta (Ticagrelor)
Coumadin (Warfarin)
Flolan (Epoprostenol sodium)
Fragmin (Dalteparin)
Heparin [generic name]
Integrelin (Eptifibatide)
Lovenox (Enoxaparin)
Normiflo (Ardeparin)
Orgaran (Danaparoid)
Persantine (Dipyridamole)
Plavix (Clopidogrel)
Pletal (Cliostazol)
Pradaxa (Dabigatran etexilate mesylate)
Reopro (Abciximab)
Ticlid (Ticlopidine)

Note: Blood transfusions and aspirin therapy are not collected as treatment.

Note: Donor Leukocyte Infusions: the use of donor leukocyte infusions for treatment of hematopoietic neoplasms, specifically leukemias, is increasing. Abstract as bone marrow transplant when a reportable hematopoietic neoplasm is treated with donor leukocyte infusion, even if it is not listed in the treatment section of the Heme DB for the specific neoplasm.

Date of Initial Treatment

(NAACCR Item #1260, 1270)

Date Therapy Initiated *(SEER pg. 112-114 , NAACCR Item# 1260)*
Date of First Course of Treatment *(FORDS pg. 229, NAACCR Item #1270)*

Description

The date the first course of treatment (surgery, radiation, systemic or other) started at any facility, hospital and non-hospital setting.

Explanation

This field is used to measure the delay between diagnosis and onset of treatment. A secondary use is as a starting point for survival statistics. This date cannot be calculated from the respective first course treatment dates if no treatment was given. Therefore, providing information about these instances is important when a physician decides not to treat a patient or the patient, patient's family or guardian declines treatment.

Coding Instructions

1. Record the earliest date of the following treatment in this field:
   - RX Date-Surgery NAACCR Data Item #1200
   - RX Date-Radiation NAACCR Data Item #1210
   - RX Date-Chemotherapy NAACCR Data Item #1220
   - RX Date-Hormone Therapy NAACCR Data Item #1230
     - Code the date that the prescription was written
   - RX Date Immunotherapy NAACCR Data Item #1240
   - RX Date-Other NAACCR Data Item #1250
   - RX. Summary - Scope of Reg Ln Surgery NAACCR Item #1292
   - RX Summ - Surg Other Reg/Dist RX NAACCR Item #1294
   - RX Summ - Transplant/Endocrine NAACCR Item #3250

2. Code the date of **excisional biopsy** as the date therapy initiated when it is the first treatment. Code the date of a biopsy documented as incisional if further surgery reveals no residual or only microscopic residual.

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

3. Date format is:

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

      ***Example*:** A patient was found to have a large polyp during a colonoscopy on January 8, 2017. A polypectomy on that date confirmed adenocarcinoma of the descending colon. The polypectomy is considered cancer directed surgery, so code the *Date of Initial Treatment* 20170108.

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

      ***Example*:** Patient had pre-op chemo in March 2017 followed by a mastectomy. The exact chemo start date is unknown. Code the *Date of Initial Treatment* as 201703.

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

Note: Treatment dates for a fetus prior to birth are to be assigned the actual date of the event. Record the type of treatment in the appropriate date item, for example, *Surgery of Primary Site.*

***Example*:** On 1/3/2017 a fetus is diagnosed with malignant teratoma. The teratoma is resected in utero 1/10/2017. Live birth is on 3/8/2017. Code the surgery date 20170110.

4. Code the date unproven therapy was initiated as the date therapy initiated.

5. Code the date of admission to the hospital for inpatient or outpatient treatment when the exact date of the first treatment is **unknown**

6. Leave blank:

   a. When no treatment is given during the first course

   b. When Treatment Status is coded 2, Active surveillance (watchful waiting). If you are a CoC facility follow CoC definition of first course.

   c. When it is known the patient had first course therapy, but it is impossible to estimate the date

   d. When it is unknown whether the patient had treatment

   e. For Death Certificate only (DCO) cases when the date is unknown and cannot be estimated

   f. Autopsy only cases

Estimating Dates

Estimating the **month**

1. Code "spring of" to April.
2. Code "summer "or "middle of the year" to July.
3. Code "fall" or "autumn" as October.
4. For "winter of," try to determine whether the physician means the first of the year or the end of the year and code January or December as appropriate. If no determination can be made, use whatever information is available to calculate the month.
5. Code "early in year" to January.
6. Code "late in year" to December.
7. Use whatever information is available to calculate the month.
8. Code the month of admission when there is no basis for estimation.
9. Leave month blank if there is no basis for approximation.

Estimating the **year**

1. Code "a couple of years" to two years earlier.
2. Code "a few years" to three years earlier.
3. Use whatever information is available to calculate the year.
4. Code the year of admission when there is no basis for estimation.

Note: FORDS instructions (see FORDS pg. 229) differ from TCR instructions. FORDS instructs for Date of First Course of Treatment to record the date when the decision of active surveillance or watchful waiting is selected as the first course of treatment. TCR will accept FORDS guide for this field but will continue to follow SEER guideline for this data item. Facilities following FORDS guidelines will not receive an edit on this data item.

Date of Initial RX Flag

(NAACCR Item #1261) (SEER pg 115)

Description

This flag explains why there is no appropriate value in the corresponding date field, Date of Initial RX-SEER (1260).

Explanation

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information previously transmitted in date field.

Coding Instructions

1. Leave this item blank if *Date of Initial Treatment* has a full or partial date recorded.
2. Assign code 10 when it is unknown whether any treatment was administered.
   - For Death Certificate Only (DCO) cases.
3. Assign code 11 when no treatment is given during the first course, the first course is active surveillance (watchful waiting) or the initial diagnosis was at autopsy.
4. Assign code 12 if the Date of Initial Treatment cannot be determined or estimated, and the patient **did** receive first course treatment. Use this code **only** as a last resource.

Table 7.1 Date of Initial RX Flag Codes

CODE	DESCRIPTION
10	No information whatsoever can be inferred from this exceptional value (unknown if therapy was administered).
11	No proper value is applicable in this context (for example, no treatment given or autopsy only).
12	A proper value is applicable but not known (for example, therapy was administered and date is unknown).
(blank)	A valid date value is provided in item *Date of Initial Treatment* (NAACCR Item #1260).

RX Summary - Scope of Reg Ln Surgery

(NAACCR Item #1292) (FORDS pg. 243-246; SEER pgs. 122-126)

Description

Indicates the removal, biopsy, or aspiration of **regional** lymph nodes at the time of surgery of the primary site or during a separate surgical procedure performed during the initial work-up of first course of therapy.

Explanation

This information is used to compare and evaluate the extent of surgical treatment.

Coding Instructions

1. Use the operative reports 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 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.

2. Record all surgical procedures that remove, biopsy, or aspirate regional lymph nodes even if surgery of the primary site is not performed. The regional lymph node surgical procedure(s) may be done to **diagnose** cancer, **stage** the disease, or as part of the initial **treatmen**t. Codes 0–7 are hierarchical. Code the procedure that is numerically higher.

3. Information to be coded for this data field is **cumulative**. It is appropriate to add the number of all the lymph nodes removed during each surgical procedure performed as part of the first course treatment.

4. Code only regional lymph node procedures in this data item. Record distant lymph node removal in *Surgical Procedure of Other Site*. Include lymph nodes that are coded as regional in the **current AJCC** Staging Manual. **Do not code distant lymph nodes removed during surgery to the primary site for this data item, distant nodes are coded in the data field** *Surgical procedure/Other Site* (NAACCR Item #1294).

   ***Example*:** Melanoma with no primary skin site identified. One axillary lymph node removed revealing melanoma. No other tumors found. The axillary lymph node is coded as regional for CS lymph node coding. Include this lymph node in *Scope of Regional LN Surgery*.

5. Include lymph nodes obtained or biopsied during any procedure within the first course of treatment. A separate lymph node surgery is not required. Coded the removal of intra-organ lymph nodes in Scope of Regional LN Surgery.

   Example: Local excision of breast cancer. Specimen includes an intra-mammary lymph node. Assign code 4 (1 to 3 regional lymph nodes removed).

6. If the operative report lists a lymph node dissection but no nodes were found by the pathologist, code the *SCOPE OF REG LN SURGERY* to 0 (No lymph nodes removed).

7. If the patient has two primaries with common regional lymph nodes, code and document the removal of regional nodes for both primaries.

   ***Example*:** Patient has a cystoprostatectomy and pelvic lymph node dissection for papillary transitional cell cancer of the bladder. Pathology identifies prostate adenocarcinoma as well as the bladder cancer and 4/21 nodes positive for metastatic adenocarcinoma. Code *Scope of Regional Lymph Node Surgery* to 5 (4 or more regional lymph nodes removed) for both primaries.

8. Code to 9 for:

   a. Primaries sites

      - Brain (C700-C709), OR

- Spinal cord (C710-C719), OR
- Cranial nerves and other parts of the central nervous system (C720-C729, C75.1-C75.3)
- Unknown or ill-defined sites (C760-C768, C809) (all histologies) (including cases diagnosed at autopsy)

b. Lymphomas with primary site in lymph node (C770–C779) AND

- 9590, 9726, 9735-9738, OR
- 9727, 9811-9818, 9823, 9827, 9837 (leukemia/lymphoma histologies)

c. Hematopoietic neoplasms

- Primary site: C421 (all histologies)
- Histologies: 9740, 9751, 9754-9759, 9762, 9930

d. Death Certificate only (DCO) cases.

Note: This table is also available in the Quick Reference.

Note: See Appendix A for additional instructions specific to Breast Surgical Codes (RX Summary-Scope of Reg LN Surgery).

Table 7.2 RX. Summary- Scope of Reg Ln Surgery Codes

CODE	DESCRIPTION	DEFINITION	GENERAL INSTRUCTIONS
0	None	No regional lymph node surgery. No lymph nodes found in the pathologic specimen. Diagnosed at autopsy.	
1	Biopsy or aspiration of regional lymph nodes, NOS	Biopsy or aspiration of regional lymph node(s) regardless of the extent of involvement.	Review the operative report of to confirm whether an excisional biopsy or aspiration of regional lymph nodes was actually performed. If additional procedures were performed on the lymph nodes, use the appropriate code 2-7.
2	Sentinel lymph node biopsy (only)	Biopsy of the first lymph node or nodes that drain a defined area of tissue within the body. Sentinel node(s) are identified by the injection of a dye or radio label at the site of the primary tumor.	The operative report states that a SLNBx was performed. Code 2 SLNBx when the operative report describes a procedure using injection of a dye, radio label, or combination to identify a lymph node (possibly more than one) for removal/examination. When a SLNBx is performed, additional non-sentinel nodes can be taken during the same

CODE	DESCRIPTION	DEFINITION	GENERAL INSTRUCTIONS
			operative procedure. These additional nonsentinel nodes may be discovered by the pathologist or selectively removed (or harvested) as part of the SLNBx procedure by the surgeon. Code this as a SLNBx 2. If review of the operative report confirms that a regional lymph node dissection followed the SLNBx, code these cases as 6
3	Number of regional lymph nodes removed unknown or not stated; regional lymph nodes removed, NOS	Sampling or dissection of regional lymph node(s) and the number of nodes removed is unknown or not stated. The procedure is not specified as sentinel lymph node biopsy.	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 SLN Bx only. Code 5 (4 or more regional lymph nodes removed). If a relatively small number of nodes were examined pathologically, review the operative report to confirm the procedure was not a SLNBx only (code 2). If a relatively large number of nodes were examined pathologically, review the operative report to confirm that there was not a SLNBx in addition to a more extensive regional lymph node dissection during the same, or separate, procedure (code 6 or 7). Infrequently, a SNLBx is attempted and the patient fails to map (i.e. no sentinel lymph nodes are identified by the dye and/or radio label injection). When mapping fails, surgeons usually perform a more extensive dissection of regional lymph nodes. Code these cases as 2 if no further dissection of regional lymph nodes was undertaken, or 6 when regional lymph nodes were dissected during the same operative event.
4	1–3 regional lymph nodes removed	Sampling or dissection of regional lymph node(s) with fewer than four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.	
5	4 or more regional lymph nodes removed	Sampling or dissection of regional lymph nodes with at least four lymph nodes found in the specimen. The procedure is not specified as sentinel node biopsy.	

CODE	DESCRIPTION	DEFINITION	GENERAL INSTRUCTIONS
6	Sentinel lymph node biopsy and code 3, 4, or 5 at same time, or timing not stated	Code 2 was performed in a single surgical procedure with code 3, 4, or 5; or code 2 and 3, 4, or 5 were performed, but timing was not stated in patient record.	SNLBx and regional lymph node dissection (code 3, 4, or 5) during the same surgical event, or timing not known. Generally, SLNBx followed by a regional lymph node completion will yield a relatively large number of nodes. However it is possible for these procedures to harvest only a few nodes. If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only. Infrequently, a SNLBx is attempted and the patient fails to map (i.e. no sentinel lymph nodes are identified by the dye and/or radio label injection.) When mapping fails, the surgeon usually performs a more extensive dissection of regional lymph nodes. Code these cases as 6.
7	Sentinel node biopsy and code 3, 4, or 5 at different times	Code 2 was followed in a subsequent surgical event by procedures coded as 3, 4, or 5.	SNLBx and regional lymph node dissection (code 3, 4, or 5) in separate surgical events. Generally, SLNBx followed by regional lymph node completion will yield a relatively large number of nodes. However, it is possible for these procedures to harvest only a few nodes. If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only.
9	Unknown or not applicable	It is unknown whether regional lymph node surgery was performed; death certificate-only; for lymphomas with a lymph node primary site; an unknown or ill-defined primary; or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease.	The status of regional lymph node evaluation should be known for surgically-treated cases (i.e., cases coded 19-90 in the data item *Surgery of Primary Site* [NAACCR Item #1290]). Review surgically treated cases coded 9 in *Scope of Regional Lymph Node Surgery* to confirm the code.

Examples:

a. Patient has a radical neck dissection and the number of lymph nodes removed is not stated. The appropriate code would be 3.

b. The patient has modified radical mastectomy with sentinel lymph node biopsy and axillary lymph node dissection. The final diagnosis is infiltrating ductal carcinoma with 2/12 axillary lymph nodes positive. The appropriate code would be 6, sentinel lymph node biopsy and code 3, 4, or 5 at same time, or timing not stated.

c. Transverse colon: Adenocarcinoma with extension into subserosa, 3/10 pericolic lymph nodes are positive. The appropriate code would be 5, four or more regional lymph nodes removed.

RX Date - Surgery

(NAACCR ITEM #1200) (FORDS pg. 233; SEER pg. 117)

Description

The date of the first cancer-directed surgical procedure performed at any facility.

Explanation

Documents the date of the first cancer-directed surgical procedure. This date may or may not reflect the date of the most definitive surgical procedure.

Coding Instructions

1. Record the date of the first surgical procedure of the types coded as *Surgical Procedure of Primary Site, Scope of Regional Lymph Node Surgery,* or *Surgical Procedure/Other Site.*

2. Date format is:

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

      ***Example*:** A patient was found to have a large polyp during a colonoscopy on January 8, 2017. 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 20170108.

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

      ***Example*:** Patient is seen for treatment recommendations following a mastectomy in March 2017. The exact day of surgery is unknown. Code the date of surgery as 201703.

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

      Example: A patient had a radical prostatectomy in 2017 and is now seen with bone mets. The month and day of the surgery are unknown. Code the date of surgery as 2017.

   d. Blank - when no known date applies (no surgery was done or it is unknown if surgery was done).

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

4. If two or more cancer-directed surgeries are performed, enter the date for the first cancer-directed surgery.

5. If surgery was done do not leave this field blank. If the date is unknown record the year of diagnosis as the surgery date and leave the month and day blank. Document in the text field that the date of surgery is unknown.

***Examples*:**

a. An incisional biopsy is performed on March 3, 2017 followed by a resection on March 17, 2017. Record the date of the resection (20170317) as the date of the first surgical procedure. An incisional biopsy is a diagnostic procedure, not a cancer-directed surgery.

b. February 1, 2017 a patient had a fine needle aspiration of a right breast mass, consistent with infiltrating ductal carcinoma. On February 15, 2017, the patient underwent a right modified radical mastectomy. The date of surgery would be recorded as 20170215.

c. Patient had a lumpectomy as part of first course of treatment for breast cancer in 2017, but the date is unknown. On June 3, 2017 she comes to your facility to begin chemotherapy. Record the date of surgery as 2017.

RX Date Surgery Flag

(NAACCR Data Item #1201) (FORDS pg.234; SEER pg. 118)

Description

This flag explains why there is no appropriate value in the corresponding date field, *RX Date Surgery*, NAACCR Item 1200.

Explanation

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

Coding Instructions

1. Leave this item blank if *Surgical Procedure of Primary Site* (NAACCR Item #1200) has a full or partial date recorded.

2. Code 10 if it is unknown whether any surgery was performed.

3. Code 11 if no surgical procedure was performed.

4. Code 12 if the *Date of First Surgical Procedure* cannot be determined or estimated, but the patient did receive first course surgery. Use this code **only** as a last resort.

Table 7.3 RX Date Surgery Flag Codes

CODE	DESCRIPTION
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any surgery performed).
11	No proper value is applicable in this context (for example, no surgery performed).
12	A proper value is applicable but not known. This event occurred, but the date is unknown and cannot be estimated. (that is, surgery was performed but the date is unknown).
(blank)	A valid date value is provided in item *Date of First Surgical Procedure* (NAACCR Item #1200).

RX Date - Most Definitive Surgical Resection of Primary Site

(NAACCR Item #3170) (FORDS pg. 236)

Description

Date of most definitive surgical resection of the primary site performed as part of the first course of treatment.

Explanation

This item is used to measure the lag time between diagnosis and the most definitive surgery of the primary site. This may or may not be the date of **RX Date - Surgery.** The most definitive surgery is the most extensive resection of the primary site done during the first course of treatment.

Example: The patient undergoes an excisional biopsy for right breast cancer on 1/2/2017, then undergoes a right modified radical mastectomy on 1/25/17. The RX Date – Surgery is 1/2/2017 since this is the date of the first surgery done as first course of treatment. 1/25/2017 is the date of the most definitive treatment, since the right modified mastectomy is more extensive than the excisional biopsy.

Note: Enter the date of the most definitive surgery even if the specimen is negative for residual malignancy.

Example: The patient undergoes a colonoscopy on 2/20/17 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 3/2/17. The resection shows no residual disease. The RX Date – Surgery is 2/20/17. The RX Date – MostDefSurg is 3/2/17 even though no cancer is found in the specimen.

RX Date - Mst Defn Srg Flag

(NAACCR Item #3171) (FORDS pg. 237)

Description

This flag explains why no appropriate value is in the field, RX Date Most Defn Srg.

Explanation

As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

1. Leave this item blank if *Date-Mst Defn Srg* (NAACCR Item #3170) has a full or partial date recorded.
2. Code 10 if it is unknown whether any surgery was performed.
3. Code 11 if no surgical procedure was performed.
4. Code 12 if the *Date –Mst Defn Srg* cannot be determined or estimated, but the patient did receive first course surgery. Use this code **only** as a last resort.

Table 7.4 RX Date – Mst Defn Srg Flag Codes

CODE	DESCRIPTION
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any surgery performed).
11	No proper value is applicable in this context (for example, no surgery performed).
12	A proper value is applicable but not known. This event occurred, but the date is unknown and cannot be estimated. (that is, surgery was performed but the date is unknown).
(blank)	A valid date value is provided in item *Date-Mst Defn Srg* (NAACCR Item #3170).

Surgical Procedure of Primary Site

(NAACCR Item #1290) (FORDS pg. 239; SEER pgs.119-120)

Description

Cancer-directed surgery is an operative procedure that actually removes, excises, or destroys cancer tissue of the primary site that is performed as part of the initial diagnostic and staging work-up or first course of therapy. Code the most definitive surgical procedure of the primary site performed at any facility as part of the first course of treatment. This field is for surgery of primary site only.

Explanation

Identifies the specific cancer-directed surgery of the primary site.

Coding Instructions

1. Code the type of surgery the patient received as part of the **first course of treatment** at any facility.

2. Code **00** if **no surgery** is performed on the primary site, **or** first course of treatment was active surveillance/watchful waiting, **or** if the case was diagnosed at autopsy; **excludes all sites and histologies that would be coded as 98**.

3. Use the site-specific coding scheme corresponding to the primary site or histology. Refer to the Site-specific Surgery Codes in Appendix B of the 2016 FORDS Manual on page 382: https://www.facs.org/~/media/files/quality%20programs/cancer/ncdb/fords%202016.ashx

4. Or, Appendix C of the 2016 SEER Coding and Staging Manual: https://seer.cancer.gov/manuals/2016/appendixc.html

Table 7.5 Surgical Procedure of Primary Site Codes

CODE	TYPE	DESCRIPTION
00	None	No surgical procedure of primary site. Diagnosed at autopsy only.
10–19	Site-specific codes; tumor destruction	Tumor destruction, no pathologic specimen produced. Refer to *Appendix B in the FORDS manual* for correct site-specific procedure code.
20–80	Site-specific codes; resection	Refer to *Appendix B in the FORDS manual* for correct site-specific procedure code.
90	Surgery, NOS	A surgical procedure to the primary site was done, but no information on the type of surgical procedure is provided.

98	Site-specific surgery codes; special	Special code for hematopoietic neoplasms; ill-defined sites; and unknown primaries. Refer to *Appendix B in the FORDS manual* for correct site-specific procedure code.
99	Unknown	Medical record does not state whether a surgical procedure of the primary site was performed and no information is available. Death certificate only.

5. Code the most **invasive, extensive, or definitive** surgery if the patient has multiple surgical procedures of the primary site even if there is no tumor found in the pathologic specimen. Codes 00–80 are listed in **hierarchical** but **not necessarily numerical order**. Code the procedure listed furthest down the list within the codes 10–80.

   ***Example*:** Patient has excisional breast biopsy that is positive for carcinoma. The patient chooses to have a modified radical mastectomy. The pathologic examination of the mastectomy specimen shows no residual tumor. Code the modified radical mastectomy.

6. Code **98** is used for hematopoietic, reticuloendothelial, immunoproliferative or myeloproliferative disease and for unknown or ill-defined sites unless the case is death certificate only.

   a. Hematopoietic neoplasms
      - Primary Site: C421 (all histologies)
      - Histologies: 9740, 9751, 9754-9759, 9762, 9930

   b. Unknown or ill-defined sites: C760-C768, C809 (all histologies)

7. Excisional biopsies that remove the entire tumor and/or leave only microscopic margins are coded in this field if no further more definitive surgery is done.

   Note: Code an **excisional biopsy**, even when documented as **incisional,** when:

   a. All disease is removed (margins free) OR

   b. All gross disease is removed and there is only **microscopic residual at the margin.**

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

FORDS Revised for 2016 pg.239 / 2016 SEER Manual, page 119

Note 1: Do not code an excisional biopsy when there is macroscopic residual disease.

Note 2: Shave or punch biopsies are most often diagnostic. Code as a surgical procedure **only** when the entire tumor is removed and margins are clear.

8. Surgery to remove regional or distant tissue or organs is coded in this field only if the tissue or organs are removed in continuity with the primary site (en bloc), except where noted in *Appendix B in the FORDS manual.* Specimens from an en bloc resection may be submitted to pathology separately.

   SEER Note: In continuity with or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily as a single specimen. Code an en bloc removal when the patient has a hysterectomy and an omentectomy.

9. 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.

10. If a previous surgical procedure to remove a portion of the primary site is followed by surgery to remove the remainder of the primary site, code the total or final results.

    ***Example*:** Patient has a partial mastectomy with positive margins. Two weeks later the patient has a modified radical mastectomy. Code the modified radical mastectomy.

11. For bladder, when only random biopsy procedures are performed, code surgery of primary site field to 00. [None; no surgery of primary site.]

12. Assign the surgery code(s) that best represents the extent of the surgical procedure that was actually carried out when surgery is aborted. If the procedure was aborted before anything took place, assign code 00.

13. For brain tumors, gross total resection (of tumor or mass) should be coded to 20, and not 55. Code 55 would indicate total resection of a lobe of the brain.

14. Code surgery for extra-lymphatic lymphoma using the site-specific surgery coding scheme (not lymph node scheme) for the primary site.

Reason for No Surgery of Primary Site

(NAACCR Item #1340) (FORDS pg. 258 SEER pgs. 128-130)

Description

Records the reason that no surgery was performed on the primary site. This field applies only to surgery of primary site.

Explanation

This data item provides information related to quality of care.

Coding Instructions

1. Assign code 0 when Surgery of Primary Site is coded in the range of 10-90 (surgery of the primary site was performed).

2. Assign a code in the range of 1-8 if Surgery of Primary Site is coded 00 or 98.

   Note: Referral to a surgeon is equivalent to a recommendation for surgery.

   a. Assign code **1** when:

      i. There is no information in the patient's medical record about surgery **AND**:

         - It is known that surgery is not usually performed for this type and/or stage of cancer

         OR

         - There is no reason to suspect that the patient would have had surgery of primary site.

         Example: The patient would not be a surgical candidate because of advance stage.

ii. The treatment plan offered multiple treatment options and the patient selected treatment that did not include surgery of the primary site.

***Example*:** Prostate cancer patient is offered three treatment options: a. Radical prostatectomy, b. Radiation therapy, or c. Hormone therapy. The patient chose radiation therapy. Assign code 1. Surgery of the primary site was not performed because it was not part of the planned first-course treatment. The treatment plan was for the patient to receive ONE of three treatment modality options. At no time did the physician recommend that the patient have all three treatments.

iii. Patient elected to pursue no treatment following the discussion of surgery. Discussion does not equal to recommendation.

iv. Watchful waiting/active surveillance (prostate).

b. Assign code **6** when it is **KNOWN** that surgery was recommended **AND** it is known that surgery was not performed **AND** there is no documentation explaining why surgery was not done.

c. Assign code **7** when the patient refuses recommended surgery **OR** makes a blanket statement that he/she refused all treatment when surgery is a customary option for the primary site/histology.

Note: Coding *Reason for No Surgery of Primary Site* as "refused" does not affect the coding of the other treatment fields. Code 7 means surgery is exactly what was recommended by the physician and the patient refused. If two treatment alternatives were offered and surgery was not chosen, code *Reason for No Surgery of Primary Site* as 1.

d. Assign code **8** when surgery is recommended, but it is unknown if the patient had the surgery.

***Example*:** There is documentation in the medical record that the primary care physician referred the patient to a surgical oncologist. Follow-back to the surgical oncologist and primary care physician yields no further information. Assign code 8.

3. Code **9** if the treatment plan offered multiple choices, but it is unknown which treatment, if any, was provided. For death certificate only (DCO) cases, and autopsy only cases.

Note: This table is also available in Quick Reference, Appendix H.

Table 7.6 Reason for No Surgery Codes

CODE	DESCRIPTION
0	Surgery of the primary site was performed.
1	Surgery of the primary site was not performed because it was not part of the planned first course treatment.
2	Surgery of the primary site was not recommended/performed because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, etc.)
5	Surgery of the primary site was not performed because the patient died prior to planned or recommended surgery.
6	Surgery of the primary site was not performed; it was recommended by the patient's physician, but was not performed as part of the first course of therapy. No reason was noted in the patient record.

CODE	DESCRIPTION
7	Surgery of the primary site was not performed: it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in the patient's record.
8	Surgery of the primary site was recommended, but it is unknown if it was performed. Further follow-up is recommended.
9	It is unknown whether surgery of the primary site was recommended or performed. Death certificate only. Diagnosed at autopsy.

***Examples*:**

a. A patient with primary tumor of the liver is not recommended for surgery due to advanced cirrhosis. The reason for no primary site surgery is 2, not recommended due to comorbid conditions.

b. A patient is referred to another facility for recommended surgical resection of a non-small cell lung carcinoma. There is no further information from the facility to which the patient was referred. The reason for no surgery of primary site is 8, recommended but unknown if performed.

RX Summ - Surg Other Reg/Dist RX Code

(NAACCR Item #1294) (FORDS pgs. 251-252; SEER pg. 127)

Description

Indicates the surgical removal of other regional site(s), distant site(s), or distant lymph node(s) beyond the primary site. Code the surgical procedure of other sites the patient received, at any facility, as part of the first course of treatment.

Explanation

Documents the extent of surgical treatment and is useful in evaluating the extent of metastatic disease.

Coding Instructions

1. The codes are **hierarchical.** Record the **highest numbered code** that describes the surgical resection of *distant lymph nodes or regional/distant tissues or organs* the patient received as part of the **first course of treatment** at any facility.

2. Do not code tissues or organs such as an appendix that were removed incidentally, and the organ was not involved with cancer.

   Note: Incidental removal of organs means that tissue was removed for reasons other than removing cancer or preventing the spread of cancer. Examples of incidental removal of organ(s) would be removal of appendix, gallbladder, etc., during abdominal surgery.

3. Codes 1-5 have priority over codes 0 and 9.

Table 7.7 RX Summ– Surg Other Reg/Dist RX Codes

CODE	DESCRIPTION	DEFINITION
0	None	No surgical procedure of non-primary site was performed. Diagnosed at autopsy.
1	Non-primary surgical procedure performed	Non-primary surgical procedure to other site(s), unknown if the site(s) is regional or distant.
2	Non-primary surgical procedure to other regional sites	Resection of regional site.
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.

***Examples*:**

a. The incidental removal of the appendix during a surgical procedure to remove a primary malignancy in the right colon is coded to 0.

b. Surgical biopsy of metastatic lesion from liver with an unknown primary is coded to 1.

c. Surgical ablation of solitary liver metastasis with a hepatic flexure primary is coded to 2 (Site regional by stage).

d. Excision of distant metastatic lymph nodes with a rectosigmoid primary is coded to 3.

e. Removal of a solitary brain metastasis with a lung primary is coded to 4 (site distant by stage).

f. Excision of a solitary liver metastasis and hilar lymph node with a rectosigmoid primary is coded to 5.

g. Assign code **1**:

   i. When any surgery is performed to remove tumors and the primary site is unknown or ill-defined (C760-C768, C809).

   ii. When any surgery is performed for hematopoietic neoplasms (C421 or M-9740, 9751, 9754-9759, 9762, 9930).

   iii. When the involved contralateral breast is removed for a single primary breast cancer.

RX Text Surgery

(NAACCR Item #2610)

Description
Text area for information describing all surgical procedures performed as part of treatment.

Explanation
Text documentation is an essential component of a complete abstract and used extensively for quality assurance, consolidation of information from multiple sources, and special studies.

Coding Instructions

1. Text information **MUST BE PROVIDED BY ALL FACILITIES.**
2. Document all first course surgery regardless of where it was done, in date order.
3. Document if no surgery was done, or if it cannot be determined if intended surgery was done.

   Example: 5/1/17 patient had a right lobe thyroidectomy. On 6/8/17 patient had completion thyroidectomy.

Note: See the Text Documentation section of the 2017 TCR CRH for further explanation and examples. **Please, do NOT enter text in this fields when treatment is either not done, or unknown if done. This information is conveyed by the treatment flags.**

Date Radiation Started

(NAACCR Item #1210) (FORDS pg. 237; SEER pg.140)

Description
The date the radiation therapy began at any facility as part of the first course of treatment.

Explanation
Identifies the date radiation therapy was initially started.

Coding Instructions

1. Record the date of the first cancer-directed radiation therapy.
2. Date format is:

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

      ***Example*:** A patient with breast cancer begins external beam radiation therapy on April 10, 2017. Code the date of radiation therapy as 20170410.

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

      Example: A patient was diagnosed with prostate cancer and underwent brachytherapy in January 2017 but the day is not known. Record date of radiation therapy as 201701.

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

      ***Example*:** A patient is seen with brain cancer in July 2017. It is known that the patient had radiation therapy earlier in the year, but the month and day are unknown. Record the date of radiation therapy as 2017.

d. Blank - when no known date applies (no radiation therapy was given or it is unknown if radiation was given).

***Example*:** A patient with a malignant brain tumor has refused all therapy including radiation therapy. Leave the date of radiation therapy blank.

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

4. If two or more types of radiation therapy are delivered, (for example: beam and isotopes; beam and implants) enter the date for the **first** type of radiation therapy.

5. If radiation therapy is given do not leave this field blank. If the date is not known record the year of diagnosis as the start date and leave the month and day blank. Document in the text field that the date of radiation therapy is unknown.

RX Date Radiation Flag

(NAACCR Item #1211) (FORDS pg. 260-261; SEER pg. 132)

Description

This flag explains why there is no appropriate value in the corresponding date field *Date Radiation Started.*

Explanation

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information previously transmitted in date field.

Coding Instructions

1. Leave this item blank if *Date Radiation Started* has a full or partial date recorded.

2. Code 10 if it is unknown whether any radiation was given.

3. Code 11 if no radiation is planned or given.

4. Code 12 if *Date Radiation Started* cannot be determined, but the patient did receive first course radiation. Use this code **only** as a last resource.

5. Code 15 if radiation is planned, but has not yet started and the start date is not yet available.

Table 7.8 RX Date Radiation Flag Codes

CODE	DESCRIPTION
10	No information whatsoever can be inferred from this exceptional value (unknown if any radiation was given).
11	No proper value is applicable in this context (for example, no radiation given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, radiation was given but the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (for example, radiation therapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up).
(blank)	A valid date value is provided in item *Date Radiation Started* (NAACCR Item 1210).

Radiation - Regional Treatment Modality

(NAACCR Item #1570) (FORDS pgs. 267-269)

Description

Records the dominant modality of radiation therapy used to deliver the clinically most significant dose to the primary volume of interest during first course of treatment.

Explanation

Radiation treatment is frequently delivered in two or more phases which can be summarized as "regional" and "boost" treatments. To evaluate patterns of radiation oncology care, it is necessary to know which radiation resources were employed in the delivery of therapy. For outcomes analysis, the modalities used for each of these phases can be very important.

Coding Instructions

1. Radiation treatment modality will typically be found in the radiation oncologist's summary letter for the first course of treatment. Segregation of treatment components into regional and boost, and determination of the respective treatment modality may require assistance from the radiation oncologist to ensure consistent coding.

2. In the event multiple radiation therapy modalities were employed in the treatment of the patient, record only the dominant modality (the greatest dose of radiation). It may be necessary to consult with the radiation oncologist to determine the dominant modality.

Note: that in some circumstances the boost treatment may precede the regional treatment. Record only the dominant modality.

3. For purposes of this data item, photons and x-rays are equivalent.

4. Radioembolization is defined as embolization combined with injecting small radioactive beads or coils into an organ or tumor. Code as brachytherapy when the tumor embolization is performed using a radioactive agent or radioactive seeds. Use code 50.

5. Tomotherapy is a form of intensity modulated radiation therapy (IMRT). Use code 31.

6. MammoSite radiation therapy is accomplished by the placement of wires with a radioactive bead attached. The MammoSite devise is the applicator with a balloon tipped end that is inserted into the surgical cavity which results from the removal of the tumor. MammoSite would be coded as brachytherapy, intracavitary, as there is no direct insertion into tissue.

7. Record all radiation therapy given as first course of treatment, even if it is palliative.

8. Do not confuse a radioiodine **scan** with treatment. Only treatment is recorded in this item.

Table 7.9 Radiation– Regional Treatment Modality Codes

CODE	TYPE	DESCRIPTION
00	No radiation treatment	Radiation therapy was not administered to the patient.
20	External beam, NOS	The treatment is known to be external beam, but there is insufficient information to determine the specific modality.
21	Orthovoltage	External beam therapy administered using equipment with a maximum energy of less than one (1) million volts (MV). Orthovoltage energies are typically expressed in units of kilovolts (kV).
22	Cobalt-60, Cesium-137	External beam therapy using a machine containing either a Cobalt-60 or Cesium-137 source. Intracavitary use of these sources is coded to 50 or 51.
23	Photons (2-5 MV)	External beam therapy using a photon-producing machine with beam energy in the range of 2-5 MV.
24	Photons (6-10 MV)	External beam therapy using a photon-producing machine with beam energy in the range of 6-10 MV.
25	Photons (11-19 MV)	External beam therapy using a photon-producing machine with beam energy in the range of 11-19 MV.
26	Photons (> 19 MV)	External beam therapy using a photon-producing machine with beam energy more than 19 MV.
27	Photons (mixed energies)	External beam therapy using more than one energy over the course of treatment.
28	Electrons	Treatment delivered by electron beam.
29	Photons and electrons mixed	Treatment delivered using a combination of photon and electron beams.
30	Neutrons with or without photons/electrons	Treatment delivered using neutron beam.
31	IMRT	Intensity modulated radiation therapy, an external beam technique that should be clearly stated in medical record.
32	Conformal or 3-D therapy	An external beam technique using multiple, fixed portals shaped to conform to a defined target volume. Should be clearly described as conformal or 3-D therapy in medical record.
40	Protons	Treatment delivered using proton therapy.
41	Stereotactic radiosurgery, NOS	Treatment delivered using stereotactic radiosurgery, type not specified in medical record.
42	Linac radiosurgery	Treatment categorized as using stereotactic technique delivered with a linear accelerator.
43	Gamma knife	Treatment categorized as using stereotactic technique delivered with a gamma knife machine.
50	Brachytherapy, NOS	Brachytherapy, interstitial implants, molds, seeds, needles, or intracavitary applicators of radioactive materials not otherwise specified.

CODE	TYPE	DESCRIPTION
51	Brachytherapy, intracavitary, low dose rate (LDR)	Intracavitary (no direct insertion into tissues) radioisotope treatment using LDR applicators and isotopes (Cesium-137, Fletcher applicator).
52	Brachytherapy, intracavitary, high dose rate (HDR)	Intracavitary (no direct insertion into tissues) radioisotope treatment using HDR after-loading applicators and isotopes.
53	Brachytherapy, Interstitial, LDR	Interstitial (direct insertion into tissues) radioisotope treatment using LDR sources.
54	Brachytherapy, Interstitial, HDR	Interstitial (direct insertion into tissues) radioisotope treatment using HDR sources.
55	Radium	Infrequently used for LDR interstitial and intracavitary therapy.
60	Radioisotopes, NOS	Iodine-131, Phosphorus-32, etc.
61	Strontium-89	Treatment primarily by intravenous routes for bone metastases.
62	Strontium-90	Same as above.
80*	Combination modality, specified	Combination of external beam radiation and either radioactive implants or radioisotopes. *Do not use for cases diagnosed on or after January 1, 2003.
85*	Combination modality, NOS	Combination of radiation treatment modalities not specified in code 80. *Do not use for cases diagnosed on or after January 1, 2003.
98	Other, NOS	Radiation therapy administered, but the treatment modality is not specified or is unknown.
99	Unknown	It is unknown whether radiation therapy was administered.

*For cases diagnosed prior to January 1, 2003, the codes reported in this data item describe any radiation therapy administered to the patient as part of the entire first course of treatment. Codes 80 and 85 describe specific converted descriptions of radiation therapy coded according to *Vol. II, ROADS* rules and **should not** be used to record regional radiation therapy for cases diagnosed on or after January 1, 2003.

RX Summ - Radiation

(NAACCR Item #1360) (SEER pgs. 133-137)

Description

Codes for the type of radiation therapy performed as part of the first course of treatment, even if it is palliative.

Explanation

Identifies the type of radiation therapy administered from either external or internal.

Coding Instructions

1. Assign code 0 when:

   a. The medical record states that radiation was not given, was not recommended, or was not indicated.

   b. There is no information in the patient's medical record about radiation **AND**:

      - It is known that radiation is not usually performed for this type and/or stage of cancer **OR**
      - There is no reason to suspect that the patient would have had radiation.

   c. The treatment plan offered multiple treatment options and the patient selected treatment that did not include radiation.

   d. Patient elected to pursue no treatment following the discussion of radiation treatment. Discussion does not equal a recommendation.

   e. Watchful waiting/active surveillance (prostate).

   f. Patient diagnosed at autopsy.

   g. Radiotherapy recommended, but patient died before receiving radiotherapy.

2. Assign code 1 for:

   a. Beam radiation directed to cancer tissue. The source of the beam radiation is not coded. Sources may include, but are not limited to: X-ray, cobalt, linear accelerator, neutron beam, betatron, intensity modulated radiation therapy (IMRT), spray radiation, stereotactic radiosurgery such as gamma knife, cyberknife, and proton beam.

   b. Total body irradiation (TBI) prior to a bone marrow transplant.

3. Assign code 2 when the radiation is delivered by interstitial implant, seeds, needles or intracavitary applicators. The radioactive material used in implants includes, but is not limited to: cesium, radium, radon, radioactive gold, and iodine.

   ***Example*:** Brachytherapy with 125 seeds. Assign code 2. Seeds are always low dose therapy because they are left in place and the radioactivity decays over time.

4. Assign code 3

   a. When radioactive isotopes are given orally, intracavitary or by intravenous injection. Radioactive isotopes include but are not limited to: I-131 or P-32.

   b. For 90-Yttrium and for 131-Iodine when given with Rituxan as treatment for lymphoma. (Code Rituxan as **immunotherapy**).

      Note: Rituxan is given in combination with the monoclonal antibody Zevalin conjugated to 90-Yttrium or the monoclonal antibody Bexxar conjugated to 131-Iodine in the treatment of NHL. The monoclonal antibody is only the delivery agent for radioisotope. Do not code Zevalin or Bexxar as chemotherapy. Refer to the definition of Monoclonal Antibodies.

5. Assign code 4 when the patient has beam radiation **and** either radioactive implants or radioisotopes.

6. Assign code 7 when:

   a. The patient refused recommended radiotherapy.

   b. The patient made a blanket refusal of all recommended treatment and radiotherapy is a customary option for the primary site/histology.

   c. The patient refused all treatment before any was recommended and radiotherapy is a customary option for the primary site/histology.

7. Assign code 8 when:

   a. Radiation has been recommended, but there is no confirmation of its actually being delivered.

   b. The only information available is that the patient was referred to a radiation oncologist.

   Note: Review cases coded 8 periodically for later confirmation of radiation therapy.

   ***Example*:** Mammocyte intracavitary radiation therapy device was placed in the breast, but there is no documentation of radiation actually being given. Assign code 8. Check this case periodically and update the code when further information becomes available.

8. Assign code 9 when there is no documentation that radiation was recommended or performed.

Table 7.10 RX Summ-Radiation Codes

CODE	DESCRIPTION
0	None; Diagnosed at autopsy
1	Beam radiation
2	Radioactive implants
3	Radioisotopes
4	Combination of 1 with 2 or 3
5	Radiation, NOS-method of source not specified
7	Patient or patient's guardian refused radiation therapy
8	Radiation recommended, unknown if administered
9	Unknown if radiation administered, death certificate only (DCO) cases

Translation of Regional Treatment Modality and/or Boost Treatment Modality Field to Radiation

RX Summ-Rad. Code	Radiation	RegTreatment Modality Code	Regional Treatment Modality and/or Boost Treatment
0	None	00	No radiation treatment
1	Beam radiation	20	External beam, NOS
		21	Orthovoltage
		22	Cobalt-60, Cesium-137
		23	Photons (2-5 MV)
		24	Photons (6-10 MV)
		25	Photons (11-19 MV)
		26	Photons (>19 MV)

RX Summ-Rad. Code	Radiation	RegTreatment Modality Code	Regional Treatment Modality and/or Boost Treatment
		27	Photons (mixed energies)
		28	Electrons
		29	Photons and electrons mixed
		30	Neutrons, with or without photons/electrons
		31	IMRT
		32	Conformal or 3-D therapy
		40	Protons
		41	Stereotactic radiosurgery, NOS
		42	Linac radiosurgery
		43	Gamma Knife
2	Radioactive implants	50	Brachytherapy, NOS
		51	Brachytherapy, intracavitary, LDR
		52	Brachytherapy, intracavitary, HDR
		53	Brachytherapy, interstitial, LDR
		54	Brachytherapy, interstitial, HDR
		55	Radium
3	Radioisotopes	60	Radioisotopes, NOS
		61	Strontium-89
		62	Strontium-90
4	Combination of 1 with 2 or 3	80	Combination modality, specified
		85	Combination modality, NOS
5	Radiation therapy, NOS, method or source unspecified	98	Other, NOS
9	Unknown	99	Unknown

RX Text Radiation

(NAACCR Item #2620 and 2630)

Description

Text area for manual documentation of information regarding treatment of the tumor being reported with beam radiation and/or other radiation therapy.

Explanation

Text documentation is an essential component of a complete abstract and used extensively for quality assurance, consolidation of information from multiple sources, and special studies.

Coding instructions

1. Text information to support radiation treatment **MUST BE PROVIDED BY ALL FACILITIES.**

2. Document all first course therapy radiation treatment regardless of where it was done, in date order.

3. Document if no radiation therapy was done, or if it cannot be determined if intended radiation therapy was done.

   ***Example*:** External beam radiation therapy completed on 6/15/17, start date not given. Estimate start date 5/2017.

Note: See the Text Documentation section of the 2017 Handbook (page 248) for further explanation and examples.

Please do not to enter text in this field when treatment is either not done, or unknown if done. This information is conveyed by the treatment flags.

RX Summary - Surgery/Radiation Sequence

(NAACCR Item #1380) (FORDS pg. 276-277; SEER pg.138-139)

Description

Records the sequencing of radiation and surgical procedures given as part of the first course of treatment.

Explanation

The sequence of radiation and surgical procedures given as part of the first course of treatment cannot always be determined using the date on which each modality was started or performed. This data item can be used to more precisely evaluate the timing of delivery of treatment to the patient.

Coding Instructions

1. For the purpose of coding radiation sequence with surgery, "Surgery" is defined as a surgical procedure to the primary site (codes 10–90) or scope of regional lymph node surgery (codes 1–7) or surgical procedure of other site (codes 1–5). If all of these procedures are coded 0, then this item should be coded 0.

2. Assign code 0 when:

   a. The patient did not have either surgery or radiation.

   b. The patient had surgery but not radiation.

   c. The patient had radiation but not surgery.

   d. It is unknown whether or not the patient had surgery and/or radiation.

3. If a patient received both radiation therapy and any one or a combination of the following surgical procedures: Surgical procedure of primary site, regional lymph node surgery, or surgical procedure of another site, then code this item 2–9 as appropriate.

4. If multiple first course treatment episodes were given such that both codes 4 and 7 seem to apply, use the code that defines the first sequence that applies.

   a. Assign code 4 when there at least two episodes or fractions of radiation therapy.

Example:
1. Preoperative radiation therapy was administered to shrink a large, bulky lesion.
2. Resection was performed.
3. Postoperative radiation therapy was administered after resection.

b. Assign code **7** when there are at least two surgeries; radiation was administered between one surgical procedure and a subsequent surgical procedure.

Example 1:
1. Sentinel lymph node biopsy.
2. Radiation therapy.
3. Surgery of primary site.

Code Radiation Sequence with Surgery as 7 (surgery both before and after radiation).

Example 2:
1. Lymph node aspiration.
2. Radiation.
3. Surgery of primary site.

Code Radiation Sequence with Surgery as 7 (surgery both before and after radiation) BECAUSE lymph node aspiration is coded in Scope of Regional Lymph Node Surge.

Note: This table is also available in the Quick Reference, Appendix H.

Table 7.11 RX Summary-Surgery/Radiation Sequence Codes

CODE	LABEL	DESCRIPTION
0	No radiation therapy and/or surgical procedures	No radiation therapy given or **unknown** if radiation therapy given; and/or no surgery of the primary site; no scope of regional lymph node surgery; no surgery to other regional site(s), distant site(s), or distant lymph node(s) or it is **unknown** whether any surgery was given.
2	Radiation therapy before surgery	Radiation therapy given before surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
3	Radiation therapy after surgery	Radiation therapy given after surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
4	Radiation therapy both before and after surgery	At least two courses of radiation therapy are given before and surgery to the primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
5	Intraoperative radiation therapy	Intraoperative therapy given during surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).

CODE	LABEL	DESCRIPTION
6	Intraoperative radiation therapy with other therapy administered before or after surgery	Intraoperative radiation therapy given during surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s) with other radiation therapy administered before or after surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
7	Surgery both before and after radiation (for cases diagnosed 1/1/2012 and later)	Radiation was administered between two separate surgical procedures to the primary site; regional lymph nodes; surgery to other regional site(s), distant site(s), or distant lymph node(s).
9	Sequence unknown, but both surgery and radiation were given	Administration of radiation therapy and surgery to primary site, scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s) were performed and the sequence of the treatment is not stated in the patient record.

***Examples*:**

a. Due to other medical conditions surgery was not performed. The patient received palliative radiation therapy to alleviate pain. Use code 0.

b. Patient received radiation therapy prior to resection of a lung lesion. Use code 2.

c. A patient underwent excisional biopsy of a right breast mass followed by radiation therapy to breast. Use code 3.

d. Preoperative radiation therapy was given to a large bulky vulvar lesion, followed by a lymph node dissection. Radiation therapy was then given to treat positive lymph nodes. Use code 4.

e. A cone biopsy of the cervix was followed by intracavitary implant for IIIB cervical carcinoma. Use code 5.

f. Stage IV vaginal carcinoma was treated with 5,000 cGy to the pelvis followed by a lymph node dissection and 2,500 cGy of intracavitary brachytherapy. Use code 6.

g. A primary of the head and neck was treated with surgery and radiation prior to admission, but the sequence is unknown. Use code 9.

h. Patient has an unknown primary. A radical neck dissection is done followed by radiation therapy. Use code 3.

Reason For No Radiation

(NAACCR Item #1430) (FORDS pg. 281)

Description

Records the reason that no regional radiation therapy was administered to the patient.

Explanation

When evaluating the quality of care, it is useful to know the reason that various methods of therapy were not used, and whether the failure to provide a given type of therapy was due to the physician's

failure to recommend that treatment, or due to the refusal of the patient, a family member, or the patient's guardian.

Coding Instructions

1. If *Regional treatment Modality* (NAACCR Item #1570) is coded 00, then record the reason based on documentation in patient record.

2. Code **1** if the treatment plan offered multiple alternative treatment options and the patient selected treatment that did not include radiation therapy.

   ***Example*:** A patient with Stage I prostate cancer is offered either surgery OR brachytherapy to treat his disease. The patient elects to be surgically treated. Code *Reason for No Surgery* 1.

3. Code **7** if the patient refused recommended radiation therapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.

4. Code **8** if it is known that a physician recommended radiation treatment, but no further documentation is available yet to confirm its administration.

5. Cases coded **8** should be followed and updated to a more definitive code as appropriate.

6. Code **9** if the treatment plan offered multiple alternative treatment options, but it is unknown which treatment, if any, was provided.

Table 7.12 Reason for No Radiation Codes

CODE	DESCRIPTION
0	Radiation therapy was administered.
1	Radiation therapy was not administered because it was not part of the planned first course treatment. Diagnosed at autopsy.
2	Radiation therapy was not recommended/administered because it was contraindicated due to other patient risk factors (comorbid conditions, advanced age, progression of tumor prior to planned radiation).
5	Radiation therapy was not administered because the patient died prior to planned or recommended therapy.
6	Radiation therapy was not administered; it was recommended by the patient's physician, but was not administered as part of first course treatment. No reason was noted in patient record.
7	Radiation therapy was not administered; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in patient record.
8	Radiation therapy was recommended, but it is unknown whether it was administered.
9	It is unknown if radiation therapy was recommended or administered. Death certificate cases only.

Date Chemotherapy Started

(NAACCR Item 1220) (FORDS pg. 285; SEER pg. 148)

Description

The date of initiation of chemotherapy that is part of the first course of treatment.

Explanation

Collecting dates for each treatment modality allows the sequencing of multiple treatments and aids in the evaluation of time intervals from diagnosis to treatment and from treatment to recurrence.

Coding Instructions

1. Record the first or earliest date on which chemotherapy was administered by any facility.
2. Date format is:
   a. YYYYMMDD - when the complete date is known and valid.

      ***Example*:** A patient with colon cancer begins 5-FU on February 5, 2017. Record the date as 20170205.

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

      ***Example*:** A patient started chemotherapy in March 2017 but the exact day is not known. Record 201703.

   c. Blank - when no known date is applicable (no chemotherapy was given or it is unknown if chemotherapy was given).
3. Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.
4. Do not leave the date blank if chemotherapy was administered. If the date is unknown code the year of diagnosis as the start date and leave the day and month blank. Document in the text field that the complete first date of chemotherapy is not known.

   ***Example*:** The patient had breast cancer diagnosed in April 2017. She has completed chemotherapy and now comes to your facility for radiation therapy. Record the date of chemotherapy as 2017.

RX Date Chemo Flag

(NAACCR Item #1221) (FORDS pgs. 286-287; SEER pg. 143)

Description

This flag explains why there is no appropriate value in the corresponding date field.

Explanation

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information previously transmitted in date fields.

Instructions

1. Leave this item blank if *Date Chemotherapy Started* has a full or partial date recorded.
2. Code 10 if it is unknown whether any chemotherapy was given.

3. Code 11 if no chemotherapy is planned or given.

4. Code 12 if the *Date Chemotherapy Started* cannot be determined or estimated, but the patient did receive first course chemotherapy. Use this code **only** as a last resort.

5. Code 15 if chemotherapy is planned, but not yet started.

Table 7.13 RX Date Chemo Flag Codes

CODE	DESCRIPTION
10	No information whatsoever can be inferred from this exceptional value (unknown if chemotherapy was given).
11	No proper value is applicable in this context (no chemotherapy given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, chemotherapy was given but the date is unknown and cannot be estimated).
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). Case was diagnosed between 2003 and 2009 and the facility did not record *Date Chemotherapy Started* (NAACCR Item #1220) at that time.

RX Summ - Chemo (Chemotherapy)

(NAACCR Item #1390) (FORDS pg. 288-289; SEER pgs. 144-149)

Description

Chemotherapy is a chemical (or group of chemicals) administered to treat cancer. Chemotherapy consists of a group of anti-cancer drugs that inhibit the reproduction of cancer cells. Chemotherapeutic agents may be administered by intravenous infusion or given orally.

Explanation

This data item allows for the evaluation of the administration of chemotherapeutic agents as part of the first course of therapy.

Coding Instructions

1. Refer to *SEER*RX* for direction on coding systemic therapy appropriately.

2. Code the chemotherapeutic agents whose actions are chemotherapeutic only; **do not code** the method of **administration**.

3. When chemotherapeutic agents are used as radiosensitizers or radioprotectants, they are given at a much lower dosage and do not affect the cancer. Radiosensitizers and radioprotectants are classified as ancillary drugs. **Do not code as chemotherapy**.

Note: Do not assume that a chemo agent given with radiation therapy is a radiosensitizers. Seek additional information. Compare the dose given to the dose normally given for treatment.

4. The physician may change a drug during the first course of therapy because the patient cannot tolerate the original agent .

a. This is a continuation of the first course of therapy when the chemotherapeutic agent that is substituted belongs to the same group (alkylating, antimetabolites, natural products, or other miscellaneous).

b. Do **not** code the new agent as first course therapy when the original chemotherapeutic agent is changed to one that is NOT in the same group. Code only the original agent as first course.

c. Use *SEER*RX* and compare the subcategory of each chemotherapy agent to determine whether or not they belong to the same group (subcategory). See "Chemotherapeutic Agents" below for the groups and their definitions.

5. Code as treatment for both primaries when the patient receives chemotherapy for invasive carcinoma in one breast and also has in situ carcinoma in the other breast. Chemotherapy would likely affect both primaries.

6. Assign Code 00 when:

   a. The medical record documents chemotherapy was not given, was not recommended, or was not indicated.

   b. There is no information in the patient's medical record about chemotherapy **AND**

      - It is known that chemotherapy is not usually performed for this type and/or stage of cancer **OR**
      - There is no reason to suspect that the patient would have had chemotherapy

   c. If the treatment plan offered multiple treatment options and the patient selected treatment that did not include chemotherapy.

   d. Patient elects to pursue no treatment following the discussion of chemotherapy. **Discussion does not equal a recommendation.**

   e. Watchful waiting/active surveillance is the first course of treatment (e.g., CLL).

   f. Patient diagnosed at autopsy.

      Example: Patient is diagnosed with plasma cell myeloma. There is no mention of treatment or treatment plans in the medical record. Follow-back finds that the patient died three months after diagnosis. There are no additional medical records or other pertinent information available. Assign code 00 since there is no reason to suspect that the patient had been treated.

7. Do not code combination of ancillary drugs administered with single agent chemotherapeutic agents as multiple chemotherapy. For example, the administration of 5-FU (antimetabolite) and Leucovorin (ancillary drug) is coded to single agent (Code 02).

8. Code to **01** if chemotherapy was administered as first course treatment, but the type and number of agents is not documented in the patient record.

9. Assign Code **02** when single agent chemotherapy was administered as first course therapy.

   Single agent chemotherapy: Only one chemotherapeutic agent was administered to destroy cancer tissue during the first course of therapy. The chemotherapeutic agent may or may not have been administered with other drugs classified as immunotherapy, hormone therapy, ancillary, or other treatment.

Note: Do not code combination of ancillary drugs administered with single agent chemotherapeutic agents as multiple chemotherapy. For example the administration of 5-FU (antimetabolite) and Leucovorin (ancillary drug) is coded to single agent (Code 02).

10. Assign code **03** if multiagent chemotherapy was administered as first course therapy.

    Multiple agent chemotherapy: Planned first course of therapy included two or more chemotherapeutic agents and those agents were administered. The planned first course of therapy may or may not have included other agents such as hormone therapy, immunotherapy, or other treatment in addition to the chemotherapeutic agents.

11. Assign code **82** when chemotherapy is a customary option for the primary site/histology but it was not administered due to patient risk factors such as advanced **age** or **comorbid** conditions(s) (heart disease, kidney failure, other cancer etc.).

12. Assign code **87** if the patient **refused** the recommended chemotherapy, made a **blanket refusal** of all recommended treatment, or **refused all treatment** before any was recommended and chemotherapy is a customary option for the primary site/histology.

13. Assign code **88** when the only information available is that the patient was **referred** to an oncologist or there was an insertion of a **port-a-cath**.

Note: Review cases coded **88** periodically for later confirmation of chemotherapy. If follow-up indicates the patient was never seen by the oncologist, change the code to 00.

Note: A referral to a clinical oncologist is equivalent to a recommendation.

Chemotherapy recommended: A consult recommended chemotherapy, or the attending physician documented that chemotherapy was recommended. A referral to a clinical oncologist is equivalent to a recommendation.

14. Assign code **99** when there is no documentation that chemotherapy was recommended or administered. For death certificate only (DCO) cases.

Chemotherapeutic Agents

Chemotherapeutic agents are chemicals that affect cancer tissue by means other than hormonal manipulation. Chemotherapeutic agents can be divided into five groups:

- Alkylating agents
- Antimetabolites
- Natural Products
- Targeted therapy
- Miscellaneous

Alkylating Agents

Alkylating agents are **not cell-cycle-specific**. Although they are toxic to all cells, they are most active in the resting phase of the cell. Alkylating agents directly damage DNA to prevent the cancer cell from reproducing. Alkylating agents are used to treat many different cancers including acute and chronic leukemia, lymphoma, Hodgkin disease, multiple myeloma, sarcoma, and cancers of the lung,

breast and ovary. Because the drugs damage DNA they can cause long-term damage to the bone marrow and can, in rare cases, lead to acute leukemia. The risk of leukemia from alkylating agents is "dose-dependent." Examples of alkylating agents include:

- Mustard gas derivatives/nitrogen mustards: Mechlorethamine, Cyclophosphamide, Chlorambucil, Melphalan, and Isosfmide
- Ethylemines: Thiotepa and Hexamethylmelamine
- Alkylsulfonates: Busulfan
- Hydrazines and Trizines: Alkretamine, Procarbazine, Decarbazine, and Temozolomide
- Nitrosureas: Camustine, Lomustine and Streptozcin. Nitrosureas are unique because they can cross the blood-brain barrier and can be used in treating brain tumors
- Metal salts: Carboplatin, Cisplatin, and Oxaliplatin

Antimetabolites

Antimetabolites are cell-cycle specific. Antimetabolites are very similar to normal substances within the cell. When the cells incorporate these substances into the cellular metabolism, they are unable to divide. Antimetabolites are classified according to the substances with which they interfere.

- Folic acid antagonist: Methotrexate
- Pyrimidine antagonist: 5-Florouracil, Foxuridine, Cytarabine, Capecitabine, and Gemcitabine
- Purine antagonist: 6-Mercaptopurine and 6-Thioguanine
- Adenosine deaminase inhibitor: Cladribine, Fludarabine, Nelarabine, and Pentostatin

Natural Products

1. Plant Alkaloids are **cell-cycle specific** which means they attack the cells during various phases of division. They block cell division by preventing microtubule function. Microtubules are vital for cell division. Without them, division cannot occur. Plant alkaloids, as the name implies, are derived from certain types of plants.
    - Vinca alkaloids: Vincristine, Vinblastine, and Vinorelbine
    - Taxanes: Paclitaxel and Docetaxel
    - Podphyllotoxins: Etoposide and Tenisopide
    - Camptothecan analogs: Innotecan and Topotecan

2. Antitumor antibiotics are also **cell-cycle specific** and act during multiple phases of the cell cycle. They are made from natural products and were first produced by the soil fungus Streptomyces. Antitumor antibiotics form free radicals that break DNA strands, stopping the multiplication of cancer cells.
    - Anthracyclines: Doxorubicin, Danorubicin, Epirubicin, Mitoxantone, and Idabicin
    - Chromomycins: Dactinomycin and Plicamycin
    - Miscellaneous: Mitomycin and Bleomycin

3. Topoisomerase inhibitors interfere with the action of topoisomerase enzymes (topoisomerase I and II). They control the manipulation of the structure of DNA necessary for replication.
    - Topoisomerase I inhibitors: Ironotecan, Topotecan
    - Topoisomerase II inhibitors: Amasrine, Etoposide, Etoposide phosphate, Tenisopide

Targeted therapy
Targeted cancer therapies are drugs or other substances that block the growth and spread of cancer by interfering with specific molecules ("molecular targets") that are involved in the growth, progression, and spread of cancer. Targeted cancer therapies are sometimes called "molecularly targeted drugs," "molecularly targeted therapies," "precision medicines," or similar names. Examples of molecularly targeted therapy are imatinib (Gleevec), lapatinib (Tykerb), erlotinib (Tarceva), sunitinib (Sutent).

Molecular targeted therapy
MTT. Agents in this type of therapy are vastly different from the traditional chemotherapeutic agents. These new drugs are designed to target unique or abnormally-expressed molecules within cancer cells while sparing normal cells.

Miscellaneous
Miscellaneous antineoplastics that are unique—

- Ribonucleotide reductase inhibitor: Hydroxyurea
- Adrenocortical steroid inhibitor: Mitotane
- Enzymes: Asparaginase and Pegaspargase
- Antimicrotubule agent: Estramustine
- Retinoids: Bexatene, Isotretinoin, Tretinoin (ATRA)

Coding for Tumor Embolization

The American College of Surgeons Commission on Cancer (CoC), the Centers for Disease Control and Prevention National Program of Cancer Registries (NPCR), and the SEER Program have collaborated to clarify and refine coding directives for tumor embolization and are jointly issuing the following instructions.

Definitions

Chemoembolization
A procedure in which the blood supply to the tumor is blocked surgically or mechanically and anticancer drugs are administered directly into the tumor. This permits a higher concentration of drug to be in contact with the tumor for a longer period of time.

Radioembolization
Embolization combined with the injection of small radioactive beads or coils into an organ or tumor.

Tumor embolization
The intentional blockage of an artery or vein to stop the flow of blood through the desired vessel.

Coding Instructions

Code as Chemotherapy when the embolizing agent(s) is a chemotherapeutic drug(s). Use https://seer.cancer.gov/seertools/seerrx/ to determine whether the drugs used are classified as chemotherapeutic agents. Use codes 01, 02, 03 as specific information regarding the agent(s) is documented.

Example: The patient has hepatocellular carcinoma (primary liver cancer). From a procedure report: Under x-ray guidance, a small catheter is inserted into an artery in the groin. The catheter's tip is threaded into the artery in the liver that supplies blood flow to the tumor. Chemotherapy is injected through the catheter into the tumor and mixed with particles that embolize or block the flow of blood to the tumor.

Do not code pre-surgical embolization of hypervascular tumors with particles, coils or alcohol. Pre-surgical embolization is typically performed to prevent excess bleeding during the resection of the primary tumor. Examples where pre-surgical embolization is used include meningiomas, hemangioblastomas, paragangliomas, and renal cell metastases in the brain.

Note: This table is also available in the Quick Reference, Appendix H.

Table 7.14 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. Death certificate only.

***Examples*:**

a. A patient with primary liver cancer is known to have received chemotherapy. The type(s) of agent(s) delivered is not documented in the medical record. Record **code 01** and document the information in the treatment documentation text field.

b. A patient with Stage III colon cancer is treated with a combination of fluorouracil and levamisole. Code the fluorouracil as a single agent and the levamisole as an immunotherapeutic agent. Record **code 02** and document the information in the treatment documentation data field.

c. A patient with early stage breast cancer receives chemotherapy. The medical record indicated a **combination regimen** containing doxorubicin is to be administered. Record **code 03** and document the information in the treatment documentation data field.

d. Following surgical resection of an ovarian mass the physician recommends chemotherapy. The medical record states chemotherapy was not delivered and the reason is not documented. Record **code 86** and document that the medical record states chemo not delivered but no reason given.

e. Patient has hepatocellular carcinoma. Under x-ray guidance, a small catheter is inserted into an artery in the groin. The catheter's tip is threaded into the artery in the liver that supplies blood flow to the tumor. A chemotherapy agent is injected through the catheter into the tumor and mixed with particles that embolize or block the flow of blood to the diseased tissue. Record **code 02** and document that chemoembolization was done.

RX Text Chemo

(NAACCR Item # 2640)

Description

Text area for documentation of information regarding chemotherapy treatment of the reported tumor.

Explanation

Text documentation is an essential component of a complete abstract and used extensively for quality assurance, consolidation of information from multiple sources, and special studies.

Coding Instructions

1. Text information to support chemotherapy treatment information **MUST BE PROVIDED BY ALL FACILITIES.**
2. Document all first course therapy chemotherapy information regardless of where it was done, in date order.
3. Document if no chemotherapy was given, or if it cannot be determined if intended chemotherapy was given.

   ***Example*:** 3/15/17 Oncologist recommends 4 cycles adjuvant taxol and carboplatin. PT wants treatment closer to home, referred to oncologist in his area. PT seen on 10/4/17 and physician notes patient has completed 4 cycles of taxol and carboplatin.

Note: See the Text Documentation section of the 2017 Handbook (page 248) for further explanation and examples.

Please do not to enter text in this field when treatment is either not done, or unknown if done. This information is conveyed by the treatment flags.

Date Hormone Therapy Started

(NAACCR Item #1230) (FORDS pg. 292; SEER pg. 150)

Description

Records the date of initiation of hormone therapy that is part of the first course of treatment.

Explanation

Collecting dates for each treatment modality allows the sequencing of multiple treatments and aids in the evaluation of time intervals from diagnosis to treatment and from treatment to recurrence.

Coding Instructions

1. Record the first or earliest date on which hormone therapy was administered by any facility.
2. Date format is:
   a. YYYYMMDD - when the complete date is known and valid.

      ***Example*:** A patient with recently diagnosed prostate cancer begins Lupron therapy on January 21, 2017. Record the date as 20170121.

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

      ***Example*:** A patient with breast cancer completed chemotherapy and then began Tamoxifen in April 2017, but the exact day is not known. Record the start date as 201704.

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

      ***Example*:** A patient with prostate cancer started Lupron therapy earlier this year, but there is no information regarding the month and day. Record 2017 as the start date.

   d. Blank - when no known date applies (no hormone therapy was given, or it is unknown if any hormone therapy was given).
3. Punctuation marks (slashes, dashes, etc.) are not allowed in any date field.
4. If hormone therapy was administered do not leave the date blank. If the start date is not known, record the year of diagnosis as the start date and leave the month and day blank. Document in the text field that the date of hormone treatment is unknown.

RX Date - Hormone Flag

(NAACCR ITEM #1231) (FORDS pgs. 293-294; SEER pg.151)

Description

This flag explains why there is no appropriate value in the corresponding date field *Date Hormone Therapy Started*.

Explanation

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information previously transmitted in the date field.

Coding Instructions

1. Leave this item blank if *Date Hormone Therapy Started* has a full or partial date recorded.
2. Code 10 if it is unknown whether any hormone therapy was given.
3. Code 11 if no hormone therapy is planned or given.
4. Code 12 if the *Date Hormone Therapy Started* cannot be determined or estimated, but the patient did receive first course hormone therapy. Use this code **only** as a last resort.
5. Code 15 if hormone therapy is planned, but not yet started.

Table 7.15 RX Date-Hormone Flag Codes

CODE	DESCRIPTION
10	No information whatsoever can be inferred from this exceptional value (unknown if any hormone therapy was given).
11	No proper value is applicable in this context (no hormone therapy given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, hormone therapy was given but the date is unknown and cannot be estimated).
15	Information is not available at this time, but it is expected that it will be available later (hormone therapy is planned as part of first course treatment, but had not yet started at the time of the last follow-up).
(blank)	A valid date is provided in item *Date Hormone Therapy Started* (NAACCR Item #1230). Case was diagnosed between 2003 and 2009 and the facility did not record *Date Hormone Therapy Started* NAACCR Item #1230) at that time.

RX Summ - Hormone - Hormone Therapy (Hormone/Steroid Therapy)

(NAACCR Item #1400) (FORDS pgs. 295-296; SEER pgs. 158-160)

Description

Hormone therapy is a drug or group of drugs that is delivered to change the hormone balance. Hormone therapy may affect a long-term control of the cancer growth. It is not usually curative.

Note: Hormone therapy is administered to treat cancer tissue and is considered to achieve its effect through change of the hormone balance. Some cancers, such as prostate or breast, depend upon hormones to develop. When a malignancy arises in these tissues, it is usually hormone-responsive. Other primaries and histologic types may be hormone-responsive, such as melanoma and hypernephroma.

Explanation

This data item allows for the analysis of hormone treatment as part of the first course of therapy.

Coding Instructions

1. Code the type of hormone therapy the patient received as part of the **first course of treatment** at any facility. Hormone therapy may involve the delivery of one or a combination of agents.

2. Refer to *SEER*Rx* for direction on coding hormone therapy appropriately.

3. Code the hormonal agent given as part of combination chemotherapy regimen, such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone), or COPP (cyclophosphamide, vincristine, procarbazine, prednisone), whether it affects the cancer cells or not.

Note: Do not code prednisone as hormone therapy when it is administered for reasons other than chemotherapeutic treatment.

4. Some types of cancers are slowed or suppressed by hormones. These cancers are treated by administering hormones and should be coded in this data field.

   ***Example*:** Endometrial cancer may be treated with progesterone. Even if the progesterone is given for menopausal symptoms, it has an effect on the growth or recurrence of endometrial cancer and should be coded.

5. Assign code **00** when
   a. The medical record states that hormone therapy was not given, was not recommended, or was not indicated
   b. There is no information in the patient's medical record about hormone therapy **AND**
      - It is known that hormone therapy is not usually performed for this type and/or stage of cancer **OR**
      - There is no reason to suspect that the patient would have had hormone therapy
   c. If the treatment plan offered multiple treatment options and the patient selected treatment that did not include hormone therapy
   d. Patient elected to pursue no treatment following the discussion of hormone therapy treatment. Discussion does not equal a recommendation
   e. Watchful waiting, active surveillance (prostate)
   f. Patient diagnosed at autopsy
   g. Hormone treatment was given for a non-reportable condition or as chemoprevention prior to diagnosis of a reportable condition

      Example 1: Tamoxifen given for hyperplasia of breast four years prior to breast cancer diagnosis. Code 00 in Hormone therapy. Do not code tamoxifen given for hyperplasia as treatment for breast cancer.

      Example 2: Patient with a genetic predisposition to breast cancer is on preventative hormone therapy. Do not code hormone therapy given before cancer is diagnosed.
6. Code to **01** for thyroid replacement therapy, which inhibits the thyroid stimulating hormone (TSH). TSH is a product of the pituitary gland that stimulates tumor growth.
7. Code to 82, 85, 86, or 87 if it is known that hormone therapy is usually delivered for this type and stage of cancer, but it was not delivered.
8. Code to **87** if the patient refused recommended hormone therapy, made a blanket refusal of all recommended treatment and hormone therapy is a customary option for the primary site/histology, or refused all treatment before any was recommended and hormone therapy is a customary option for the primary site/histology.
9. Code **88** when the only information available is that the patient was referred to an oncologist.

Note: Review cases coded **88** periodically for later confirmation of hormone therapy. If follow-up with the oncologist indicates that the patient was never there, change to code to 00.

10. Do not code as hormone replacement therapy when it is given because it is necessary to maintain normal metabolism and body function.
11. If prednisone or other hormone is delivered for other reasons, **do not** code as hormone therapy.

***Examples*:**

a. A patient is given prednisone to stimulate the appetite and improve nutritional status. Prednisone is not coded as hormone therapy. Code to 00.

b. A patient has advanced lung cancer with multiple metastases to the brain. The physician orders Decadron to reduce the edema in the brain and relieve the neurological symptoms. Decadron is not coded as hormone therapy. Code to 00.

Exception: Decadron is coded as hormonal treatment **for lymphoid leukemias, lymphomas, and multiple myelomas only.** It is delivered to achieve its effect on cancer tissue through change of the hormone balance.

Hormone Categories

Hormones may be divided into several categories—

- Androgens: Fluoxymesterone
- Anti-androgens: Bicalutamide (Casodex), flutamide (Eulexin), and nilutamde (Nilandron)
- Corticosteroids: Adrenocorticotrophic agents
- Estrogens
- Progestins
- Estrogen antagonists, Anti-estrogens: Fulvestrant (Faslodex), tamoxifen, and toremifene (Fareston).
- Aromatase inhibitors, Antiaromatase: Anastrozole (Arimidex), exemestane (Aromasin), and letrozole (Femara)
- GnRH or LH-RH: Lupron, Zoladex
- Polypeptid hormone release suppression: Octreotide
- Somatostatin analog: Octreotide
- Thyroid hormones: Levothyroxine, liothyronine, Synthroid

Note: This table is also available in the Quick Reference, Appendix H.

Table 7.16 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. Death certificate only.

***Examples*:**

a. A patient diagnosed with metastatic prostate cancer is administered flutamide (an anti-androgenic agent) as part of the first course of therapy. Code to 01 and document the information in the Treatment Documentation data field**.**

b. A patient with metastatic prostate cancer declines the administration of Megace (a progestational agent) as part of the first course of therapy and the refusal is documented in the medical record. Code to 87 and document the information in the Treatment Documentation data field**.**

c. Patient with endometrial cancer is treated with **progesterone**. Even if the progesterone is given for menopausal symptoms, it has an effect on the growth or recurrence of endometrial cancer. Code to 01 and document the information in the Treatment Documentation data field.

d. A patient with **follicular** or **papillary** cancers of the thyroid is treated with thyroid hormone to suppress/inhibits serum thyroid stimulating hormone (TSH). If a patient with papillary and/or follicular cancer of the thyroid is given **TSH**, code the treatment in this field. Code to 01 and document the information in the Treatment Documentation data field**.**

e. Lupron is a hormonal treatment for prostate cancer. Code as hormonal treatment when **Lupron** is given for prostate cancer.

f. Bromocriptine suppresses the production of prolactin, which causes growth in pituitary adenoma. Code bromocriptine as hormone treatment for pituitary adenoma.

Note: Surgical removal of organs for hormone manipulation (such as orchiectomy for prostate cancer) is not coded in this data item. Code these procedures in the data field Hematologic Transplant and Endocrine Procedures.

RX Text Hormone

(NAACCR Item #2650)

Description

Text area for information about hormonal treatment.

Explanation

Text documentation is an essential component of a complete abstract and used extensively for quality assurance, consolidation of information from multiple sources, and special studies.

Coding Instructions

1. Text information to support hormone therapy **MUST BE PROVIDED BY ALL FACILITIES.**
2. Document all first course hormone therapy regardless of where it was done.
3. Document if no hormone therapy was given, or if it is unknown if intended hormone therapy was given.

   ***Example*:** After being diagnosed with adenocarcinoma of the prostate on 1/11/17, the patient opted for hormonal treatment and started Lupron on 2/1/17.

Please do not enter text in this field when treatment is either not done, or unknown if done. This information is conveyed by the treatment flags.

Date Immunotherapy Started

(NAACCR Item #1240) (FORDS pg. 299; SEER pg. 155)

Description

Records the date of initiation of immunotherapy or a biologic response modifier (BRM) that is part of the first course of treatment.

Explanation

Collecting dates for each treatment modality allows the sequencing of multiple treatments and aids in the evaluation of time intervals from diagnosis to treatment and from treatment to recurrence.

Coding Instructions

1. Record the first or earliest date on which immunotherapy or a biologic response modifier was administered by any facility. This date corresponds to administration of the agents coded in *Immunotherapy*.

2. Date format is:

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

      ***Example*:** A patient with multiple myeloma begins treatment with interferon on March 12, 2017. Record the date as 20170312.

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

      ***Example*:** A patient with melanoma received lymphokine-activated killer cells in January 2017 the day is not known. Code 201701.

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

      ***Example*:** A patient diagnosed with lung cancer with malignant pleural effusion earlier in 2017 has been treated with Picibanil, but the exact date is not known. Record 2017 as the date immunotherapy started.

   d. Blank - when no known date applies (no immunotherapy was given or it is unknown if immunotherapy was given).

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

4. If immunotherapy was administered do not leave the date blank. If the start date is not known, record the year of diagnosis as the start date and leave the month and day blank. Document in the text field that the start date is unknown.

RX Date - Immunotherapy Flag

(NAACCR Item #1241) (FORDS pgs. 300-301; SEER pg. 156)

Description

This flag explains why there is no appropriate value in the corresponding date field.

Explanation

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information previously transmitted in date fields.

Coding Instructions

1. Leave this item blank if *Date Immunotherapy Started* has a full or partial date recorded.
2. Code 10 if it is unknown whether any immunotherapy was given.
3. Code 11 if no immunotherapy was planned or given.
4. Code 12 if *Date Immunotherapy Started* cannot be determined or estimated, but the patient did receive first course immunotherapy or a biologic response modifier. Use this code **only** as a last resort.
5. Code 15 if immunotherapy is planned, but not yet started.

Table 7.17 RX Date-Immunotherapy Flag Codes

CODE	DESCRIPTION
10	No information whatsoever can be inferred from this exceptional value (unknown if immunotherapy was given).
11	No proper value is applicable in this context (no immunotherapy given)
12	A proper value is applicable but not known. This event occurred, but date is unknown (that is, immunotherapy was given but the date is unknown and cannot be estimated).
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). Case was diagnosed between 2003 and 2009 and the facility did not record *Date Immunotherapy Started* (NAACCR Item #1240) at that time.

RX Summ - BRM (Immunotherapy)

(NAACCR Item #1410) (FORDS pgs. 302-303; SEER pgs. 157-159)

Description

Immunotherapy uses the body's immune system, either directly or indirectly, to fight cancer or to reduce the side effects that may be caused by some cancer treatments. Record only those treatments that are administered to affect the cancer cells.

Explanation

This data item allows for the analysis of the administration of immunotherapeutic (biological therapy, biotherapy or biological response modifier) agents as part of the first course of therapy.

Immunotherapy is designed to:

1. Make **cancer cells** more r**ecognizable** and therefore more **susceptible** to destruction by the immune system.
2. **Boost** the killing power of **immune** system cells, such as T-cells, NK-cells, and macrophages.
3. **Alter** the **growth patterns** of cancer cells to promote behavior like that of healthy cells.
4. **Block** or **reverse** the process that **changes** a normal cell or a pre-cancerous cell into a cancerous cell.
5. **Enhance** the body's ability to **repair** or **replace** normal cells damaged or destroyed by other forms of cancer treatment, such as chemotherapy or radiation.
6. **Prevent** cancer cells from **spreading** to other parts of the body.

Types of Immunotherapy:

Cancer Treatment vaccines: Also called therapeutic vaccines, are a type of immunotherapy. The vaccines work to boost the body's natural defenses to fight a cancer. Doctors give treatment vaccines to people already diagnosed with cancer. The vaccines may:

- Prevent cancer from returning
- Destroy any cancer cells still in the body after other treatment
- Stop a tumor from growing or spreading Please refer to SEER*Rx to determine how to code non-FDA approved vaccines.

Interferons: Interferons belong to a group of proteins called cytokines. They are produced naturally by the white blood cells in the body. Interferon-alpha is able to slow tumor growth directly as well as activate the immune system. It is used for a number of cancers including multiple myeloma, chronic myelogenous leukemia (CML), hairy cell leukemia, and malignant melanoma.

Interleukins (IL-2): are often used to treat kidney cancer and melanoma.

Monoclonal Antibodies: Monoclonal antibodies (Mab) are produced in a laboratory. The artificial antibodies are used in a variety of ways in systemic therapy and can be chemotherapy, immunotherapy, or ancillary drugs. Some are injected into the patient to seek out and disrupt cancer cell activities. When the monoclonal antibody disrupts tumor growth, it is coded as chemotherapy. Other Mabs are linked to radioisotopes (conjugated monoclonal antibodies). The Mab finds and attaches to the target tumor cells and brings with it the radioisotope that actually kills the tumor cell.

The monoclonal antibody itself does nothing to enhance the immune system. Conjugated monoclonal antibodies such as tositumomab (Bexxar) or ibritumomab (Zevalin) are coded to the part of the drug that actually kills the cells, usually radioisotopes. A third function of Mab is to enhance the immune response against the cancer, either by identifying tumor cells that are mimicking normal cells, or by boosting the body's natural defenses that destroy foreign cells. Consult SEER*Rx for the treatment category in which each monoclonal antibody should be coded.

Coding Instructions

1. Assign code **00** when:

    a. The medical record states that immunotherapy was not given, not recommended, or not indicated

    b. There is no information in the patient's medical record about immunotherapy **AND**
    - It is known that immunotherapy is not usually given for this type and/or stage of cancer **OR**
    - There is **no reason to suspect** that the patient would have had immunotherapy

    c. The treatment plan offered multiple treatment options and the patient selected treatment that did not include immunotherapy

    d. Patient elects to pursue no treatment following the discussion of immunotherapy. Discussion does not equal a recommendation.

    e. Active surveillance, watchful waiting is the first course of treatment (e.g., prostate)

    f. Patient diagnosed at autopsy

    g. Anti-thymocyte globulin treatment is given. Anti-thymocyte globulin is used to treat transplant rejection. Do not code as immunotherapy.

2. Code **87** when

    a. The patient refused recommended immunotherapy

    b. The patient made a blanket refusal of all recommended treatment and immunotherapy is a customary option for the primary site/histology

    c. The patient refused all treatment before any was recommended and immunotherapy is a customary option for the primary site/histology

3. Code to **88** when the only information available is that the patient was referred to an oncologist.

    Note: Review cases coded 88 periodically for later confirmation of immunotherapy

4. Code to **99**

    a. When there is no documentation that immunotherapy was recommended or performed **AND**

    b. Immunotherapy is usually given for this type and/or stage of cancer **OR**

    c. For death certificate only (DCO) cases

Table 7.18 Immunotherapy Codes

CODE	DESCRIPTION
00	None, immunotherapy was not part of the first course of therapy; not customary therapy for this cancer; diagnosed at autopsy only
01	Immunotherapy administered as first course of therapy.
82	Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age, 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 immunotherapy agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Note: Table is also available in the Quick Reference, Appendix H.

RX Text Immunotherapy

(NAACCR Item #2660)

Description

Text information describing all immunotherapy or Biological Response Modifiers given as part of first course of treatment.

Explanation

Text documentation is an essential component of a complete abstract and used extensively for quality assurance, consolidation of information from multiple sources, and special studies.

Coding Instructions

1. Text information **MUST BE PROVIDED BY ALL FACILITIES** if treatment was given, completed, or incompleted.

2. Document all first course immunotherapy regardless of where it was done.

3. Document if no immunotherapy was given, or if it cannot be determined if intended immunotherapy was given. Do not include irrelevant information.

Note: See the Text Documentation section of the 2017 Handbook (page 248) for further explanation and examples.

Please do not to enter text in this field when treatment is either not done, or unknown if done. This information is conveyed by the treatment flags.

RX Summ - Transplant/Endocrine

(NAACCR Item #3250) (FORDS pgs. 306-307; SEER pgs. 160-162)

Description

This data item records systemic therapeutic procedures administered as part of the first course of treatment. These procedures include bone marrow transplants (BMT) and stem cell harvests with rescue (stem cell transplant), endocrine surgery and/or radiation performed for hormonal effect (when cancer originates at another site), and a combination of transplants and endocrine therapy.

Explanation

This treatment involves the alteration of the immune system or changes the patient's response to tumor cells, but does not involve the delivery of antineoplastic agents.

Definitions:

Bone marrow transplant (BMT): Procedure where bone marrow is used to restore stem cells that were destroyed by chemotherapy and/or radiation. Replacing the stem cells allows the patient to undergo higher doses of chemotherapy.

BMT Allogeneic: Receives bone marrow from a donor. This includes haploidentical (or half-matched) transplants.

BMT Autologous: Uses the patient's own bone marrow. The tumor cells are filtered out and the purified blood and stem cells are returned to the patient.

> ***Note***: Used for breast cancer, lymphoma, leukemia, aplastic anemia, myeloma, germ cell tumors, ovarian cancer, and small cell lung cancer.

BMT Syngeneic: Bone marrow received from an identical twin

Conditioning: High-dose chemotherapy with or without radiation administered prior to transplant such as BMT and stem cells to kill cancer cells. This conditioning also destroys normal bone marrow cells so the normal cells need to be replaced (rescue). The high dose chemotherapy is coded in the Chemotherapy field and the radiation is coded in the Radiation field.

Hematopoietic Growth Factors: A group of substances that support hematopoietic (blood cell) colony formation. The group includes erythropoietin, interleukin-3, and colony-stimulating factors (CSFs). The growth-stimulating substances are ancillary drugs and not coded.

Non-Myeloablative Therapy: Uses immunosuppressive drugs pre- and post-transplant to ablate the bone marrow. These are not recorded as therapeutic agents.

Peripheral Blood Stem Cell Transplant (PBSCT): Rescue that replaces stem cells after conditioning.

Rescue: Rescue is the actual BMT or stem cell transplant done after conditioning.

Stem Cells: Immature cells found in bone marrow, blood stream and umbilical cords. The stem cells mature into blood cells.

Stem cell transplant: Procedure to replenish supply of healthy blood-forming cells. Also known as bone marrow transplant or umbilical cord blood transplant, depending on the source of the stem cells.

Umbilical cord stem cell transplant: Treatment with stem cells harvested from umbilical cord blood.

Donor Leukocyte Infusions: A type of therapy in which lymphocytes from the blood of a donor are given to a patient who has already received a stem cell transplant from the same donor. The donor lymphocytes may kill remaining cancer cells. Donor lymphocyte infusion is used to treat chronic myelogenous leukemia (CML) that has come back and myeloma. It is being studied in the treatment of other types of cancer. The use of donor leukocyte infusions for treatment of hematopoietic neoplasms, specifically leukemias, is increasing. Abstract as bone marrow transplant when a reportable hematopoietic neoplasm is treated with donor leukocyte infusion, even if it is not listed in the treatment section of the Heme DB for the specific neoplasm.

Coding Instructions

1. Assign code **00** when:

    a. The medical record states that there was no hematologic transplant or endocrine therapy, or these were not recommended, or not indicated.

    b. There is no information in the patient's medical record about transplant procedure or endocrine therapy **AND**

    - It is known that transplant procedure or endocrine therapy is not usually performed for this type and/or stage of cancer **OR**
    - There is no reason to suspect that the patient would have had transplant procedure or endocrine therapy.

    c. The treatment plan offered multiple treatment options and the patient selected treatment that did not include transplant procedure or endocrine therapy.

    d. Patient elects to pursue no treatment following the discussion of transplant procedure or endocrine therapy. Discussion does not equal a recommendation.

    e. Active surveillance/watchful waiting is the first course of treatment (e.g., CLL).

    f. Patient diagnosed at autopsy.

2. Assign code **10** if the patient has "mixed chimera transplant (mini-transplant or non-myeloablative transplant). These transplants are a mixture of the patient's cells and donor cells.

3. Codes **11** and **12** have priority over code 10 (BMT, NOS).

4. Assign code **12** (allogeneic) for a syngeneic bone marrow transplant (from an identical twin) or for a transplant from any person other than the patient, or donor leukocyte infusion.

5. Assign code **20** when the patient has a stem cell harvest followed by a rescue or reinfusion (stem cell transplant, including allogenic stem cell transplant) as first course therapy. If the patient does not have a rescue, code the stem cell harvest as 88, recommended, unknown if administered. Use code **20** for umbilical cord stem cell transplant (single or double).

6. Assign code **30** for endocrine radiation and/or surgery. Endocrine irradiation and/or endocrine surgery are procedures that suppress the naturally occurring hormonal activity of the patient and therefore alter or affect the long-term control of the cancer's growth. These procedures must be **bilateral** to qualify as endocrine surgery or endocrine radiation. If only one gland is intact at the start of treatment, surgery and/or radiation to that remaining gland qualify as endocrine surgery or endocrine radiation.

   ***Examples*:**
   a. Bilateral orchiectomy for prostate cancer.
   b. Bilateral oophorectomy for breast cancer.
   c. Bilateral adrenalectomy for microadenoma.
   d. Bilateral hypophysectomy for pituitary cancer
   e. Bilateral radiation to ovaries for breast cancer, or to testicles for prostate cancer

7. Code 86 if the treatment plan offered multiple options which included a transplant, and the patient selected treatment that did include a transplant procedure.

8. Code to 87 if the patient **refused** a recommended transplant or endocrine procedure, made a **blanket refusal** of all recommended treatment, or **refused all treatment** before any was recommended.

9. Assign code **88** when the only information available is that the patient was referred to an oncologist for consideration of hematologic transplant or endocrine procedure.

10. Assign code **99** when there is no documentation that transplant procedure or endocrine therapy was recommended or performed. For death certificate only (DCO) cases.

Note: This table is also available in the Quick Reference, Appendix H.

Table 7.19 RX Summ– Transplant/Endocrine Codes

CODE	DESCRIPTION
00	No transplant procedure or endocrine therapy was administered as part of first course of therapy; not customary therapy for this cancer; diagnosed at autopsy only
10	A bone marrow transplant procedure was administered, but the type was not specified.
11	Bone marrow transplant-autologous.
12	Bone marrow transplant- allogeneic.
20	Stem cell harvest (Stem cell transplant) and infusion.
30	Endocrine surgery and/or endocrine radiation therapy as first course of therapy
40	Combination of endocrine surgery and/or radiation with a transplant procedure. (Combination of codes 30 and 10, 11, 12, or 20) as first course of therapy.
82	Transplant procedure and/or endocrine therapy was not recommended/ administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age, progression of disease prior to administration).
85	Transplant procedure and/or endocrine surgery/radiation were not administered because the patient died prior to planned or recommended therapy.
86	Transplant procedure and/or endocrine surgery/radiation were not administered. It was recommended by the patient's physician, but was not administered as part of first course therapy. No reason was noted in the planned or recommended therapy.

CODE	DESCRIPTION
87	Transplant procedure and/or endocrine surgery/radiation were not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Transplant procedure and/or endocrine therapy was recommended, but it is unknown if it was administered.
99	It is unknown whether transplant procedure or endocrine therapy was recommended or administered because it is not documented in the medical record. Death certificate only.

RX Summary Systemic/Surgery Sequence

(NAACCR Item #1639) (FORDS pgs. 308-309; SEER pg. 169)

Description

Records the sequencing of systemic therapy and surgical procedures given as part of the first course of treatment.

Explanation

The sequence of systemic therapy and surgical procedures given as part of the first course of treatment cannot always be determined using the date on which each modality was started or performed. This item can be used to more precisely evaluate the timing of delivery of treatment to the patient.

Systemic therapy is defined as:

- Chemotherapy
- Hormone therapy
- Biological response therapy/immunotherapy
- Bone marrow transplant
- Stem cell harvests
- Surgical and/or radiation endocrine therapy

Coding Instructions

1. Code the administration of systemic therapy in sequence with the first surgery performed, described in the item *date of first surgical procedure* (NAACCR Item #1200).

2. If none of the following surgical procedures were performed: *Surgical procedure of primary site* (NAACCR Item #1290), S*cope of Regional Lymph Node Surgery* (NAACCR Item #1292), S*urgical Procedure/Other Site* (NAACCR Item #1294), then this item should be coded 0.

3. If the patient received both systemic therapy and any one or a combination of the following surgical procedures: *Surgical Procedure of Primary Site* (NAACCR Item #1290), S*cope of Regional Lymph Node Surgery* (NAACCR Item #1292), *Surgical Procedure/Other Site* (NAACCR Item #1294), then code this item 2–9, as appropriate.

4. If multiple first course treatment episodes were given such that both codes 4 and 7 seem to apply, use the code that defines the first sequence that applies.

   ***Example*:** The sequence chemo, then surgery, then hormone therapy, then surgery is coded 4 for "chemo then surgery then hormone."

Note: This table is also available in the Quick Reference, Appendix H.

Table 7.20 RX Summary Systemic/Surgery Sequence Codes

CODE	LABEL	DESCRIPTION
0	No systemic therapy and/or surgical procedures; Unknown if surgery and/or systemic therapy given	No systemic therapy was given: and/or no surgical procedure of primary site; no scope of regional lymph node surgery; no surgery to other regional site(s), distant site(s), or distant lymph node(s); or no reconstructive surgery was performed. Diagnosed at autopsy. Death certificate only. (***Note**: This differs from FORDS instruction.)*
2	Systemic therapy before surgery	Systemic therapy was given before surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
3	Systemic therapy after surgery	Systemic therapy was given after surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
4	Systemic therapy both before and after surgery	At least two courses of systemic therapy were given, before and after any surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
5	Intraoperative systemic therapy	Intraoperative systemic therapy was given during surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s).
6	Intraoperative systemic therapy with other therapy administered before or after surgery	Intraoperative systemic therapy was given during surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) with other systemic therapy administered before or after surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
7	Surgery both before and after systemic therapy (effective for cases diagnosed 1/1/2012 and later)	Systemic therapy was administered between two separate surgical procedures to the primary site; regional lymph nodes, surgery to other regional site(s), distant site(s), or distant lymph node(s)
9	Sequence unknown	Administration of systemic therapy and surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) were performed and the sequence of the treatment is not stated in the patient record. It is unknown if systemic therapy was administered and/or it is unknown if surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) were performed.

***Examples*:**

a. Due to other medical conditions surgery was not performed. The patient received palliative radiation therapy to alleviate pain. Record **code 0** and document the information in the treatment documentation data field.

b. Patient with prostate cancer received hormone therapy prior to a radical prostatectomy. Record **code 2** and document the information in the treatment documentation data field.

c. Patient underwent a colon resection followed by a 5-FU based chemotherapy regimen. Record **code 3** and document the information in the treatment documentation data field.

d. Patient with breast cancer receives pre-operative chemotherapy followed by post-operative Tamoxifen. Record **code 4** and document the information in the treatment documentation data field.

e. Patient with intracranial primary undergoes surgery at which time a glial wafer is implanted into the resected cavity. Record **code 5** and document the information in the treatment documentation data field.

f. Patient with metastatic colon cancer receives intraoperative chemotherapy to the liver followed by 5-FU. Record **code 6** and document the information in the treatment documentation data field.

g. An unknown primary of the head and neck was treated with surgery and chemotherapy prior to admission, but the sequence is unknown. The patient enters for radiation therapy. Record **code 9** and document the information in the treatment documentation data field.

Date Other Treatment Started

(NAACCR Item #1250) (FORDS pg. 310; SEER pg. 165)

Description

The date other treatment began as first course of therapy.

Explanation

Records the date **other** treatment is delivered that is not included in surgery, radiation therapy, and systemic treatment.

Coding Instructions

1. Record the date the other treatment was delivered.

2. Date format is:

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

      ***Example*:** A patient with polycythemia vera was first treated with phlebotomy on February 20, 2017. Record Date of Other Treatment as 20170220.

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

      ***Example*:** A patient with pancreatic cancer is enrolled in a double-blind clinical trial in May 2017, but the day is not known. Record Date of Other Treatment as 201705.

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

***Example*:** A patient diagnosed with essential thrombocythemia in 2017 and has since been treated with aspirin, but the exact date is unknown. Code the date as 2017.

d. Blank - when no known date applies (no other therapy was given or it is unknown if other therapy was given).

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

4. Do leave blank if other treatment is given. If the date is unknown record the year of diagnosis and leave the month and day blank. Document in the text field that the date is unknown.

RX Date - Other Treatment Flag

(NAACCR Item #1251) (FORDS pgs. 311-312; SEER pg. 166)

Description

This flag explains why there is no appropriated value in the corresponding date field, *Date Other Treatment Started,* NAACCR Item #1250.

Explanation

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

Coding Instructions

1. Leave this item blank if *Date Other Treatment Started* (NAACCR Item #1250) has a full or partial date recorded.

2. Code 10 if it is unknown whether any other treatment was given (*Other Treatment*, NAACCR Item #1420, is 9).

3. Code 11 if no other treatment is planned or given (*Other Treatment* 0, 7 or 8).

4. Code 12 if *Date Other Treatment Started* cannot be determined or estimated, but the patient did receive first course other treatment. Use this code **only** as a last resort.

Table 7.21 RX Date-Other Flag Codes

CODE	DESCRIPTION
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any Other Treatment was given).
11	No proper value is applicable in this context (for example, no Other Treatment given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, Other treatment was given but date is unknown).
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 value is provided in item *Date Other Treatment Started* (NAACCR Item #1250).

Other Treatment

(NAACCR Item #1420) (FORDS pg. 313; SEER pgs. 167-169)

Description

Other Therapy identifies treatment given that cannot be classified as surgery, radiation, systemic therapy, or ancillary treatment. This data item includes all complementary and alternative medicine used by the patient in conjunction with conventional therapy or in place of conventional therapy.

Explanation

Used to evaluate treatment practices and for special studies.

Coding Instructions

1. Assign code **0** when:

   a. There is no information in the patient's medical record about other therapy **AND**

      - It is known that other therapy is not usually performed for this type and/or stage of cancer **OR**
      - There is no reason to suspect that the patient would have had other therapy.

   b. First course of treatment was active surveillance/watchful waiting.

   c. The treatment plan offered multiple treatment options and the patient selected treatment that did not include other therapy.

   d. Patient elects to pursue no treatment following the discussion of other therapy. Discussion does not equal a recommendation.

   e. Patient was diagnosed at autopsy.

2. Assign code **1** for

   a. Hematopoietic treatments such as: phlebotomy or aspirin

      Note: Do not code blood transfusion as treatment.

      Rationale: Blood transfusions may be used for any medical condition that causes anemia. It would be virtually impossible for the registrar to differentiate between blood transfusions used for a co-morbidity (i.e., anemia) from those given as prophylactic treatment of a hematopoietic neoplasm

   b. PUVA (Psoralen (P) and long-wave ultraviolet radiation (UVA)) in the RARE event that it is used as treatment for extremely thin melanomas or cutaneous T-cell lymphomas (e.g. Mycosis Fungoides).

   c. Photophoresis. This treatment is used ONLY for thin melanoma or cutaneous T-cell lymphoma (Mycosis Fungoides).

   d. Cancer treatment that could not be assigned to the previous treatment fields (surgery, radiation, chemotherapy, immunotherapy, or systemic therapy).

3. Assign code **2** for any experimental or newly developed treatment, such as a clinical trial, that differs greatly from proven types of cancer therapy.

Note: Hyperbaric oxygen has been used to treat cancer in clinical trials, but it is also used to promote tissue healing following head and neck surgeries. Do not code the administration of hyperbaric oxygen to promote healing as an experimental treatment.

4. Assign code **3** when the patient is enrolled in a double blind clinical trial. When the trial is complete and the code is broken, review and recode the therapy.

5. Assign code **6** for

   a. Cancer treatment administered by nonmedical personnel.

   b. **Unconventional** methods whether they are the only therapy or are given **in combination** with conventional therapy.

   c. **Alternative** therapy ONLY if the patient receives no other type of treatment.

      Example: Lupron given for breast cancer. Assign code 6. Lupron is not an approved hormone treatment for breast cancer and should not be coded in the hormone field.

6. Assign code **8** when **other therapy** was recommended by the physician **but there is no information** that the treatment was given.

7. Assign code **9** when there is no documentation that other therapy was recommended or performed
   a. For death certificate only (DCO) cases.

Note: Do not code ancillary drugs in this field. There is no coding scheme for ancillary drugs such as Leucovorin.

A quote from the website for the National Cancer Institute (NCI), Office of Cancer Complementary and Alternative Medicine (OCCAM) defines Complementary and Alternative Medicine (CAM) as any medical system, practice, or product that is not thought of as "western medicine" or standard medical care.

- Complementary medicine means it is used along with standard medicine, also called conventional medicine.
- Alternative medicine is used in place of standard treatments.

CAM treatments may include dietary supplements, megadose vitamins, herbal preparations, acupuncture, massage therapy, magnet therapy, spiritual healing, and meditation.

The OCCAM was established to coordinate and enhance activities of the NCI in complementary and alternative medicine research as it relates to the prevention, diagnosis, and treatment of cancer, cancer-related symptoms and side effects of conventional cancer treatment.

See complete information on types of complementary and alternative medicine specific to cancer at http://www.cancer.gov/about-cancer/treatment/cam. For additional information on cancer and other diseases, please visit https://nccih.nih.gov/health/integrative-health.

Coding for Tumor Embolization

The American College of Surgeons Commission on Cancer (CoC), the Centers for Disease Control and Prevention National Program of Cancer Registries (NPCR), and the SEER Program have collaborated to clarify and refine coding directives for tumor embolization and are jointly issuing the following instructions.

Definitions:

Chemoembolization: A procedure in which the blood supply to the tumor is blocked surgically or mechanically and anticancer drugs are administered directly into the tumor. This permits a higher concentration of drug to be in contact with the tumor for a longer period of time.

Radioembolization: Tumor embolization combined with injecting small radioactive beads or coils into an organ or tumor.

Tumor embolization: The intentional blockage of an artery or vein to stop the flow of blood through the desired vessel.

Coding Instructions
Code as "Other Therapy" when tumor embolization is performed using alcohol as the embolizing agent. Use code 1.

Example: For head and neck primaries: Ideally, an embolic agent is chosen that will block the very small vessels within the tumor but spare the adjacent normal tissue. Liquid embolic agents, such as ethanol or acrylic, and powdered particulate materials can penetrate into the smallest blood vessels of the tumor.

Use code **1** for embolization of a tumor in a site other than the liver when the embolizing agent is unknown. **Do not** code pre-surgical (pre-operative) embolization of hypervascular tumors with agents such as particles, coils, or alcohol as a treatment. Pre-surgical embolization is typically performed to prevent excess bleeding during the resection of the primary tumor. Examples where pre-surgical embolization is used include meningiomas, hemangioblastomas, paragangliomas, and renal cell metastases in the brain.

Note: This table is also available in the Quick Reference, Appendix H.

Table 7.22 Other Treatment Codes

CODE	TYPE	DESCRIPTION
0	None	All cancer treatment was coded in other treatment fields (surgery, radiation, systemic therapy). Patient received no cancer treatment.
1	Other	Cancer treatment that cannot be appropriately assigned to specific treatment data items (surgery, radiation, systemic). Use this code for treatment unique to hematopoietic diseases. *See **Examples**
2	Other-Experimental	This code is not defined. It may be used to record participation in facility-based clinical trials.
3	Other-Double Blind	A patient is involved in a double-blind clinical trial. Code the treatment actually administered when the double-blind trial code is broken.
6	Other-Unproven	Cancer treatments administered by non-medical personnel.

CODE	TYPE	DESCRIPTION
7	Refusal	Other treatment was not administered. It was recommended by the patient's physician, but this treatment (which would have been coded 1, 2, or 3) was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
8	Recommended; unknown if done	Other treatment was recommended, but it is unknown whether it was administered.
9	Unknown	It is unknown whether other treatment was recommended or administered, and there is no information in the medical record to confirm the recommendation or administration of other treatment.

***Examples*:**

a. A patient with polycythemia vera is treated with phlebotomies. Use code 1 for polycythemia vera ONLY according to the *Hematopoietic and Lymphoid Neoplasm Coding Manual* page 22 for cases diagnosed January 2010 and later. Phlebotomy may be called blood removal, bloodletting, or venisection.

b. A patient with pancreatic cancer is enrolled in a double-blind clinical trial. The treatment agents are unknown. Use code 3.

c. A patient was treated for melanoma with PUVA (psoralen and long-wave ultraviolet radiation). Code this treatment as *Other Treatment,* code 1.

RX Text Other

(NAACCR Item #2670)

Description

Text area for information describing all other treatment given as part of first course of treatment.

Explanation

Text documentation is an essential component of a complete abstract and used extensively for quality assurance, consolidation of information from multiple sources, and special studies.

Coding Instructions

1. Text information **MUST BE PROVIDED BY ALL FACILITES.**

2. Document all first course other treatment regardless of where it was done, in date order.

3. Document if no other treatment was given, or if it is unknown if intended other treatment was given.

Note: See the Text Documentation section of the 2017 TCR Handbook (page 248) for further explanation and examples.

Please do not enter text in this field when treatment is either not done, or unknown if done. This information is conveyed by the treatment flags.

RX Summ - Treatment Status

(NAACCR Item #1285) (FORDS pg. 232; SEER pg. 116)

Description

This data item summarizes whether the patient received any treatment or the tumor was under active surveillance.

Explanation

This item documents active surveillance (watchful waiting) and eliminates searching each treatment modality to determine whether treatment was given.

Coding Instructions

1. This item may be left blank for cases diagnosed prior to 2010.
2. Treatment given after a period of active surveillance is considered subsequent treatment and it is not coded in this item.
3. Use code 0 when treatment is refused or the physician decides not to treat for any reason such as the presence of comorbidities.
4. Assign code 1 when the patient receives treatment collected in any of the following fields:
   a. Surgery of primary site
   b. Scope of regional lymph node surgery
   c. Surgical procedure of other site
   d. Radiation
   e. Chemotherapy
   f. Hormone therapy
   g. Immunotherapy
   h. Hematologic transplant and endocrine procedures
   i. Other therapy

Note: Any type of first course cancer directed treatment, including surgery, is to be coded as "Treatment given".

Table 7.23 RX Summ - Treatment Status Codes

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

***Examples*:**

a. An elderly patient with pancreatic cancer requested no treatment. Use code 0.

b. 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.

c. Treatment plan for a lymphoma patient is active surveillance. Use code 2.

Date of Last Contact or Death

(NAACCR Item #1750) (FORDS pg. 304; SEER pg. 172-174)

Description

The date of last contact with the patient or the date the patient expired.

Explanation

This information is used for follow-up and patient outcome studies.

Coding Instructions

1. Record the date the patient was last seen at your facility, date of last contact, or date of death.

2. Date format is YYYYMMDD.

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

4. If patient is known to be deceased, but date of death is not available, date of last contact should be recorded in this field. In the *Text Remarks-Other Pertinent Information* text area, document that the patient is deceased and the date of death is not available.

Vital Status

(NAACCR Item #1760) (FORDS pg. 329)

Description

Records the vital status of the patient as of the *date of last contact or death* known to the reporting facility through all available resources. If the patient has multiple tumors, vital status should be the same for all tumors.

Explanation

This information is used for outcome studies.

Coding Instructions

1. Code the patient's vital status as of the date recorded in the *date of last contact or death* field. Use the most current and accurate information available.

2. If a patient has multiple primaries **simultaneously**, all records should have the same vital status.

Table 7.24 Vital Status Codes

CODE	DESCRIPTION
0	Dead
1	Alive

Place of Death - State
(NAACCR Item #1942)

Description
State where the patient died and where certificate of death is filed.

Explanation
When a hospital reports a place of death, the information can help in death certificate matching.

Coding Instructions
See Appendix B of the *SEER Program Code Manual* at https://seer.cancer.gov/tools/codingmanuals/index.html for numeric and alphabetic lists of places and codes. Leave blank if patient alive.

Place of Death - Country
(NAACCR Item #1944)

Description
Code for the country in which the patient died and where certificate of death is filed.

Explanation
When a hospital reports a place of death that is outside of the registry's country, the information can signal a death for which the death certificate will not be available from another state or through the NDI linkage.

Coding Instructions
Use the International Standards Organization (ISO) 3166-1 Country Three Character Codes, whenever possible, augmented by custom codes. Leave blank if patient alive.

Table 7.25 Place of Death Sample Codes

CODE	DESCRIPTION
USA	United States
ZZN	North America NOS
ZZC	Central America NOS
ZZX	Non-US NOS
ZZU	Unknown

Date Abstracted
(NAACCR Item #2090)

Description:
Record the date the registrar determined the tumor report was complete (all first course therapy administered or treatment plan coded and documented) and the case has passed edits.

Explanation
This field is used for TCR data quality and timeliness evaluation.

Coding Instructions

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

2. Record the year, month, and day (YYYYMMDD) the form was completed.

Abstractor Initials

(NAACCR Item #570) (FORDS pg. 335)

Description

Records the initials or assigned code of the individual abstracting the case.

Explanation

This data item is used for providing feedback for quality control.

Coding Instruction

1. Record the initials of the person abstracting the case.

TNM Edition Number

(NAACCR Item #1060) (FORDS pg. 366 ; SEER pg. 71 Section V:Stage of Disease at Diagnosis)

Description

A code that indicates the edition of the AJCC manual used to stage the case. This applies to the manually coded TNM values for the patient. It does not apply to the Derived AJCC T, N, M and AJCC Stage Group fields.

Explanation

TNM codes have changed over time and conversion is not always simple. Therefore, a case-specific indicator is needed to allow grouping of cases for comparison.

Code	Decription
00	Not staged (cases that have AJCC staging scheme and staging was not done)
01	First Edition
02	Second Edition (published 1983)
03	Third Edition (published 1988)
04	Fourth Edition (published 1992), recommended for use for cases diagnosed 1993-1997
05	Fifth Edition (published 1997), recommended for use for cases diagnosed 1998-2002
06	Sixth Edition (published 2002), recommended for use for cases diagnosed 2003-2009
07	Seventh Edition (published 2009), recommended for use with cases diagnosed 2010+
88	Not applicable (cases that do not have an AJCC staging scheme)
99	Edition unknown

Coding Instruction

1. Code based on the edition of the AJCC manual that was used to stage the case.

8

DOCUMENTATION OF CANCER DIAGNOSIS, EXTENT OF DISEASE, AND TREATMENT

DOCUMENTATION OF CANCER DIAGNOSIS, EXTENT OF DISEASE, AND TREATMENT

TEXT DOCUMENTATION OF CANCER DIAGNOSIS, EXTENT OF DISEASE, AND TREATMENT

(NAACCR Text Item #s 2220, 2520, 2530, 2540, 2550, 2560, 2570, 2590, 2580, 2600, 2610, 2620, 2640, 2650, 2660, 2670, 2680)

Text information to support cancer diagnosis, stage, and treatment codes **MUST BE PROVIDED BY ALL FACILITIES**. Document all types of the **first course** of definitive treatment administered, regardless of where the treatment was received, in chronological order.

Text documentation is an important element of a complete abstract. It is critical for quality assurance and special studies. Text is used to support coded values and to provide supplemental information not transmitted within coded values. Complete text documentation facilitates consolidation of information from multiple reporting sources. The text field must contain a description that has been entered by the abstractor. Cancer Registry software generating text automatically from coded data cannot be utilized to support coded values. Information documenting the disease and treatment must be entered manually from the medical record. **TNM staging is not an acceptable substitute for stage documentation**.

Text documentation should explain where the cancer started, where it went (lymph nodes, other organs) and how it got there (direct extension, metastasis, implants). Clinical and pathological findings should be documented.

<u>NO treatment</u>: Do not enter text in the treatment text fields when treatment either not done, or unknown if done. This information is conveyed by the treatment flags. Do not use words such as "none" or "unknown" or N/A.

Always use text to document certain basic information:

1. The date of the examination or procedure (Example: 6/15/2017); **keep dates in chronological order.**
2. The name of the examination or procedure (Example: excisional biopsy).
3. The results of the examination or procedure-any pertinent **positive or negative** information (Examples: negative margins, chest X-ray negative, liver biopsy positive for metastasis).
4. The diagnostic impression, final diagnosis, or final conclusion if one is given (Example: Ductal carcinoma of left breast).
5. The planned treatment, whether or not it is known if treatment was given (Example: chemotherapy planned after left modified mastectomy).
6. The date and type of treatment given, even if it was done at another institution (Example: 6/15/2017 5FU administered at ABC hospital).
7. Specific subsite of primary site (Example: upper outer quadrant of left breast).
8. Specific number, chain of lymph nodes examined and results (Example: 3/16+ left axillary lymph nodes).

9. Specific information about metastatic spread of disease to lymph nodes and/or other organs and tissues (Example: metastasis to 15 supraclavicular lymph nodes; brain metastasis).

10. 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.

11. Demographic information such as age at diagnosis, race and sex of the patient should also be recorded in text fields (Example: 76 year old Caucasian male).

Unknown is used when there is insufficient information to determine stage or extent of disease. If the primary site is unknown (C809) then the Summary Stage must be unknown. Document where the cancer was found if the primary site is unidentified.

Documentation is necessary to verify all coded fields regarding types and timing of treatment. Please **do not** enter text in treatment fields, including "unknown" or "n/a", when treatment is either not done, or unknown if done. This information is conveyed by the treatment flags. If a port is placed for chemotherapy, record this information but do not code that chemotherapy was given unless it is known that it was.

Call your Health Service Region for technical assistance if additional direction is needed to determine the appropriate information to document. TCR staff may request copies of the necessary reports with your data submission in order to assist you.

Types of Reports to Review

Medical imaging can provide key information for evaluating clinical extent of disease. For example, a CT of the lung can show the size and location of the tumor within the lung. It can demonstrate the presence of pleural effusion, or extension of the tumor to other tissues such as ribs, chest wall or pleura. Bone scans and MRI or CT of the brain are often used to evaluate for metastatic sites. History and Physical reports sometimes give the results from outside imaging studies. Documentation of all positive and negative findings from imaging exams should be recorded in the Summary Stage Documentation field.

Physical exam or **History and Physical (H&P)** can provide the size for palpable masses and information regarding palpable lymph nodes. For example, during a digital rectal exam (DRE) the prostate is palpated. The physician will note findings such as nodularity, induration, fixation of seminal vesicles, enlargement, firmness, etc. All positive and negative findings pertinent to the patient's cancer are an important aspect of Collaborative Staging and must be noted in the Summary Stage Documentation field to support coding. Patient demographics can also be found in the H&P. Record age, race and sex when available. This information is useful in record consolidation.

Pathology reports provide key information including **cell type**, **grade**, **size** and **location** of tumor, **number of lesions or foci**, **depth of invasion**, **spread of tumor to other organs**, and **lymph node involvement**. Record each of these items in the Summary Stage Documentation. Be sure to record the furthest extension that the pathologist mentions, for example: confined to mucosa; into subserosa; through full thickness of abdomen wall, etc.

Operative reports will often contain the surgeon's observations regarding involvement or lack of involvement of lymph nodes or other organs. The operative report will also contain detailed information of the exact type of surgery performed, tissue or organ(s) excised, and tissue or organ(s) left intact. Record these findings in the Summary Stage Documentation.

Discharge summaries, clinical notes, or progress reports are good sources for treatment information. Review all available reports and document all planned treatment, as well as the date and modalities of known treatment in the Treatment Documentation. Give specific information when available such as type and number of courses of chemotherapy. If no treatment is planned or the patient refuses recommended treatment, include this information in the text field.

Lab results are used to code many of the Site-Specific Factors. Source documents for many of the Site Specific Factors can be found in Appendix A, General Coding Information, page 269.

Specific Instruction on Involvement

Lymph Node Involvement: Per **SEER** Summary Stage 2000, page 7, for solid tumors, the terms "fixed" or "matted" and "mass in the mediastinum, retroperitoneum, and/or mesentery" (with no specific information as to tissue involved) are considered involvement of lymph nodes . Any other terms, such as "palpable," "enlarged," "visibly swelling," "shotty," or "lymphadenopathy" should be ignored (except for lung primaries) unless there is a statement from the physician of involvement, either clinical or pathological. A metastatic nodule in connective tissue of a lymph drainage area is considered to be evidence of lymph node metastasis. **AJCC** guidelines are different and encourages critical thinking by the abstractor.

Exception: Lymphomas: *Any* mention of lymph nodes is indicative of involvement. In staging lymphomas, bilateral node involvement should be considered 2 chains for the purpose of assigning a stage. For example, bilateral involvement of inguinal lymph nodes would be considered 2 chains. Refer to **AJCC** manual, 7th ed, chapter 57A under critetia for organ involvement for further instructions.

SEER Note: Regional lymph nodes are not palpable (inaccessible) for sites such as bladder, kidney, prostate, esophagus, stomach, lung, liver, corpus uteri, and ovary. The best description concerning regional lymph node involvement will be the surgeon's evaluation at the time of exploratory surgery or definitive surgery or from radiologic exam.

Venous Invasion: An assessment of blood vessels **within** the primary organ. This does not constitute regional or distant spread of malignancy.

Lymphatic Invasion: A microscopic assessment of involvement of the lymphatic channels **within** the primary organ and at the margins of resection. This is an assessment of the potential, from the primary tumor, to metastasize to lymph nodes, even though the tumor has extended no further than the lymph channels and is still confined to the primary site.

Residual Tumor: Refers to the status of the margins after a surgical procedure of the primary site. It is important to document this information if it is available in the pathology and/or operative report. ***Microscopic residual tumor*** is identified by the pathologist through the microscope but is not grossly visualized. An example would be a positive margin of resection when the surgeon stated that the tumor was completely removed. ***Macroscopic residual tumor*** is identified during the procedure by the surgeon and is a tumor that is grossly visualized. An example of this would be tumor adhering to another structure that the surgeon could not remove.

Note: When there is doubt about assigning the appropriate stage, assign the lesser stage. Do not over stage.

Determination of the cancer stage is both a subjective and objective assessment of how far the cancer has spread. The following list of terms may be used to determine involvement for **SEER Summary Staging only.**

Note: Do not use these lists for case finding or to determine multiple primaries or histology.

Table 8.1 - Consider as Involvement (SEER SS 2.000)

adherent	induration
apparent(ly)	infringe/infringing
appears to	into*
comparable with	intrude
compatible with	invasion to, into, onto, out onto
consistent with	most likely
contiguous/continuous with	onto*
encroaching upon*	overstep
extension to, into, onto, out onto	presumed
features of	probable
fixation to a structure other than primary**	protruding into (unless encapsulated)
fixed to another structure**	suspected
impending perforation of	suspicious
impinging upon	to*
impose/imposing on	up to
incipient invasion	

*interpreted as involvement whether the description is clinical or operative/pathological
**interpreted as involvement of other organ or tissue

Table 8.2 - Do Not Consider as Involvement (SSEER SS 2.000)

abuts	extension to without invasion/involvement of
approaching	kiss/kissing
approximates	matted (except for lymph nodes)
attached	possible
cannot be excluded/ruled out	questionable
efface/effacing/effacement	reaching
encased/encasing	rule out
encompass(ed)	suggests
entrapped	very close to
equivocal	worrisome

TEXT FIELD EXAMPLES

The following table lists **suggestions** for the type of text to include for each text field.

Table 8.3 Text Field Examples

NAACCR TEXT FIELD AND DATA ITEM#	TEXT SUGGESTIONS	DATA ITEM(S) VERIFIED WITH TEXT
Other Pertinent Information #2680	• Age, sex and race of patient • Spanish/Hispanic Origin • Place of birth • Country of Birth • Insurance/primary payer information • Name of Follow Up Physician • Unknown demographic information (unknown SS#, unknown address at diagnosis) • Overflow or problematic coding issues	Date of Birth **#240** Country of Birth #**254** Sex #**220** Race 1-5 **#160-164** Spanish/Hispanic Origin **#190** Place of Birth **#250** Physician Follow Up **#2470** Primary Payer at Dx **#630**
Other Primary Tumors #2220	• Site of *Other Primary* • Morphology of *Other Primary* • DX Date of *Other Primary*	Sequence Number **#560**
Summary Stage Documentation #2600	• Date(s) of procedure(s) including biopsies and clinical procedures that provide staging information such as x-rays • Organs involved by direct extension • Size of tumor • Status of margins • Number and sites of positive lymph nodes • Metastatic sites • Physician's specialty (Surgeon, Oncologist, etc.) • Physician's comments	Date of Initial Diagnosis **#390** Diagnostic Confirmation **#490** Primary site **#400** Morphology/Behavior **# 522, 523** Collaborative Stage variables **#2800-2930** Regional Nodes Positive **#820** Regional Nodes Examined **#830** Laterality **#410**
Summary Stage Documentation –PE #2520	• Date of diagnosis • History relating to cancer diagnosis • Impression pertaining to cancer diagnosis • Positive and negative clinical findings • Palpable lymph nodes • Treatment plan	Date of First Contact **#580** Date of Diagnosis **#390** Race 1-5 **#160-164** Span/Hispanic Origin **#190** Sex **#220** Primary Site **#400** Laterality **#410** Histology ICD-O-3 **#522** Sequence # Hospital **#560** Collaborative Stage variables **#2800-2930** SEER Summary Stage 2000 **#759**

NAACCR TEXT FIELD AND DATA ITEM#	TEXT SUGGESTIONS	DATA ITEM(S) VERIFIED WITH TEXT
Summary Stage Documentation-Xray/Scan #2530	• Date and type of X-ray or Scan • Primary site • Histology (if given) • Tumor location • Tumor size • Lymph nodes • Record positive and negative findings • Distant disease or mets	Date of Diagnosis **#390** Primary Site **#400** Laterality **#410** Histology ICD-O-2 **#420** Histology ICD-O-3 **#522** Collaborative Stage variables **#2800-2930** SEER Summary Stage 2000 **#759**
Summary Stage Documentation-Scopes #2540	• Dates of endoscopic exams • Primary site • Histology • Tumor location • Tumor size • Site and type of endoscopic biopsy • Positive and negative clinical findings	Date of Diagnosis **#390** Diagnostic Confirmation **#490** Primary Site **#400** Laterality **#410** Histology ICD-O-2 **#420** Histology ICD-O-3 **#522** Collaborative Stage variables **#2800-2930** SEER Summary Stage 2000 **#759** RX Date-Surgery **#1300**
Summary Stage Documentation-Lab Tests #2550	• Type of lab test/tissue specimen • Both positive and negative findings • Tumor markers, special studies etc. Including : Estrogen Receptor Assay (ERA), Progesterone Receptor Assay (PRA), Her2/neu, Human Chorionic Gonadotropin (hCG) • Date of lab tests	Primary Site **#400** Grade **#440** Diagnostic Confirmation **#490** Collaborative Stage variables **#2800-2930** Date of Diagnosis **#390**
Summary Stage Documentation-Op #2560	• Dates and descriptions of biopsies and all other surgical procedures from which staging information was derived • Number of lymph nodes removed • Size of tumor removed • Documentation of residual tumor • Evidence of invasion of surrounding areas • Reason primary site surgery could not be completed	Date of Diagnosis **#390** Diagnostic Confirmation **#490** Primary Site **#400** Collaborative Stage variables **#2800-2930** SEER Summary Stage 2000 **#759** Reason for No Surgery **#1340**
Summary Stage Documentation Path #2570	• Dates of procedures • Anatomic source of specimen • Type of tissue specimen	Date of Diagnosis **#390** Primary Site **#400** Laterality **#410** Histologic Type ICD-O-3 **#522**

NAACCR TEXT FIELD AND DATA ITEM#	TEXT SUGGESTIONS	DATA ITEM(S) VERIFIED WITH TEXT
	• Tumor type and grade (include all modifying adjectives: predominantly, with features of etc.) • Gross tumor size • Extent of tumor spread • Involvement of resection margin • Number of lymph nodes involved and examined • Both positive and negative findings • Record any additional comments from the pathologist, including differential diagnosis considered and any ruled out or favored	Grade **#440** Collaborative Stage variables **#2800-2930** Diagnostic Confirmation **#490** RX Summ-Surg Prim Site **#670** RX Sum-Scope Reg LN Sur **#1392** RX Summ-Surg Oth Reg/Dis **# 1394** SEER Summary Stage 2000 **#759** Regional Nodes Positive **#820** Regional Nodes Examined **#830** RX Date-Surgery **#1300** Reason for No Surgery **#1340** RX Summ-Surg/Rad Seq **#1380** RX Summ-Systemic/Sur Seq **#1639**
Final Diagnosis (Primary, Laterality) #2580	• Location of primary site of tumor • Information on laterality of tumor	Primary site **#400** Laterality **#410**
Final Diagnosis (Morphology, Behavior, Grade) #2590	• Morphology/Behavior • Grade of tumor	Morphology/Behavior **#522, #523** Grade **#440**
Rx Text Surgery #2610	• Date of each surgical procedure • Type(s) of surgical procedure(s), including surgery to other and distant sites • Lymph nodes removed • Regional tissues removed • Metastatic Sites • Facility and date for each procedure • Record positive and negative findings. Record Positive findings first. • Reason for no surgery • Other treatment information, e.g. planned procedure aborted.	DX confirmation **#490** RX Date Surgery **#1300** Surgery Rx Code **#1390** RX Summ Scope of Reg LN Surgery **#1392** RX Summ-Surg Other/Dist RX Code **#1394** Reason for No Surgery **#1340** RX-Summ-Radiation # **1360**

NAACCR TEXT FIELD AND DATA ITEM#	TEXT SUGGESTIONS	DATA ITEM(S) VERIFIED WITH TEXT
Rx Text-Radiation #2620	• Date radiation treatment began and ended • Where treatment given • Type(s) of radiation • Planned doses • Other treatment information (discontinued after 2 treatments.)	Date Radiation Started **#1310** Rad-Regional RX Modality Code **#1570** RX Summ-Surg/Rad Sequence **#1380**
Rx Text-Chemo #2640	• Date when chemotherapy began and ended • Where chemotherapy was given • Type of chemotherapy (name of agent(s) and doses planned/received • Other treatment information (treatment cycle incomplete.)	Chemotherapy Code **#1390** RX Date-Systemic **#3230** Systemic/Surgery Sequence **#1639** RX Date Chemo **#1220**
Rx Text-Hormone #2650	• Planned hormone treatment • Date treatment was started • Where treatment was given • Type of hormone or antihormone • Type of endocrine surgery or radiation • Other treatment Information, e.g. Treatment cycle incomplete.	Hormone Code **#1400** RX Date-Systemic **#3230** Systemic/Surgery Sequence **#1639**
Rx Text-BRM Immunotherapy #2660	• Date treatment began • Where treatment was given e.g. at this facility, at another facility • Planned immunotherapy treatment • 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.	Immunotherapy Code #**1340**
Rx Text-Other #2670	• Date treatment was started • Where treatment was given • Type of other treatment • Other treatment information (incomplete)	Date of Initial Treatment **#1360** RX Summ-Other **#1420** RX Date-Other **#1350**

The pertinent information in the following examples has been documented in **bold lettering** for easier identification of required text.

Please do not enter text in treatment fields, including "unknown" or "n/a", when treatment is either not done, or unknown if done. This information is conveyed by the treatment flags

DOCUMENTATION EXAMPLES

Case #1 Lung

IMAGING REPORTS

2/18/17 VA Clinic: **CT Chest**: Findings: **Supraclavicular, axillary, and mediastinal structures unremarkable. No mediastinal or hilar adenopathy**. There is a **2.8 x 2.4 x 4.8cm mass in the right lower lobe.** The margins are well defined with minimal peripheral ground-glass opacity, **probably some degree of obstructive pneumonitis**. The **remainder of the lungs is clear.**

Impression: Lobulated soft tissue **mass in the right lower lobe consistent with neoplasm. No evidence of adenopathy, mediastinal or hilar spread.**

2/28/17 CT Brain Your Hospital: Impression: **No evident disease process.**

PATHOLOGY REPORTS

2/28/17 Your Hospital: Final Diagnosis: **Fine Needle Aspirate, right lower lobe lung: positive for malignant cells**

3/1/17 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

3/15/17: **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)

2/18/17 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

2/28/17 Fine Needle Aspirate RLL lung: positive for malignant cells

2/28/17 Ct Brain: No evident dz process

3/1/17 RLL Resection: MD Squamous cell car, 2 nodules 5cm and 0.5cm, margin free, 0/3 peribronchial, paratracheal and pretracheal lns

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

3/1/17 RLL lobectomy with mediastinal ln dissection

3/15/17 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

6/25/17 River Ranch Radiology **CT Chest**: I see **no pneumothorax or pleural effusion**. There is an **11.7 x 8.5cm soft tissue mass in the right apex.** There is associated **marked mediastinal lymphadenopathy** with enlarged **nodes in** the **anterior mediastinum, enlarged nodes lying lateral to** the **main pulmonary artery,** and **enlarged nodes in** the **pretracheal and precarinal region.** There are **enlarged nodes around the right hilum.** The **left lung appears normal.**

Conclusion: Right upper lobe mass with associated marked mediastinal lymphadenopathy. The findings are **highly suspicious for a primary carcinoma of the lung.**

7/1/17 Oncology Associates **Bone scan**: Non-specific increased uptake at L3 and L5, **no obvious metastasis.**

7/1/17 Oncology Associates **MRI brain: Diffuse cerebral atrophy**

BRONCHOSCOPY REPORT

6/26/17 Bronchoscopy: The **vocal cords** were visualized and **appeared to move normally.** The bronchoscope was passed to the trachea, which was widely patent. **No endobronchial lesions were noted.** There was a small amount of bleeding from the right upper orifice. **No lesions were noted at the right lower lobe or right middle lobe**. Endobronchial biopsy was performed times six at the right upper lobe. Bleeding was minimal.

PATHOLOGY REPORT

6/26/17 Right upper lobe mass biopsy Final Diagnosis: **non-small cell carcinoma**

CLINICAL REPORTS

7/5/17 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

7/15/17 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)

6/25/17 CT chest: no pneumothorax or pleural effusion, 11.7cm mass in rt apex, highly suspicious for lung carcinoma, marked mediastinal lymphadenopathy, enlarged nodes in anterior mediastinum, enlarged nodes lateral to main pulmonary artery, in pretracheal and precarinal region and in rt hilum, lft lung appears normal

6/26/17 Bronchoscopy: vocal cords appear to move normally, no endobronchial, rll or rml lesions

6/26/17 RUL mass bx: Non-small cell carcinoma

7/1/17 Bone Scan: no mets

7/1/17 MRI brain: diffuse cerebral atrophy

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

7/5/17 concurrent chemo/radiation therapy recommended

7/15/17 Discharge Summary: PT has been treated with VP-16 x 3 days along with daily radiation therapy

Case #3 Breast

IMAGING REPORTS

1/2/17 Mammogram: Left breast: No dominant masses, or suspicious calcifications, or architectural disturbances are present. **In the right breast** there is a **3.5 x 4.6cm irregular spiculated mass in the lower-outer quadrant.**

Impression: Large mass in the lower-outer quadrant of the right breast, biopsy is recommended.

1/13/17 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

1/10/17 Core biopsy right breast lower outer quadrant: Final Diagnosis: Infiltrating ductal carcinoma, poorly differentiated, ER and PR positive, HER2 ICH 0, negative.

CLINICAL REPORTS

1/15/17 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.

2/1/17 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)
1/2/17 Mammogram: Lt breast no masses, Rt breast 4.6cm mass in LOQ, biopsy recommended.
1/10/17 Bx rt breast LOQ Infil ductal car, PD, ER and PR positive, HER2 IHC 0-Negative
1/13/17 CT Chest: Bone destruction posterior ribs/spine, probably mets from breast ca, CT Abdomen/Pelvis: no abnormal findings
1/15/17 Surg consult: marked lymphadenopathy in rt axilla

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

1/15/17 Surg Consult: Patient referred to radiation oncology for consideration of radiation therapy to bony mets.

2/1/17 Oncology note: Pt has decided to try alternative therapy, declined radiation therapy and chemotherapy.

Case #4 Breast

IMAGING REPORTS

6/1/17 Mammogram: In the **right breast** there is a **1.2 x 1.5cm mass in the upper-outer quadrant**. There is **no evidence of axillary lymphadenopathy**. The **left breast appears normal.**

6/14/17 Chest Xray: Within normal limits

6/14/17 Bone Scan: Impression**: No evidence of skeletal disease. Thoracic and lumbar spine negative for metastases.**

PATHOLOGY REPORTS

6/8/17 Right breast fine needle aspiration cytology: Adenocarcinoma

6/15/17 Right breast modified radical mastectomy: Final Diagnosis: **Infiltrating ductal carcinoma, tubular type, 1.4cm, margins clear, Bloom Richardson score 3, no dermal or lymphatic invasion, no evidence of tumor in 32 regional lymph nodes, Estrogen and Progesterone Receptors negative, HER2 IHC 3+, positive.**

CLINICAL REPORTS

6/1/17 History and Physical: Family physician noted **2cm mass in right breast on physical exam**. No pain or tenderness; **no nipple discharge; no skin changes**. Slight nipple retraction. Freely movable mass. **Left breast: no masses palpated. No enlarged lymph nodes.**

10/13/17 Oncology Clinic Follow-up Note: Patient started **3 cycles of adjuvant Adriamycin and Cytoxan on 7/20/17**, recently completed and now **has begun Tamoxifen.**

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

6/1/17 Mammogram: 1.5cm mass rt breast UOQ, no lymphadenopathy, lt breast appears normal

6/1/17 H&P 2cm mass in right breast, no masses palpated in lt breast, no enlarged lymph nodes

6/14/17 CXR: WNL; Bone Scan: no evident mets

6/8/17 Rt Breast fine needle aspiration = adenoca

6/15/17 Rt breast mastectomy: infiltrating duct carcinoma, tubular type, 1.4cm, margin clear, Bloom Richardson score 3, 0/32 LNS positive, ER/PR negative, HER2 IHC 3+ positive.

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

6/15/17 Rt breast modified radical mastectomy

10/13/17 Oncology note: pt had 3 cycles Adriamycin and Cytoxan begun on 7/20/17, recently completed and has begun Tamoxifen.

Case #5 Colon/Rectum

IMAGING REPORTS:

4/20/2017 CT Abdomen and Pelvis

Conclusion:

1. **Two areas of circumferential colonic wall thickening affecting the distal sigmoid colon and a loop of colon in the right lower quadrant/right pelvic region with multiple low-density lesions being noted in the liver. Although these could represent incidental benign hepatic cysts, metastatic liver disease cannot be excluded** at this time as colonic carcinoma is one of the causes of cystic liver metastasis. It should be noted **although there are shotty lymph nodes present, there is no definite lymphadenopathy** demonstrated.

2. **History of uterine cancer in 2003** with evidence of prior hysterectomy. This is not usually a cause of cystic liver metastasis.

3. **Otherwise, unremarkable CT scan of the abdomen and pelvis** with other incidental findings as noted above.

4/25/17 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:

4/15/2017 Final Diagnosis: **Colon biopsy at 135cm moderately differentiated adenocarcinoma, mucin producing signet ring cell, high grade**

5/1/2017 Final Diagnosis **right hemicolectomy**

A. **High-grade mucin-producing signet ring cell carcinoma, 4 cm in size and located in colon near ileocolic junction, tumor invades pericolonic adipose tissue, (PT3)**
B. **No evidence of lymph node metastasis among seven lymph nodes. (PNO)**
C. **Excision margin is negative.**
D. **Microsatellite Instability-Stable**
E. **KRAS mutated**
F. **Normal heterozygous state (Normal LOH)**

OPERATIVE REPORT:

Date of Procedure: 5/1/17

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: 5/15/17

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, 2017.

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)

4/15/17 Colon biopsy at 135cm: Moderately differentiated adenoca, mucin producing signet ring cell, high grade.

4/20/17 Ct Abdomen and Pelvis: 2 areas circumferential colonic wall thickening affecting the distal sigmoid colon and a loop of colon in the rt lower quadrant/rt pelvic region. Multiple liver lesions could represent benign hepatic cysts, mets liver dz cannot be excluded; shotty lymph nodes present, no definitive lymphadenopathy, otherwise unremarkable CT abdomen and pelvis; pt has a history of uterine cancer in 2003 with evidence of hysterectomy

4/25/17 Whole body PET scan: no focal areas of increased uptake in liver to suggest hepatic mets

5/1/17 Operative report: Liver palpated, found to be unremarkable, no lesion in colon other than rt colon

5/1/17 Right hemicolectomy: High-grade mucin producing signet ring cell carcinoma, 4cm, located near ileocolic junction, invades pericolonic adipose tissue, 0/7LNS positive, excision margin is negative; MSI-stable, KRAS mutated, normal LOH

5/15/17 Oncology consult: The patient may benefit from adjuvant chemotherapy; unknown if chemotherapy given.

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

5/1/17 Right Hemicolectomy

Case #6 Melanoma

IMAGING REPORTS

5/10/17 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

5/3/17 Final Diagnosis: **Shave biopsy skin of left forearm, Malignant melanoma**

5/11/17 Final Diagnosis: **Wide excision of skin of left forearm**, **Malignant melanoma, nodular type, Clark's Level III, Breslow's depth 1.0mm, papillary dermis invaded, no ulceration present no mitosis present. Margins of resection free, but within less than 2mm**. **LDH Less than 1.5 x upper limit of normal for lactate dehydrogenase (LDH) assay**

ONCOLOGY REPORT

6/15/17 The patient was **started on an interferon regimen today**.

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

5/3/17 Shave bx skin of lt forearm: Malignant melanoma

5/10/17 CT chest: Probably malignant involvement of lt axillary lymph nodes, remainder of exam normal

5/11/17 Wide exc skin of lt forearm: Malignant melanoma, nodular type, Clark's Level 3, Breslow's depth 1.0mm, papillary dermis invaded, no ulceration, no mitosis, margin free but within less than 2mm, LDH Range 1: Less than 1.5 x upper limit of normal for lactate dehydrogenase (LDH) assay

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

5/11/17 Wide excision of skin of lt forearm

6/15/17 started interferon regimen

Case #7 Melanoma

IMAGING REPORTS

11/18/2017 Chest Xray: Within normal limits

11/24/17 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:
11/13/17 Final Diagnosis: **Excision of lesion** on **right side of neck**, 1.5 x .0.8 x 0.5 cm specimens contains a pigmented, **0.4 x 0.3cm area consistent with malignant melanoma in situ, extending to margins of excision.**

Your Facility:
11/25/17 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)

11/18/17 CXR: Within normal limits

11/24/17 CT Chest/abdomen/pelvis: No evidence of mets in chest, abdomen or pelvis

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

11/13/2017 Exc of lesion rt side of neck: 0.4x0.3cm malignant melanoma in situ, Ext to margin

11/25/17 Wide re-excision of skin rt neck, negative for residual melanoma, margins negative

Case #8 Lymphoma

IMAGING REPORTS

2/2/17 CT Chest Impression: Extensive **right and left hilar lymphadenopathy**, **enlarged lymph nodes in the mediastinum.**

2/2/17 CT Abdomen Impression: **Splenomegaly, otherwise within normal limits**.

2/4/17 PET scan: Intense **focus of tracer uptake seen in peri-portal region consistent with lymphoma**.

PATHOLOGY REPORTS

2/3/17 Biopsy of **left axillary lymph nodes, Follicular Lymphoma, Gr 1**

H&P

2/2/17 Patient presents with **bilateral cervical and axillary lymphadenopathy**, **night sweats, and fevers for last couple of months.**

ONCOLOGY CONSULT

2/13/17 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)

2/2/17 H&P Pt has bilateral cervical and axillary lymphadenopathy, hx of night sweats, fevers

2/2/17 CT Chest: rt and lt hilar lymphadenopathy, enlarged lymph nodes in the mediastinum

2/2/17 CT Abdomen: Splenomegaly, otherwise within normal limits

2/3/17 Biopsy lt axillary lns: Follicular Lymphoma, Gr 1

2/4/17 PET scan: focus of tracer uptake in peri-portal region consistent with lymphoma

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

2/5/17 Combination chemotherapy including Rituxan, other types of chemo not mentioned

Case #9 Prostate

IMAGING REPORTS

4/14/17 CT Abdomen/Pelvis Impression: 1. Tiny cyst in the liver.
2. **No lymphadenopathy in abdomen or pelvis**

4/14/17 Bone scan Impression: Evidence of previous fracture in right 13th rib, otherwise **negative bone scan**

PATHOLOGY REPORTS

4/1/17 Final Diagnosis: Prostate **core needle biopsy, adenocarcinoma present in 8 of 13 cores, Gleason Score 3+3=6**

CLINICAL REPORTS

3/27/17 Surgical consult: Patient is seen in consultation because **PSA elevated at 6**. **DRE shows slightly enlarged prostate with no nodularity or induration**. The **abdomen and pelvis** are examined and **show no palpable abnormalities**

7/1/17 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 6/15/17.**

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

3/27/17 PE: DRE shows slightly enlarged prostate with no nodularity or induration, abdomen and pelvis with no palpable abnormalities, PSA 6

4/1/17 Prostate core needle biopsy: adenocarcinoma in 8/13 cores, Gleason Score 3+3=6

4/14/17 CT Abdomen/Pelvis: no lymphadenopathy in abdomen or pelvis

4/14/17 Bone scan: negative

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

External beam radiation therapy completed on 6/15/17, start date not given; estimate start date 5/2017

A

APPENDIX A: CODING GUIDELINES AND RECORDING INSTRUCTIONS

APPENDIX A

Appendix A consists of Coding Guidelines and Instructions for recording information such as Site-Specific coding, lab tests, tumor markers, and other reports for Site-Specific Factors. The information comes from Collaborative Stage Data Collection System User Documentation and Coding Instructions, version 02.05 published by American Joint Committee on Cancer (Chicago, IL), SEER, FORD, and other sources.

Site Specific Factors collected by the TCR:
https://www.dshs.texas.gov/tcr/training/2017-handbook.aspx

The site specific surgery codes are from The American College of Surgeons Commission on Cancer's Standards of the Commission on Cancer Volume II: Facility Oncology Registry Data Standards (FORDS).

The Site-Specific Surgery Codes can be found in Appendix B of the FORDS Manual on page 382-449: https://www.facs.org/~/media/files/quality%20programs/cancer/ncdb/fords%202016.ashx

CODING GUIDELINES AND RECORDING INSTRUCTIONS

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- Breast p. 274
- Colon p. 280
- Esophagus p. 281
- Kaposi Sarcoma p. 283
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Required Site-Specific Factors (SSFs) **p. 287**

Recording Information:
Lab Tests, Tumor Markers, and Other Reports in Site-Specific Factors **p. 289**

Site-Specific Factors Common to Several Primary Sites/Histologies **p. 293**
- Mitotic Count p. 293
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Other SSFs, Morphology and Primary Site Notes **p. 297**
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SEER SITE-SPECIFIC CODING GUIDELINES

Bladder
C670 – C679

Reportability

Do **not** report bladder cancer based on **UroVysion** test results alone. Report the case if there is a physician statement of malignancy and/or the patient was treated for cancer.

Not reportable

Papillary urothelial neoplasms of low malignant potential (PUNLMPs)

The WHO classification categorizes "PUNLMP" as borderline, 8130/1. The definition is "a papillary urothelial tumor which resembles the exophytic urothelial papilloma, but shows increased cellular proliferation exceeding the thickness of normal urothelium." The histopathologic description is "the papillae of PUNLMP are discrete, slender and not fused and are lined by multilayered urothelium with minimal to absent cytologic atypia….Mitoses are rare and have a basal location."

Papilloma of bladder

The WHO classification categorizes "urothelial papilloma" as benign, 8120/0. The definition is "composed of a delicate fibrovascular core covered by urothelium indistinguishable from that of normal urothelium." The histopathologic description is "characterized by discrete papillary fronds with occasional branching…the epithelium lacks atypia…mitoses are absent to rare and, if present, are basal in location and not abnormal. The lesions are often small and occasionally show concomitant inverted growth pattern. Rarely, papilloma may show extensive involvement of the mucosa."

Primary Site

C670 Trigone of bladder
Base of bladder
Floor
Below interureteric ridge (interureteric crest, or interureteric fold)

C671 Dome of bladder
Vertex
Roof
Vault

C672 Lateral wall of bladder
Right wall
Left wall
Lateral to ureteral orifice
Sidewall

C673 Anterior wall of bladder

C674 Posterior wall of bladder

C675 Bladder neck
Vesical neck
Internal urethral orifice

C676 Ureteric orifice
Just above ureteric orifice

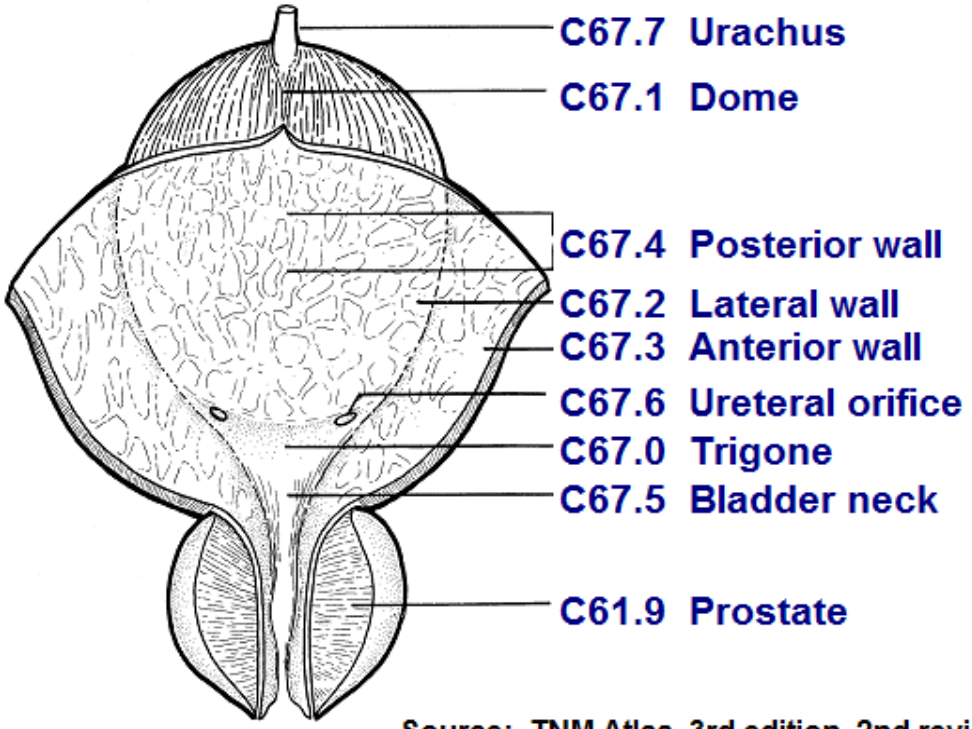
C677 Urachus
Mid umbilical ligament

C678 Overlapping lesion of bladder
Lateral-posterior wall (hyphen)
Fundus

C679 Bladder, NOS
Lateral posterior wall (no hyphen)

*The interureteric ridge is a fold of mucous membrane extending across the bladder between the ureteric orifices and forms one of the boundaries for the trigone of the bladder.

Bladder Anatomy and ICD-O-3



Source: TNM Atlas, 3rd edition, 2nd revision

Priority Order for Coding Subsites

Use the information from reports in the following priority order to code a subsite when the medical record contains conflicting information:

Operative report (TURB)
Pathology report

Multifocal Tumors:
Invasive tumor in more than one subsite

Assign site code C679 when the tumor is multifocal (separate tumors in more than one subsite of the bladder).

If the TURB or pathology proves invasive tumor in one subsite and in situ tumor in all other involved subsites, code to the subsite involved with **invasive** tumor.

Bladder Wall Pathology

The bladder wall is composed of three layers. There may be "sub layers" within the major layer of the bladder.

Table A.1 Bladder

BLADDER LAYER	SUB LAYER	SYNONYMS	STAGING	DESCRIPTION
Mucosa		Epithelium, transitional epithelium, urothelium, mucosal surface, transitional mucosa	No blood vessels, in situ/ noninvasive	First layer on inside of bladder; Lines bladder, ureters, and urethra
	Basement Membrane		No invasion of basement membrane is in situ Invasion/ penetration of basement membrane is invasive	First layer on inside of bladder; Lines bladder, ureters, and urethra
	Submucosa	Submucous coat, lamina propria, areolar connective tissue	Invasive	Areolar connective tissue interlaced with the muscular coat. Contains blood vessels, nerves, and in some regions, glands
Lamina propria		Submucosa, Suburothelial connective tissue, subepithelial tissue, stroma, muscularis mucosa, transitional epithelium	Invasive	
Muscle	Bladder wall	Muscularis, muscularis propria, muscularis externa, smooth muscle	Invasive	

The following terms are used when the tumor has extended **through the bladder wall** (invades regional tissue):

Serosa (Tunica serosa): The outermost serous coat is a reflection of the peritoneum that covers the superior surface and the upper parts of the lateral surfaces of the urinary bladder. The serosa is part of visceral peritoneum. The serosa is reflected from these bladder surfaces onto the abdominal and pelvic walls.

Perivesical fat

Adventitia: Some areas of the bladder do not have a serosa. Where there is no serosa, the connective tissue of surrounding structures merges with the connective tissue of the bladder and is called adventitia.

Histology [1]

Most bladder cancers are transitional cell carcinomas. Other types include squamous cell carcinoma and adenocarcinoma.

Adenocarcinomas tend to occur in the urachus or, frequently, the trigone of the bladder [2]

Other bladder histologic types include sarcoma, lymphoma, and small cell carcinoma.

Rhabdomyosarcoma occurs in children.

Behavior Code

Code the behavior as malignant /3, **not** in situ /2, when

- the only surgery performed is a transurethral resection of the bladder (TURB) documenting that depth of invasion cannot be measured because there is no muscle in the specimen **AND**
- the physician's TNM designation is **not** available **OR**
- the pathology report says the submucosa is invaded with tumor **OR**
- the pathology report does not mention whether the submucosa is free of tumor or has been invaded by tumor

Code the behavior as in situ /2 when

- the TNM designation is Ta for TURB with no muscle in the specimen

1 PDQ
2 Clinical Oncology, 8th edition

First Course Treatment

BCG

Code BCG as both surgery and immunotherapy. See the SEER manual, Appendix C, Bladder Surgery Codes, SEER Note under code 16.

Treatment Modalities (most common treatments)

- TURB with fulguration
- TURB with fulguration followed by intravesical BCG (bacillus Calmette-Guerin) is usually used for patients with multiple tumors or for high-risk patients.
- TURB with fulguration followed by intravesical chemotherapy
- Photodynamic therapy (PDT) using laser light and chemotherapy
- Segmental cystectomy (rare)
- Radical cystectomy in patients with extensive or refractory superficial tumor
- Internal irradiation (needles, seeds, wires, or catheters placed into or near the tumor) with or without external-beam irradiation
- Chemotherapy
- Immunotherapy/biologic therapy

Breast
C500 – C509

Primary Site

C500 Nipple (areolar)
Paget disease without underlying tumor

C501 Central portion of breast (subareolar) area extending 1 cm around areolar complex
Retroareolar
Infraareolar
Next to areola, NOS
Behind, beneath, under, underneath, next to, above, cephalad to, or below nipple
Paget disease with underlying tumor
Lower central

C502 Upper inner quadrant (UIQ) of breast
Superior medial
Upper medial
Superior inner

C503 Lower inner quadrant (LIQ) of breast
Inferior medial
Lower medial
Inferior inner

C504 Upper outer quadrant (UOQ) of breast
Superior lateral
Superior outer
Upper lateral

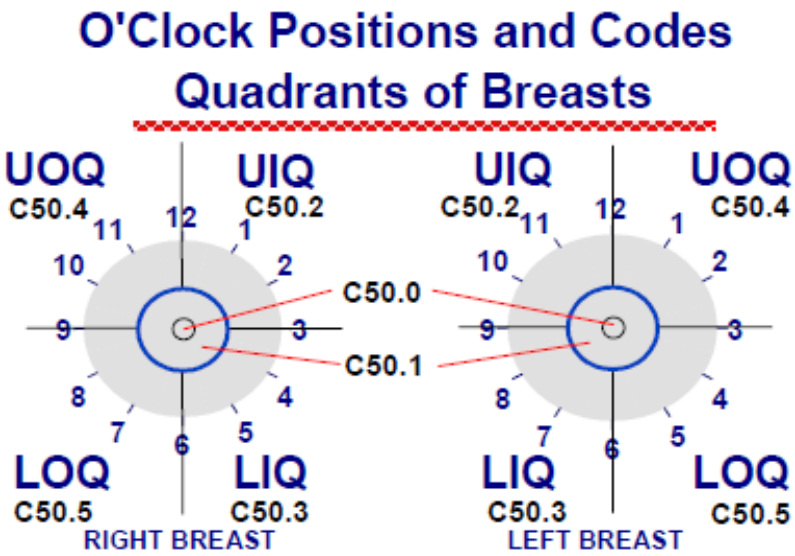
C505 Lower outer quadrant (LOQ) of breast
Inferior lateral
Inferior outer
Lower lateral

C506 Axillary tail of breast
Tail of breast, NOS
Tail of Spence

C508 Overlapping lesion of breast
Inferior breast, NOS
Inner breast, NOS
Lateral breast, NOS
Lower breast, NOS
Medial breast, NOS
Midline breast NOS
Outer breast NOS
Superior breast, NOS
Upper breast, NOS
3:00, 6:00, 9:00, 12:00 o’clock

C509 Breast, NOS
Entire breast
Multiple tumors in different subsites within breast
Inflammatory without palpable mass
¾ or more of breast involved with tumor
Diffuse (tumor size 998)

Additional Subsite Descriptors
The position of the tumor in the breast may be described as the positions on a clock



Coding Subsites
Use the information from reports in the following priority order to code a subsite when there is conflicting information:

1. Pathology report
2. Operative report
3. Physical examination
4. Mammogram, ultrasound

Code the subsite with the **invasive** tumor when the pathology report identifies invasive tumor in one subsite and in situ tumor in a different subsite or subsites.

Code the specific quadrant for multifocal tumors all within one quadrant

- Do **not** code C509 (Breast, NOS) in this situation

Code the primary site to C508 when

- There is a single tumor in two or more subsites **and** the subsite in which the tumor originated is unknown
- There is a single tumor located at the 12,3, 6, or 9 o'clock position on the breast

Code the primary site to C509 when there are multiple tumors (two or more) in at least two quadrants of the breast

Laterality
Laterality must be coded for all subsites.

Breast primary with positive nodes and no breast mass found: Code laterality to the side with the positive nodes

First Course Treatment

Six types of standard treatment are used:

1. Surgery
   - Breast-conserving surgery: Operation includes lumpectomy, partial mastectomy also called segmental mastectomy, and subcutaneous mastectomy.
   - Other types of surgery: Total mastectomy, modified radical mastectomy, extended radical mastectomy.
2. Sentinel lymph node biopsy followed by surgery.
3. Radiation Therapy
4. Chemotherapy
5. Hormone therapy
6. Targeted therapy

Surgery Codes
(Except for M9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY
19 Local tumor destruction, NOS

No specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003)

20 Partial mastectomy, NOS; less than total mastectomy, NOS
21 Partial mastectomy WITH nipple resection
22 Lumpectomy or excisional biopsy
23 Reexcision of the biopsy site for gross or microscopic residual disease
24 Segmental mastectomy (including wedge resection, quadrantectomy, tylectomy)
Procedures coded 20–24 remove the gross primary tumor and some of the breast tissue (breast-conserving or -preserving surgery). There may be microscopic residual tumor.

SEER Note: When a patient has a procedure (e.g., lumpectomy) with reconstruction, code only the procedure (e.g., lumpectomy , code 22) as the surgery.

30 Subcutaneous mastectomy

A subcutaneous mastectomy, also called nipple sparing mastectomy, is the removal of breast tissue without the nipple and areolar complex or overlying skin. It is performed to facilitate immediate breast reconstruction. Cases coded 30 may be considered to have undergone breast reconstruction.

40 Total (simple) mastectomy, NOS
- 41 WITHOUT removal of uninvolved contralateral breast
  - 43 Reconstruction, NOS
  - 44 Tissue
  - 45 Implant
  - 46 Combined (tissue and implant)
- 42 WITH removal of uninvolved contralateral breast
  - 47 Reconstruction, NOS
  - 48 Tissue
  - 49 Implant
  - 75 Combined (tissue and implant)

SEER Note: "Tissue" for reconstruction is defined as human tissue such as muscle (latissimus dorsi or rectus abdominis) or skin in contrast to artificial prostheses (implants). Placement of a tissue expander at the time of original surgery indicates that reconstruction is planned as part of the first course of treatment.

A total (simple) mastectomy removes all breast tissue, the nipple, and the areolar complex. An axillary dissection is not done.

For **single** primaries only, code removal of involved contralateral breast under the data item **Surgical Procedure/Other Site** (NAACCR Item # 1294).

SEER Note: Example of single primary with removal of involved contralateral breast--Inflammatory carcinoma involving both breasts. Bilateral simple mastectomies. Code Surgery of Primary Site 41 and code Surgical Procedure of Other Site 1.

If **contralateral breast** reveals a **second primary**, each breast is abstracted separately. The surgical procedure is coded 41 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed on that site.

SEER Note: Placement of a tissue expander at the time of original surgery means that reconstruction is planned as part of the first course of treatment. When an expander is placed, code the mastectomy and reconstruction. Reconstruction that is planned as part of first course treatment is coded 43-49 or 75, regardless of whether it is done at the time of mastectomy or later.

SEER Note: Reconstruction may be done at the same time as the mastectomy or may be done later. Code 43-49, or 75 if the operative report or medical record states reconstruction will be done later, or if a tissue expander is inserted during the mastectomy procedure. Tissue expander insertion precedes reconstruction.

76 Bilateral mastectomy for a single tumor involving both breasts, as for bilateral inflammatory carcinoma.

50 Modified radical mastectomy
- 51 WITHOUT removal of uninvolved contralateral breast
  - 53 Reconstruction, NOS
  - 54 Tissue
  - 55 Implant
  - 56 Combined (tissue and implant)
- 52 WITH removal of uninvolved contralateral breast
  - 57 Reconstruction, NOS
  - 58 Tissue
  - 59 Implant
  - 63 Combined (tissue and implant)

Removal of all breast tissue, the nipple, the areolar complex, and variable amounts of breast skin in continuity with the axilla. The specimen may or may not include a portion of the pectoralis major muscle.

SEER Note: "In continuity with" or "en bloc" means that all the tissues were removed during the same procedure, but not necessarily in a single specimen. "Tissue" for reconstruction is defined as human tissue such as muscle (latissimus dorsi or rectus abdominis) or skin in contrast to artificial prostheses (implants). Placement of a tissue expander at the time of original surgery indicates that reconstruction is planned as part of the first course of treatment.

Assign code 51 or 52 if a patient has an excisional biopsy and axillary dissection followed by a simple mastectomy during the first course of therapy. Code the cumulative result of the surgeries, which is a modified radical mastectomy in this case. Code the most invasive, extensive or definitive surgery in Surgery of Primary Site.

If **contralateral breast** reveals a **second primary**, each breast is abstracted separately. The surgical procedure is coded 51 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed on that site.

For **single** primaries only, code removal of involved contralateral breast under the data item **Surgical Procedure/Other Site** (NAACCR Item # 1294).

60 Radical mastectomy, NOS
- 61 WITHOUT removal of uninvolved contralateral breast
  - 64 Reconstruction, NOS
  - 65 Tissue
  - 66 Implant
  - 67 Combined (tissue and implant)
- 62 WITH removal of uninvolved contralateral breast
  - 68 Reconstruction, NOS
  - 69 Tissue
  - 73 Implant
  - 74 Combined (tissue and implant)

SEER Note: Involves removal of breast tissue, nipple, areolar complex, variable amount of skin, pectoralis minor, and/or pectoralis major, as well as en bloc axillary dissection. “Tissue” for reconstruction is defined as human tissue such as muscle (latissimus dorsi or rectus abdominis) or skin in contrast to artificial prostheses (implants). Placement of a tissue expander at the time of original surgery indicates that reconstruction is planned as part of the first course of treatment.

70 Extended radical mastectomy
- 71 WITHOUT removal of uninvolved contralateral breast
- 72 WITH removal of uninvolved contralateral breast

SEER Note: Involves removal of breast tissue, nipple, areolar complex, variable amounts of skin, pectoralis minor, and/or pectoralis major, as well as removal of internal mammary nodes and en bloc axillary dissection.

80 Mastectomy, NOS

Specimen sent to pathology for surgical events coded 20-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Colon
C180 – C189

The prognosis of patients with colon cancer is related to the degree of penetration of the tumor through the bowel wall, the presence or absence of nodal involvement, and the presence or absence of distant metastases.

Primary Site

Priority Order for Coding Primary Site

Use the information from reports in the following priority order to code the primary site when there is conflicting information:

Resected cases
- Operative report with surgeon's description
- Pathology report
- Imaging

Polypectomy or excision without resection
- Endoscopy report
- Pathology report

Subsites

Code the subsite with the most tumor when the tumor overlaps two subsites.

Code C188 when both subsites are equally involved.

Surgery SEER notes

SEER Note*:* Code 30 (Partial colectomy [but less than hemicolectomy] segmental resection) includes but is not limited to the following procedures: Appendectomy (for an appendix primary only), enterocolectomy, ileocolectomy, partial colectomy, NOS, partial resection of transverse colon and flexures, and segmental resection (such as cecectomy or sigmoidectomy). Note that the removal of a short portion of the distal ileum is **not** "removal of a contiguous organ".

SEER Note*:* Code 40 (Subtotal colectomy/hemicolectomy -total right or left colon and a portion of transverse colon), includes extended (but less than total) right or left colectomy. Note that the removal of a short portion of the distal ileum is **not** "removal of a contiguous organ".

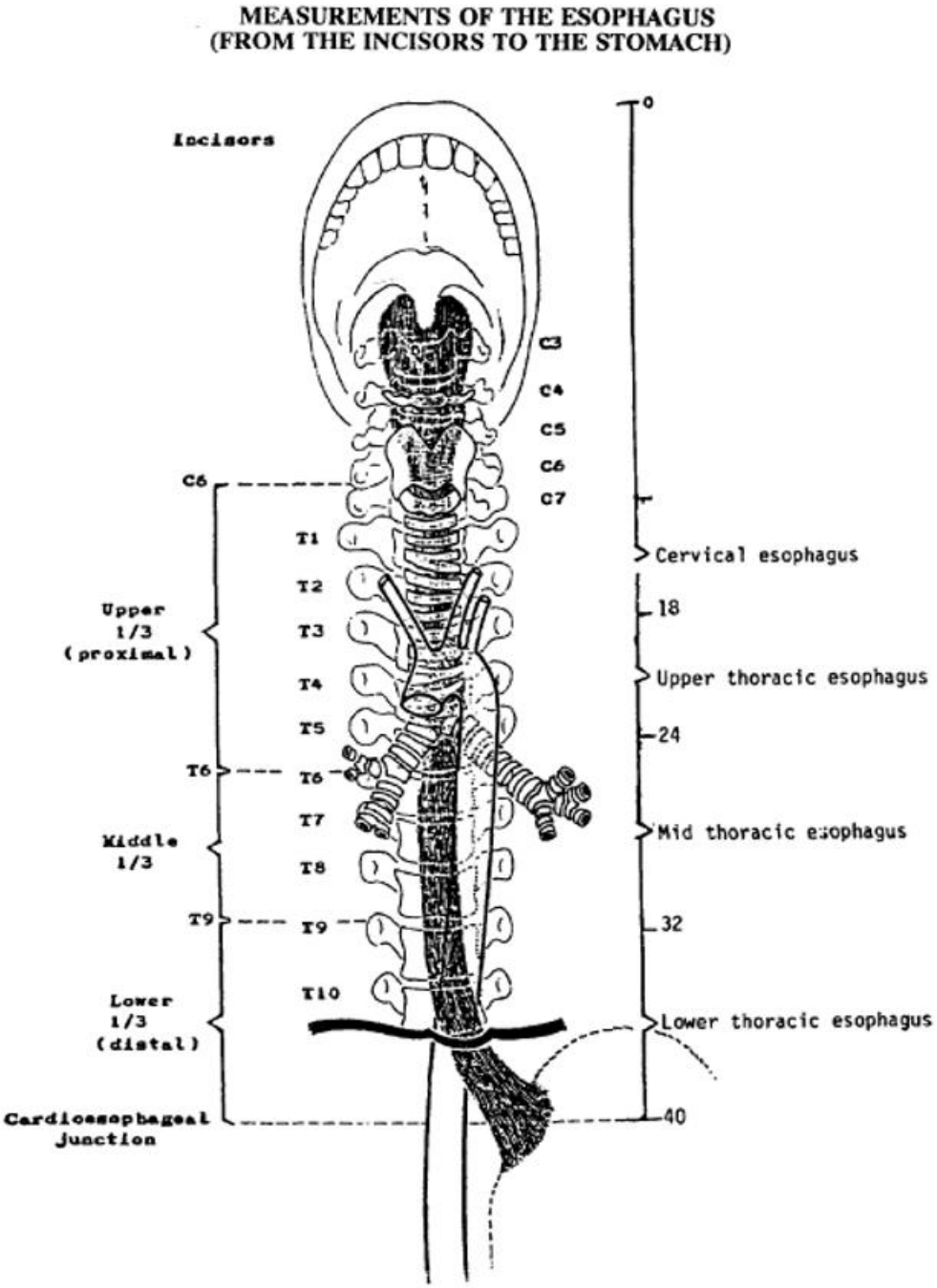
SEER Note*:* Removal of a short portion of the distal ileum is **not** "removal of a contiguous organ".

SEER Note*:* "In continuity with" or "en bloc" means that all of the tissues were removed during the same procedure, but not necessarily in a single specimen.

Esophagus
C150 – C155, C158 – C159

Primary Site

There are two systems that divide the esophagus into three subsites. The first system divides the esophagus into the upper third, middle third, and lower third. The second system describes the subsites as the cervical esophagus, the thoracic esophagus and the abdominal esophagus. The subsites for these two different systems are not identical. Assign the ICD-O-3 topography code that describes the primary site documented in the medical record. See the following image for an illustration of both systems.



First Course Treatment

Do **not** code proton pump inhibitors (PPI) as treatment

Do **not** code RFA for Barrett's esophagus as treatment
HALO 90 ultra radiofrequency ablation (RFA) of Barrett's esophagus is used to reduce progression of high-grade dysplasia to esophageal cancer. It is not used to treat esophageal cancer.

Kaposi Sarcoma
M9140 (of all sites)

Primary Site

Kaposi sarcoma that is not AIDS-related is a rare condition. It usually presents as localized disease with an easily recognized primary site.

AIDS-related Kaposi sarcoma usually presents as a disseminated disease with involvement of mucosal surfaces, visceral surfaces of organs, and skin. It is important to review consecutive records carefully to determine the extent of involvement at diagnosis. Review of a single record may reveal only the site being treated during that admission.

1. Code the Kaposi sarcoma to the **primary site in which it arises.**

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

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

Lung
C340 – C349

Primary Site

C340 Main bronchus
Carina
Hilum
Bronchus intermedius

C341 Upper lobe, lung
Lingula
Apex
Pancoast tumor

C342 Middle lobe, lung (Right lung only)

C343 Lower lobe, lung
Base

C348 Overlapping lesion of lung

C349 Lung, NOS
Bronchus, NOS

Laterality

Laterality must be coded for all subsites except carina.

Pancoast Tumor

Pancoast tumor is a lung cancer in the upper-most segment of the lung that directly invades the brachial plexus (nerve bundles) of the neck, causing pain. It is by definition malignant. Code the date of diagnosis from the imaging report when a Pancoast tumor is identified on imaging prior to biopsy.

Rectosigmoid Junction
C199

Primary Site
A tumor is classified as **rectosigmoid** when differentiation between rectum and sigmoid is not possible.

A tumor is classified as **rectal** if
- lower margin lies less than 16 cm from the anal verge **or**
- any part of the tumor is located at least partly within the supply of the superior rectal artery

Anatomic Transition from Sigmoid to Rectum
In the sigmoid colon, approximately 12 to 15 cm from the dentate line, the tenia coli fuse to form the circumferential longitudinal muscle of the rectal wall.

The **rectum** is defined clinically as the distal large intestine commencing opposite the sacral promontory and ending at the anorectal ring, which corresponds to the proximal border of the puborectalis muscle palpable on digital rectal examination. It extends 16 cm from the anal verge.[1]

Glossary

Anal verge: The lower (distal) end of the anal canal, junction between the skin of the anal canal and the perianal skin.

Anorectal ring: Top (proximal end) of the anal canal

Dentate line: An anatomic landmark located between the anal verge and the anorectal ring indicating where the rectum changes to the anal canal. Also called the pectinate line.

Tenia coli: (Plural: teniae coli). Any one of three longitudinal bands of smooth muscle in the colon. They extend from the cecum to the sigmoid colon. Each band is approximately 8 mm wide throughout most of the colon. The widths of the teniae increase in the sigmoid colon and eventually fuse into a covering of longitudinal muscle in the rectum.

1 Wittekind C, Henson DE, Hutter RVP, Sobin LH, eds. TNM Supplement: A Commentary on Uniform Use. 2nd ed. New York, NY: Wiley-Liss; 2001.

Skin - Melanoma
C44.0 – C44.9

Reportability
In situ melanoma, including early or evolving in situ melanoma, is reportable.

Early or evolving melanoma is **not** reportable.

Surgery Codes SEER Notes

SEER Note: Codes 30 to 35 include less than a wide excision, less than or equal to 1-cm margin, or status of margin is unknown. If it is stated to be a **wide excision** or **reexcision**, but the **margins are unknown**, code to 30.

> Assign a surgery code from the 30-35 range when any margin is less than 1 cm.
>
> ***Example***: Melanoma: with surgical margins greater than 1 cm for length and width but less than 1 cm for depth. Assign a surgery code in the 30-35 range. Since tumor thickness is an important prognostic factor for cutaneous melanoma, the deep margin is of particular importance.
>
> Use code 45 when there is a wide excision AND it is known that the margins of excision are greater than 1 cm.

SEER Note: If the excision or reexcision has microscopically negative margins less than 1 cm OR the margins are more than 1 cm but are not microscopically confirmed; use the appropriate code, 20-36.

REQUIRED SITE-SPECIFIC FACTORS (SSFs)

Effective with cases diagnosed in 2016 The existing CSv2 fields will continue to be used for capturing required SSFs for 2016 diagnosis forward.

SSFs necessary to calculate Derived Summary Stage 2000 or Derived AJCC 7 Stage Group (for Collaborative Stage) are no longer required for cases diagnosed in 2017; however, sitespecific factors that impact directly-assigned AJCC-TNM 7th Edition Stage Group (e.g. PSA for prostate) or that are prognostic factors of interest, remain important to collect for cancer surveillance. The Collaborative Stage SSF data items will continue to be used for this purpose. SSFs that will be required by CDC-NPCR are listed in Tables A.5 and A.6 below.

Site Specific Factors Required for Diagnosis Year 2017

The following SSF's are required and the existing SSFs in CSv2 will continue to be used to capture data items.

Table A.5 Site Specific Factors Required for Directly Assigned AJCC TNM Stage

Site (CS Schema)	SSF	Description
Appendix	SSF 11	Histopathologic Grading
GISTPeritoneum	SSF 5 and 10	Mitotic Count; Location of Primary Tumor
GISTEsophagus, GISTSmallIntestine, GISTStomach	SSF 6	Mitotic Count
GISTAppendix, GISTColon, GISTRectum	SSF 11	Mitotic Count
MycosisFungoides	SSF 1	Peripheral Blood Involvement
Placenta	SSF 1	Prognostic Scoring Index
Prostate	SSF 1, 8 and 10	PSA Lab Value, Gleason Score
Testis	SSF 13, 15, 16	Post Orchiectomy AFP, hCG, and LDH Range
BileDuctsDistal, BileDuctsPerihilar, CysticDuct, EsophagusGEJunction, LacrimalGland, LacrimalSac, MelanomaCiliaryBody, MelanomaIris, Nasopharynx, PharyngealTonsil, Stomach	SSF 25	Schema Discriminator

NOTE: NPCR will continue the requirement for Gleason Score data using SSF 8 and 10 in order to accurately determine the AJCC stage group for prostate cancer cases. This will also provide NPCR with comparable Gleason Score data to SEER and CoC for prostate cancer cases.

Table A.6 Site Specific Factors required by NPCR and TCR (but not for AJCC Staging)

Site (CS Schema)	SSF	Description
Brain, CNSOther, IntracranialGland	1	Who Grade
Breast	1	ERA
	2	PRA
	8	HER2: IHC Value
	9	HER2: IHC Interpretation
	11	HER2: FISH Interpretation
	13	HER2: CISH Interpretation
	14	HER2: Result of other test
	15	HER2: Summary Result testing
	16	Combination of ERA, PRA and HER2 Testing

RECORDING INFORMATION: LAB TESTS, TUMOR MARKERS, AND OTHER REPORTS IN SITE-SPECIFIC FACTORS

Important Notes
The following information is intended as a guide to help the registrar locate the test in the medical record and to identify which lab test results should be coded in the Collaborative Stage Data Collection System site-specific factors (SSF).

1. The results of many tumor markers and other laboratory tests vary according to the laboratory conducting the test. The normal reference range is included in the tumor marker comments as background information *only*. Some site-specific factors ask for a lab value, others ask for the "interpretation" of the lab test (normal, elevated, and so forth).

When the site-specific factor asks for the interpretation of a lab test, code the clinician's/pathologist's interpretation, if available, as first priority. This would include statements of "abnormal", "elevated", "normal", "equivocal", "present", "absent", and so forth. In addition, the physician's statement of a T, N, or M value or stage group for the case could be an implied interpretation of a lab value used to determine the TNM classification, taking all information into consideration.

> ***Example 1*:** Physician summarizes breast cancer workup by saying "HER2 IHC was positive at 3+. Registrar would code interpretation as 010 (positive).

Note: If the pathologist uses the term "indeterminate," code as 030 (borderline; undetermined if positive or negative) if that code exists in the site-specific factor. If code 030 does not exist, code as 999.

- In the absence of a physician's interpretation of the test, if the reference range for the lab is listed on the test report, the registrar may use that information to assign the appropriate code.

- When there is no clinician/pathologist interpretation of the lab test and no description of the reference range in the medical record the registrar should code 999 (not documented, unknown) to code the SSF. Do not code the lab value interpretation based on background information provided in this manual for the SSF.

  ***Example 2*:** Physician reports that Alpha Fetoprotein (AFP) collected in the office for a patient suspected to have primary liver cancer was 750 but does not interpret this value. Background information in CS User Documentation indicates a high normal would be > 500 but hepatocellular carcinoma values are > 1000. Registrar should code AFP interpretation as 999, unknown or no information.

Note: There will be some cases where an interpretation may be inferred from the background information in the CS User Documentation because the lab result is extremely abnormal. In such cases, common sense would dictate that the case should be coded as 010 (elevated) rather than 999.

2. In the site-specific notes in this document, only the codes pertaining to coding the test are listed. Refer to the specific CS schema tables for additional code choices when the test results are not in the medical record.

3. What does SI mean? SI is the French abbreviation for International System (*Systeme Internationale)*, standard units of measure (meter, kilogram, second). Most SI values are based on the kilogram and the liter. A nanogram (ng) is one-thousandth of a microgram (µg). A milliliter (ml) is one-thousandth of a liter. So a lab value expressed in µg/L is equivalent to the same value expressed in ng/ml. Some lab values, such as hormone levels, are recorded in International Units per Liter (IU/L). This is equivalent to mIU/mL. The equivalence of mIU to ng varies according to what is measured. This is one measurement conversion website: http://www.amamanualofstyle.com/page/si-conversion-calculator. There are many others available. Note that instructions for entering many lab values state that the registrars should not convert the values.

SI Conversion: 1 µg/L = 1 ng/ml. For example, 1 ng of AFP is approximately equal to 1 mIU.

Note: Micrograms (µg) per liter may be printed as ug/L.

4. Prefixes and abbreviations: Units of measure can be described and written in various ways in the medical record. In some circumstances, the unit of measure may be dependent on the printer used for the report. For example, the prefix "micron" (one millionth of a unit) is represented in scientific notation by the Greek letter *mu* (µ), but not all printers have the capability to print Greek symbols.

As a result, micro- may be printed as a lower case *u* or as the abbreviation mc. Do not confuse the abbreviation for micro- (u) with the abbreviation for Unit (an international system measurement, U).

Tables A.2 and A.3 below show abbreviations for units of measurement and the abbreviations for fractions or multiples of those units.

Table A.2 Measurement Prefixes

NUMBER	PREFIX	WRITTEN
1,000,000	Mega-	M
1,000	Kilo-	K
1 (baseline)	Deka-	Da
1/10	Deci-	d
1/100	Centi-	c
1/1000	Milli-	m
One millionth	Micro-	µ
One billionth	Nano-	n
One trillionth	Pico-	p
One quadrillionth	Femto	f

Table A.3 Unit Abbreviations

UNIT	ABBREVIATION
Liter	l
Unit	U
Meter	m
Unit of substance	mole, mol
Gram	g, gr
milli Equivalent	mEq, meq

Table A.4. Common Codes in Site-Specific Factors

CODE	DESCRIPTION
000	0 ng/ml
001	0.1 or less ng/ml
002-979	0.2-97.9 ng/ml
980	98.0 or greater ng/ml
988	Not applicable. Information not collected for this case. May include cases converted from code 888 used in CSv1 for "Not Applicable" or when the item was not collected. If this item is required to derive T, N, M, or any stage, use of code 988 may result in an error.
997	Test ordered, results not in chart
998	Test not done (test was not ordered and was not performed)
999	Unknown or no information Not documented in patient record

Code 000: In a numeric site-specific factor, such as a lab value for CEA, Chromogranin, CA-125, code 000 means a zero value on the test itself.

Rounding: Rounding instructions for most numeric site-specific factors: for numbers or percentages less than 1 (such as 0.3 or 0.4%), round up to 001. Do not round down to 000, as this means a zero value. For numbers above 1, round .1 to .4 down, and round .5 to .9 up to the next whole unit.

Examples

10.4% therapy response: Code as 010.
25% tumor necrosis: Code as 025
Size of metastasis in lymph node: 0.4 mm: Code as 001
95% chemotherapy effect: Code as 095

Upper Range of Lab Test Values: The upper range of values is usually 97.9 or 979 (depending on the type of test), with code 980 indicating that the actual test result was 98.0/980 or higher.

Code 988 – Not Applicable: Information Not Collected For This Case: In most site-specific factors, code 988 appears as 'Not applicable: Information not collected for this case.' The intended meaning for code 988 is that the registry does not routinely collect the information for cases coded using this schema. Code 988 is not intended to mean that the information is not collected for a case because the information is deemed not applicable for the particular case circumstances. This code may be used if the data field is not required by the registry's standards setters. However, code 988 cannot be used by a registry where the field is required for collection. *Example* Colon Site-Specific Factor 9, KRAS, is required for collection by COC-Accredited facilities in all areas and all registries in SEER regions. Canadian registries and registries not participating in the COC Accreditation program in National Program of Cancer Registries (NPCR) states may use code 988 if the registry makes the decision not to collect information about KRAS. COC-Accredited and SEER registries must select a code other than 988 to complete this field.

Code 997 – Test Ordered, Results Not In Chart: If it is known that the test was ordered but there is no report in the record, select the code that indicates that the test was ordered but results are not available (code description varies depending on site-specific factor and primary site). This code is useful as a quality control flag to indicate cases where information may be available at a later date.

Code 998 – Test Not Done: If there is a statement that the test was not performed, select the code that documents that the test was not done (code description varies depending on site-specific factor and primary site). Do not assume that the test was not done if the report is not available in the medical record; use code 999 instead (except as noted in the next paragraph).

Test Never Done by Facility: This code may also be used by a registry in a facility that does not perform the test. In other words, code 998 can also be used if the registry staff has discussed tests with the laboratory medicine department of the facility and the lab has indicated that it never does the test and never sends it to a reference lab. Decisions on these tests should be documented in the registry's procedure manual or coding manual and reviewed annually, as tests and procedures may be added or dropped by the facility. If the facility does offer the test (in-house or sent out), code 998 should not be used unless there is a statement in the record that the test was not done for the case.

Other Meanings: Code 998 may have other meanings in some site-specific factors, generally related to a procedure not being performed or a specimen not available. Read the definitions carefully.

***Examples*:**

Prostate SSF7: No core biopsy/TURP performed
CorpusCarcinoma SSF2: No pathologic specimen available
MelanomaSkin SSF7: No histologic examination of primary site.
Rectum SSF5: No preoperative treatment or no resection of primary site after preoperative treatment

Code 999: If there is no information in the medical record about the lab value, use code 999.

Note: Source documents are suggested for some site-specific factors as the most likely sources of information. If no source document is suggested, use any information provided in the medical record. If a pathology report is suggested, that document includes any addenda or revisions to the report, as well as synoptic report, CAP protocol, or cancer checklist information provided by the pathologist.

Note: Not all codes are discussed for each site-specific factor. In particular, guidelines for using code 988 are provided only when none or all of the standards setters require the field. When a site-specific factor is required by one to three standards setters, refer to their instructions for docmenting the field.

5. Histologic examination: Histologic examination is the assessment of a tissue specimen. Aspiration of fluid (cells) is a cytologic examination. Some site-specific factors require analysis of tissue, whereas others can be performed on any specimen (tissue or fluid). Pathologic examination can refer to either histologic or cytologic examination.

SITE-SPECIFIC FACTORS COMMON TO SEVERAL PRIMARY SITES

Note: Not all code choices are listed in the following discussions of site-specific factors. ALWAYS refer to the complete listing of codes in the corresponding tables when coding the site-specific factor(s).

Mitotic Count

Primary Sites: GIST Esophagus; GIST Stomach; GIST SmallIntestine; GIST Colon; GIST Appendix; GIST Rectum; GIST Peritoneum; TCR collects Mitotic Count for all these sites.

Source documents: pathology report

Other names: mitotic rate, mitotic index (a ratio-do not record this measurement), mitotic activity Mitotic count is a way of describing the potential aggressiveness of a tumor. For GIST tumors, the count is translated into a mitotic rate that is used with T, N, and M to stage group a case.

Record the number of cells actively dividing as determined by the pathologist. The count will vary according to the type of tumor. Follow the instructions in the SSF notes for the primary cancer being coded.

> GIST (appendix, colon, esophagus, peritoneum, rectum, small intestine, stomach): count per 50 HPF* or 5 square millimeters
>
> *The usual high power is 40 x magnifications.

This site-specific factor is a three-digit field with an implied decimal point between the second and third digits. For example, if the mitotic rate is reported as 12 mitoses per 50 HPF for a gastrointestinal stromal tumor, record as 120.

a. Use code 000 if there are no mitoses present in the high power field area designated for the primary cancer (10, 40, 50 HPF).

b. Codes in the range 001 to 008 are used when the number of mitoses is reported as a decimal number (part of a whole mitotic figure).

c. Use code 009 when the pathologist states that the mitotic rate is less than 1 mitosis per HPF area.

d. Codes in the 010 to 100 range are used when there are between 1 and 10 mitoses per HPF area.

e. Codes 990 – 992 can be used for general statements that the mitotic rate is up to the cut point for low mitotic rate for the primary site being coded or more than the cut point for a high mitotic rate.

f. Use code 996 when the unit of measurement is not consistent with the primary site specification.

g. Use code 998 when there has been no specimen from the primary site.

h. Use code 999 if there is no mention of a mitotic rate in the pathology report.

Site-Specific Factor 25 – Schema Discriminator

Head and Neck Sites
(Nasopharynx, Pharyngeal Tonsil)

Site-Specific Factor 25 – Schema Discriminator: Nasopharynx/PharyngealTonsil

Source documents: pathology report, imaging report, endoscopy report

ICD-O topography code C11.1, posterior wall of nasopharynx, includes both the mucosal surface of the posterior wall and the adenoid or pharyngeal tonsil, two different seventh edition TNM chapters. The posterior wall of nasopharynx (mucosal surface) is staged with nasopharynx, and the lymphoid tissues of the pharyngeal tonsil are staged with the oropharynx. Site-Specific Factor 25 is used for both Nasopharynx and PharyngealTonsil. Code the description of the true primary site as stated in the medical record.

a. Use code 010 when the primary site is stated as posterior wall of nasopharynx (NOS); this will present the Nasopharynx schema for coding and mapping to TNM.
b. Use code 020 when the primary site is stated as adenoid, pharyngeal tonsil or nasopharyngeal tonsil; this will present the PharyngealTonsil schema for coding and mapping to TNM.
c. See schema table for additional code choices.

Upper Gastrointestinal (UGI) Tract - Esophagus, Stomach, Small Intestine
(Also see section on gastrointestinal stromal tumors [GISTs])

Site-Specific Factor 25 – Schema Discriminator: Involvement of Cardia and Distance from Esophagogastric Junction (EGJ) (Esophagus-GE Junction, Stomach)

The esophagus chapter of the AJCC Cancer Staging Manual seventh edition includes the esophagogastric junction (also called the cardia or gastroesophageal junction) and the proximal 5 cm of the stomach. The cardia is defined as the opening or junction between the esophagus and the stomach, and it is between 0.1 and 0.4 cm in length. The cardia (C16.0) is mapped to the seventh edition esophagus staging. Two additional stomach topography codes are included in the proximal 5 cm of the stomach, the fundus (C16.1) and body (C16.2) (Figure I-2-3). This 5 cm boundary measurement is based on the Siewert classification of gastroesophageal cancers, which defines an area 5 cm above and 5 cm below the cardia or esophagogastric junction. To determine whether a cancer in the fundus or body of the stomach should be coded according to the esophagus schema or the stomach schema, it is necessary to identify the midpoint or epicenter of the tumor. If the midpoint is at or above the cardia, the tumor is definitely esophageal. If the midpoint of the tumor is within 5 cm distal to the gastroesophageal junction (GEJ) and the lesion extends to or across the GEJ, the case should be coded with the Esophagus-GE Junction schema. If the midpoint of the tumor is within 5 cm distal to the GEJ and the lesion does not extend to the GEJ, the case should be coded with the stomach schema. Any tumor with a midpoint more distal than 5 cm from the GEJ is coded with the stomach schema. In order to determine which schema should be used for gastric tumors within 5 cm of the GE junction, a schema discriminator has been included as Site-Specific Factor 25. Select the code that best describes the location and extent of the tumor. If the tumor midpoint is anywhere in the stomach other than cardia, fundus or body, use code 981. If the tumor midpoint is in the cardia itself, use code 982.

Biliary Organs
(Perihilar Bile Ducts, Cystic Duct, Distal Bile Duct)

Due to revisions to chapters in the seventh edition of the AJCC Cancer Staging Manual Intrahepatic bile ducts (C22.1) are separated from liver (C22.0). These schemas are now histology-specific.

Primary liver cancers include morphology codes 8170-8175, hepatocellular carcinoma and its subtypes. Intrahepatic bile duct histologies include 8160, cholangiocarcinoma, 8161, bile duct cystadenocarcinoma, and 8180, combined hepatocellular and cholangiocarcinoma.. The extrahepatic bile ducts are split into three chapters in TNM seventh edition: perihilar bile ducts (proximal to the origin of the cystic duct), the cystic duct, and distal bile duct (between the junction of the cystic duct and the ampulla of Vater). Perihilar bile ducts include the right, left, and common hepatic duct. Distal bile duct is essentially the common bile duct below the point where the cystic duct and common hepatic duct join.

Site-Specific Factor 25 – Schema Discriminator: Perihilar Bile Ducts, Cystic Duct, Distal Bile Duct

Code the location of the tumor, such as hepatic duct or Klatskin tumor. Code 030 will display the cystic duct schema; codes 040 and 070 will display the distal bile duct schema. All other codes will display the perihilar bile ducts schema because 70-80% of all extrahepatic bile duct malignancies arise in the perihilar ducts (right, left, and common hepatic ducts).

Table A.6 Schema Discriminator Codes

CODE	DESCRIPTION
010	Perihilar bile duct(s); Proximal extrahepatic bile duct(s); Hepatic duct(s)
020	Stated as Klatskin tumor (tumor at junction of right, left and common hepatic ducts)
030	Cystic bile duct; cystic duct (duct between gallbladder and common bile duct)
040	Common bile duct, including common duct, NOS (also called choledochal duct)
050	Diffuse involvement; More than one subsite involved, subsite of origin not stated
060	Subsite of extrahepatic bile ducts not stated OR subsite stated as middle extrahepatic bile duct AND treated with combined hepatic and hilar resection
070	Subsite of extrahepatic bile ducts not stated OR subsite stated as middle extrahepatic bile duct AND treated with pancreaticoduodenectomy
100	C24.0 - originally coded in CS version 1 (this code should not be used for 2010 diagnoses and forward)
999	Subsite of extrahepatic bile ducts not stated and not classifiable in codes 050-070

Ophthalmic Sites
(Melanoma Ciliary Body, Melanoma Iris, Lacrimal Gland, Lacrimal Sac)

Eye Structures
The major structures of the eye (globe) are the retina, conjunctiva, and uvea. The uvea consists of the iris and ciliary body (C69.4, also called the anterior uvea) and choroid (C69.3, also known as the posterior uvea). The conjunctiva (C69.0) is a clear mucous membrane that covers the white part of the eye (sclera) and lines the inside of the eyelids. The retina (C69.2) is the innermost layer of the eye containing the neurons that result in vision. The orbit (C69.6) is the bony structure surrounding the soft tissues of the eye. The lacrimal gland (C69.5) is located in the orbit superior and lateral to the globe and produces the tears that keep the eye moist.

Melanoma Ciliary Body/Melanoma Iris

Site-Specific Factor 25 – Schema discriminator: Melanoma Ciliary Body/Melanoma Iris

Iris and ciliary body have the same ICD-O topography code (C69.4). However, for purposes of stage grouping in AJCC seventh edition, iris has its own T category definitions, which were carried over into CS version 2. Ciliary body has a separate schema. Consequently, a schema discriminator is necessary to distinguish between primary sites is in the iris and ciliary body so that the appropriate CS tables will be presented to the coder.

a. Use code 020 for originating in the iris.

b. Use code 010 for tumors originating in all other structures included in code C69.4 (ciliary body, lens, sclera, uveal tract) and the general terms intraocular and eyeball.

c. Code 100 is reserved for cases coded to C69.4 in CS version 1 (before these structures were split into separate schemas).

Lacrimal Gland/Lacrimal Sac

Site-Specific Factor 25 – Schema discriminator: Lacrimal Gland/Lacrimal Sac

The lacrimal (also spelled lachrymal) gland is the only epithelial structure normally present within the orbit. Its composition is the same as epithelial salivary glands and TNM staging parallels that of the major salivary gland classification. Lacrimal gland and lacrimal sac have the same ICD-O topography code (C69.5). AJCC seventh edition staging is limited to lacrimal gland. No stage grouping is presently recommended for carcinoma of the lacrimal gland.

Code the specific site of origin for the primary tumor in the lacrimal gland or lacrimal sac. Read the codes and definitions carefully, as some codes were made obsolete in CS version 0203 and the definitions were assigned to other codes.

a. Use code 015 when the medical record indicates:
   - the primary tumor arose in the lacrimal gland
   - the primary site is lacrimal with no further information

b. Use code 025 when the medical record states:
   - the primary tumor arose in the lacrimal sac
   - the primary tumor arose in the lacrimal duct (also called nasal lacrimal duct or nasolacrimal duct)

c. Code 100 is reserved for cases coded to C69.5 in CS version 1 (before these structures were split into separate schemas).

OTHER SSFs, MORPHOLOGY, AND PRIMARY SITE NOTES

Appendix

Site-Specific Factor 11 – Histopathologic Grading (Appendix)

Source Document: pathology report

The histopathologic grading of mucinous adenocarcinomas (morphology codes 8480, 8481 and 8490) appears to have prognostic value for appendiceal carcinomas. Mucinous adenocarcinomas have a better prognosis and are graded differently from intestinal-type adenocarcinomas-a two-grade system, low or high. Adenocarcinomas of the appendix use a standard four-grade system. Grade is used in deriving AJCC stage groups IVA (low grade mucinous adenocarcinoma or well-differentiated adenocarcinoma with intraperitoneal metastasis) and IVB (high grade mucinous adenocarcinoma or moderately and poorly differentiated adenocarcinoma with non-peritoneal metastasis).

a. Code histopathologic grade for all appendix carcinomas as described in the pathology report.
b. Mucinous adenocarcinoma: Use code 011 for low grade. Use code 021 for high grade.
c. Non-mucinous adenocarcinomas (codes other than 8480, 8481, and 8490):
   - Use code 010 for Grade 1 or well differentiated.
   - Use code 020 for Grade 2 or moderately differentiated.
   - Use code 030 for Grade 3 or poorly differentiated.
   - Use code 040 for Grade 4 or undifferentiated.
d. Code 988 should not be used by any registry in the US or Canada, as all standards setters require this field.
e. Use code 998 if there was no histologic confirmation or the patient did not have surgery.
f. Use code 999 if there is no information in the record about histopathologic grade.

Skin – Mycosis Fungoides

Site-Specific Factor 1 – Peripheral Blood Involvement (Mycosis Fungoides) C S N c

Source documents: path report, clinical laboratory reports of blood analysis (tissue and blood samples)

***Other names*:** Peripheral blood involvement: circulating Sezary cells
T-cell clonality: T-cell receptor (TCR) gene rearrangement
Monoclonal: clone +, clone positive
Polyclonal: clone –, clone negative

Mycosis Fungoides is the most common type of primary cutaneous T-cell lymphoma. Sezary syndrome is a more aggressive type of primary cutaneous T-cell lymphoma in which a specific type of malignant T lymphocytes (Sezary cells) is present in the circulating blood. Staging of mycosis fungoides includes analysis of the circulating blood for Sezary cells. This analysis can be done by microscopy or flow cytometry. Results of microscopy are reported as counts of Sezary cells per cubic millimeter or the percentage of Sezary cells as a proportion of total lymphocytes. Flow cytometry looks for specific cell surface markers such as CD26.

Information about peripheral blood involvement and T-cell clonality identified by polymerase chain reaction (PCR) or Southern blot analysis is combined in a "B" category unique to mycosis Fungoides staging in the TNM system. The basic categories are B0 (no significant blood involvement); B1 (low blood tumor burden); and B2 (high blood tumor burden). Any mention of B2 puts the case into Stage IV. B0 and B1 are subcategorized by clonality. The lack of monoclonality (clone negative) generally indicates a better prognosis.

Table A.7 Mycosis Fungoides Site-Specific Factor 1 Codes

CODE	DESCRIPTION	B MAP
010	Absence of significant blood involvement: 5% or less of peripheral blood lymphocytes are atypical (Sezary) cells Clone negative Stated as B0a	B0a
020	Absence of significant blood involvement: 5% or less of peripheral blood lymphocytes are atypical (Sezary) cells. Clone positive; Stated as B0b	B0b
030	Absence of significant blood involvement: 5% or less of peripheral blood lymphocytes are atypical (Sezary) cells. Clone unknown; Stated as B0 [NOS]	B0NOS
040	Low blood tumor burden: More than 5% of peripheral blood lymphocytes are atypical (Sezary) cells but does not meet the criteria of B2. Clone negative Stated as B1a	B1a
050	Low blood tumor burden: More than 5% of peripheral blood lymphocytes are atypical (Sezary) cells but does not meet the criteria of B2. Clone positive; Stated as B1b	B1b
060	Low blood tumor burden: More than 5% of peripheral blood lymphocytes are typical (Sezary) cells but does meet the criteria of B2. Clone unknown; Stated as B1 [NOS]	B1NOS
070	High blood tumor burden: 1000/uL Sezary cells or more with positive clone; Stated as B2	B2
080	Percent of atypical peripheral blood lymphocytes not stated and B rating not stated	BX
090	Sezary cell counts, blood flow cytometry, and/or clonality results in chart, B rating not stated	BX
988	This code should not be used by any registry in the US or Canada, as all standards setters require these fields.	BX
997	Sezary cell counts, blood flow cytometry, and/or clonality tests ordered, test results not in chart, B rating not known	BX
999	Unknown or no information; not documented in patient record	BX

Code a statement of peripheral blood involvement and clonality (if given) as reported by the clinician from tissue and/or blood samples. If the physician does not provide a B rating but counts or percentages of neoplastic cells, flow cytometry test results, and/or clonality test results are performed, use the appropriate code for the amount of blood involvement with "clone unknown."

Codes 010 – 030: Absence of significant blood involvement (no peripheral blood involvement)
Codes 040 – 060: Low blood tumor burden: more than 5% of peripheral blood lymphocytes are atypical (Sezary) cells but does not meet the criteria of B2.

Breast

Coding Regional Lymph Nodes (RX summary scope of reg LN surgery)

Coding Instructions-sentinel lymph node biopsy (SLNBx), breast primary C500-C509

Use the **operative report** as the **primary source document** to determine whether the operative report was from a SLNBx, an axillary node dissection (ALND), or a combination of both SLNbx and ALND. 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 the two procedures.

1. **Code 1**: This code is assigned when there is an excisional biopsy or aspiration of regional lymph nodes. Excisional biopsy or aspiration of regional lymph nodes for breast cancer is uncommon. Review the operative report to confirm whether an excisional biopsy or aspiration of regional lymph nodes was actually performed; it is highly possible that the procedure is a SLNBx (code 2) instead. If additional procedures were performed on the lymph nodes, such as axillary lymph node dissection, use the appropriate code 2-7.

2. **Code 2**: 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. Sometimes a SLNBx is attempted and no sentinel nodes are removed because they were not identified by dye or radio label injection. Review the operative report to confirm an axillary incision was made and a node exploration conducted. When no sentinel nodes are found and therefore not removed many patients will undergo an ALND. **Use code 2 if no ALND was performed**, or 6 when ALND was performed during the same operative event.

3. **Codes 3, 4, and 5**: 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).Generally, an axillary lymph node dissection removes at least 7-9 nodes. However, it is possible for these procedures to remove or harvest few 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. **Code 6**: SLNBx and regional lymph node dissection during the same surgical event, or timing not known. Generally, SLNBx followed by an 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.

5. **Code 7**: SLNBX and regional lymph node dissection in separate surgical events. Generally, SLNBx followed by an 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.

Note: Do not use the number of lymph nodes removed and pathologically examined as the sole means of distinguishing between a SLNBx and an ALND.

Table A.8 Regional Lymph Nodes Data Fields

FIELD	DESCRIPTION
LN Pos	Number of lymph nodes microscopically positive
LN Exam	Number of lymph nodes microscopically examined

Coding regional lymph node involvement for breast cancers is more complex than for many other sites, especially when dealing with isolated tumor cells (ITCs) and micrometastases. The following definitions may help clarify concepts. For a more detailed explanation, see the section in the breast chapter of the *AJCC Cancer Staging Manual*, seventh edition, called "Specific Considerations for Evidence-Based Changes to the *AJCC Cancer Staging Manual, seventh edition*," beginning on page 362.

Isolated Tumor Cells (ITCs): Pathologists can detect isolated tumor cells (ITCs) spread from a breast cancer into regional lymph nodes. These are very small deposits of tumor cells, no larger than 0.2 mm or no more than 200 cells-so small that they are *not* considered significant for assigning stage. They usually do not show evidence of malignant activity in the nodes, such as proliferation or stromal reaction. To be identified as ITCs, they must be single tumor cells or small clusters not more than 0.2 mm. As more data are collected about these ITCs, their prognostic significance may be better understood. In both the sixth and seventh editions, nodes containing only ITCs are *not* considered positive nodes and are classified as pN0 in TNM. ITCs are most often found using immunohistochemistry tests on sentinel lymph node specimens. The ITCs may sometimes also be seen on routine H&E stained sections.

Hematoxylin and Eosin (H & E): from "Hematoxylin & Eosin: The Routine Stain," by H. Skip Brown, BA, HT (ASCP), from: http://www.sigmaaldrich.com/img/assets/7361/Primer-H&Emay04.pdf.

In histology, the standard or routine stain is the hematoxylin and eosin stain, better known as the "H&E" stain. With rare exceptions, every specimen being examined will first receive an H&E stain to give the laboratorian a visible look at the nucleus of the cells and their present state of activity. With most disease states there is abnormal growth and/or division in the nucleus of the cells. The hematoxylin and eosin stain uses two separate dyes, one staining the nucleus and the other staining the cytoplasm and connective tissue. Hematoxylin is a dark purplish dye that will stain the chromatin (nuclear material) within the nucleus, leaving it a deep purplish-blue color. Eosin is an orangish-pink to red dye that stains the cytoplasmic material including connective tissue and collagen, and leaves an orange-pink counterstain. This counterstain acts as a sharp contrast to the purplish-blue nuclear stain of the nucleus, and helps identify other entities in the tissues such as cell membrane (border), red blood cells, and fluid.

Micrometastasis: When the tumor deposits in the lymph nodes are larger than 0.2 mm but not larger than 2.0 mm, they are defined as micrometastasis. Nodes with micrometastasis *are* defined as positive for staging,

Site-Specific Factor 1 – Estrogen Receptor (ER) Assay

Other names*:* ER, **ERA,** Estrogen Receptor Assay, Estrogen Receptor Status, Estradiol Receptor, Estrogen Binding Protein, hormone receptor status (with PRA).

Site-Specific Factor 2 – Progesterone Receptor (PR) Assay

Other names: PR, PgR, Progesterone Receptor Assay, Progesterone Receptor Status, hormone receptor status (with ERA).

Code 988 should not be used by any registry in the US or Canada, as all standards setters require these fields.

The following information applies to both Estrogen Receptor and Progesterone Receptor Assays.

Source documents: pathology report (usually as an addendum), separate clinical laboratory report Estrogen receptor (ER) positivity and progesterone receptor (PR) positivity are favorable prognostic factors in breast cancer, as well as endometrial carcinoma and meningioma. Positive results indicate a favorable response to endocrine (hormonal) therapy. Combined ER and progesterone receptor (PR) positivity is associated with increased response to antiestrogen therapies.

There is a variety of ways to report information on ER and PR results, but there is almost always a summary statement that the result is positive or negative.

Table A.9 Estrogen Receptor and Progesterone Receptor Assays Examples

TEST NAME ASSAY TYPE	STAINING INTENSITY AVERAGE	PERCENT POSITIVE (%)	RESULT
ER	3+	72	Positive
PR	3+	57	Positive

***Example*:** The neoplastic cells show mild (1+/4+) cytoplasmic staining with the estrogen receptor marker. The neoplastic cells exhibit abundant (3+/4+) nuclear staining with progesterone receptor marker.

***Example*:** ER positive (72%); PR positive (68%)

Record the pathologist's interpretation of the assay value from the tumor specimen. Results from the ER or PR assay done prior to neoadjuvant therapy take priority. If assays are performed on more than one specimen and any result is interpreted as positive, code as 010 Positive/elevated. If there are no results prior to neoadjuvant treatment, code the results from a post-treatment specimen. Do not report the results of an ER or PR done as part of a multigene test such as OncotypeDX or MammaPrint.

a. Use code 010 when the ER or PR is reported as positive or elevated.

b. Use code 020 when the ER or PR is reported as negative or normal.

c. Use code 030 when the ER or PR is reported as borderline; undetermined whether positive or negative.

Note: New guidelines for interpreting test results do not provide for a borderline result. Therefore, the code for borderline will rarely, if ever, be used for diagnoses 2010 forward. The new guidelines state that any test which results in 1% of the cells staining positive is a positive test. If <1% of cells stain, the test is considered negative.

d. Code 988 should not be used by any registry in the US or Canada, as all standards setters require these fields.

e. Use code 996 when the ER or PR test was ordered but the results are not interpretable.

f. Use code 997 when the ER or PR test was ordered but the results are not in the medical record.

g. Use code 998 when there is a statement in the medical record that the test was not done, not ordered and/or not performed, for example, if the tumor tissue is completely in situ.

h. Use code 999 when:
   - there is no information in the medical record about the ER or PR test
   - it is unknown whether the ER or PR test was performed
   - the patient has only a clinical diagnosis of breast cancer

The two most common ways to report ER and PR results are the proportion score (PS) (Table A.10) and the intensity score (IS) (Table A.11). Both the PS and IS are based on immunohistochemical staining of tumor cells. The PS reports the percentage of tumor cells with positive nuclear staining. The IS is the degree of nuclear positivity; in other words, the average intensity of all positive tumor cells on a scale from pale to dark. In some reports, these two scores are combined for a total score (TS, the sum of the PS and the IS). The Allred score, "H" score, or Quick score may be reported. Each of these is a total score for proportion and intensity. For each of these, results of 0 (None + None) or 2 (<1% + 1 Weak) are considered negative and any sum from 3 to 8 is considered positive. Registrars are to record the pathologist's interpretation of the test result following the above 1 % rule and are NOT to code a value based on how the patient is treated by the clinician.

- If there is only a statement of weakly positive, the registrar should code the result as "010" Positive/elevated
- It is outside the realm of the registrar's coding responsibility to interpret the values stated on the pathology report based on how the patient was treated.
- Further, there is no statement in the CS manual that supports this interpretation, and per the CAP Approved Breast Biomarker Reporting Template, a weakly positive result falls under a positive result. (http://cancerbulletin.facs.org/forums/forum/rqrs/performance-rates/6963) (http://cancerbulletin.facs.org/forums/forum/collaborative-stage/breast/breast -ab/5528)

Table A.10 Proportion Score (PS) Codes

CODE	DESCRIPTION
0	None
1	Weak
2	Intermediate
3	Strong

Older ER and PR reports may have different cut-offs for negative and positive results.

Table A.11 Intensity Score (IS) Codes

CODE	DESCRIPTION
0	None
1	> 0 to < 1 %
2	1% to 10%
3	10% to 33%
4	33% to 66%
5	>66%

Table A.12 Immunoperoxidase (immunohistochemical) staining of tumor cell nuclei Codes

CODE	DESCRIPTION
< 5%	negative
5 – 19%	borderline; also expressed as 1+ or +
> 20%	positive; 20 – 80%; also expressed as 2+ or ++
> 80%	also expressed as 3+ or +++

Another less frequently used assay is the amount of cytosol protein in the tumor sample. This is reported in femtomoles per milligram.

Table A.13 Femtomoles (fmol/mg) of cytosol protein per milligram Codes

CODE	DESCRIPTION
< 6	negative
6-10	borderline
> 10	positive
> 100	highly positive

For further information on estrogen and progesterone receptor quantification, refer to the invasive breast cancer protocol published by the College of American Pathologists for AJCC seventh edition, published October 2009 available at:
http://www.cap.org/apps/docs/committees/cancer/cancer_protocols/2009/InvasiveBreast_09protocol.pdf.

Recording HER2 Information

Site-Specific Factor 8 – HER2: Immunohistochemistry (IHC) Test Lab Value
Site-Specific Factor 9 – HER2: Immunohistochemistry (IHC) Test Interpretation
Site-Specific Factor 11 – HER2: Fluorescence In Situ Hybridization (FISH) Test Interpretation
Site-Specific Factor 13 – HER2: Chromogenic In Situ Hybridization (CISH) Test Interpretation
Site-Specific Factor 14 – HER2: Result of Other or Unknown Test
Site-Specific Factor 15 – HER2: Summary Result of Testing
Site-Specific Factor 16 – Combinations of ER, PR, and HER2 Results

Source documents: pathology report (usually in an addendum to the report), specialized lab tests, reference laboratory report

Other names: HER2, HER2 neu, c-erbB2, c-neu

HER2 is Human Epidermal growth factor Receptor 2, a protein on the surface of cancer cells that accepts growth signals. There are actually four HER categories; only HER2 is of interest for breast cancer. The presence of too many HER2 receptors ("overexpression") indicates that the tumor may grow more aggressively. About 20-30% of breast cancers overexpress HER2. Overexpression is both a prognostic and predictive factor for breast cancer. A lack of overexpression indicates patient may not respond to certain therapies such as Herceptin (trastuzumab), which is designed to "turn off" or deregulate the overexpression of HER2. There are several ways to measure HER2: immunohistochemistry (IHC), Fluorescence In Situ Hybridization (FISH), and Chromogenic In Situ Hybridization (CISH, pronounced 'kish'). The information obtained from these tests plays a critical role in treatment planning, because HER2-positive patients tend to respond favorably to the

expensive drug Herceptin (trastuzumab) or Tykerb (lapatinib), which work by blocking these receptors and preventing growth signals from getting through to the cancer cell. HER2-positive patients also may have a greater benefit from anthracycline based adjuvant therapy, such as idarubicin. Usually only one test is performed, but if result of that single test is equivocal, American Society of Clinical Oncology (ASCO) guidelines recommend that a second test be performed.

When there is more than one HER2 NEU value available, record the highest value. If there are positive and negative values, record the positive. This same rule applies to ER and PR.

HER2 NEU results are to be recorded from IHC, FISH, CISH or another pathologic test only. Do not use results from Multigene Signatures tests (i.e. Oncotype). If you have results from Oncotype tests, record this information in a text field. This same rule applies to ER and PR.

Common Codes and Definitions for Site-Specific Factors 8 – 14

Note: Code 988 - Not applicable: information not collected for this case - should not be used by any registry in the US or Canada, as these fields are required by all standards setters.

Code 997 Test ordered, results not in chart

Note: For paired lab value and interpretation tables, code 997 in the lab value table may be used where the value is unknown but the result interpreted; code 997 in the interpretation table may be used where the value is known but the result is not interpreted.

998 Test not done (test not ordered and not performed)

Note: There must be a statement in the medical record that the test was not done or that there were other circumstances that prevented the test from being done, such as a clinical diagnosis only (no histologic specimen). The registry may also have a documented policy that the lab test is never performed by the facility and a specimen is never sent out to a reference laboratory for performance of the test.

999 Unknown; No information; Not documented in patient record.

Common Codes and Definitions for Site-Specific Factors 9, 11, 13, 14
010 Test reported as positive or elevated
020 Test reported as negative or normal or within normal limits
030 Test reported as borderline, equivocal, indeterminate, undetermined whether positive or negative

Important note for HER2 field pairs SSFs 8-9, 11 and 13
Code the lab value and interpretation from the same test (same specimen). Do not mix lab values and interpretations from different facilities in the pairs of tests. However, results can be coded from different facilities for different tests (IHC from Hospital 1 and FISH from Hospital 2).

> ***Example***:
> Facility A (breast biopsy): HER-2/neu (ACIS score): 1.7 (reflexed to FISH testing). Reference states "1.5 to 3.4 - Score 2+". Facility B (resection): HER-2/neu (HercepTest): neg for overexpression. *Using Facility A information, code SSF8 as 020 (2+) and SSF9 as 999 (interpretation not documented). Code SSF11 as 999 (interpretation not documented.*

Alternatively, using Facility B information, code SSF8 as 997 (test ordered, results not in record), SSF9 as 020 (negative), SSF11 as 999 (not documented). Do not combine the negative test result from Facility B with the lab result from Facility A.

Site-Specific Factors 8 – 9 Immunohistochemistry (IHC) Lab Value and Interpretation

Site-specific factor 8 codes the IHC score in a range of 000 to 030, with additional codes for test not done and other explanations for missing information. Site-specific factor 9 codes the interpretation of the IHC score. Read the code definitions carefully. In CS version 0203, codes 001, 002, and 003 were made obsolete and the data were converted to codes 010, 020, and 030, respectively.

Immunohistochemistry or IHC is the most commonly used test for HER2 and is usually the initial HER2 test done. IHC is a special staining process performed on fresh or frozen breast cancer tissue removed during biopsy. The stains used carry various names, such as CB11 (anti HER2 mouse monoclonal antibody), 4B5 (anti HER2 rabbit monoclonal antibody), SP1, SP2, and SP3 (rabbit monoclonal antibodies), HercepTest®, Pathway®, and others. IHC is used to show whether or not the cancer cells have HER2 receptors and/or hormone receptors on their surface. The IHC test gives a score of 0 (no expression) to 3+ (strong complete tumor cell membrane expression) that indicates the amount of HER2 receptor protein on the cells in a sample of breast cancer tissue. If the tissue scores 0 to 1+, it is called "HER2 negative," and Herceptin is not considered effective for tumors with IHC scores of 0 or 1+. When the result is 2+, the HER2 status of the tumor is not clear. This often leads to testing the tumor with FISH (see below). If the tissue score is 3+, it is called "HER2 positive," and the patient is likely to receive Herceptin as part of first course therapy. (The symbols 1+, 2+, and so forth should be read as "1 plus" or "2 plus" rather than "1 positive" or "2 positive.") It is important to note that results of the IHC test may vary from lab to lab and that some labs are more experienced with testing for HER2 than others. The IHC test results are most reliable for fresh or frozen tissue samples. IHC tends to be an unreliable way to test tissue that's preserved in wax or other chemicals.

Definitions of "positive" and "negative" interpretations for the test vary from one lab to another. Each may have a different range for normal values. Look for the interpretation of the test by patient's clinician or the facility pathologist as first priority. In the absence of the local doctor's interpretation, look on the actual lab report for that particular lab's reference values and use that information to assign the appropriate interpretation code. The codes for interpretation are similar to other site-specific factors that are evaluated as positive/elevated, negative/normal, borderline, and so forth. If neither a physician interpretation nor a lab reference range can be found, do not attempt to interpret the results; code as 999 unknown.

Site-Specific Factor 11 – Fluorescence In Situ Hybridization (FISH) Interpretation

FISH results is reported in SSF11 (interpretation). The FISH test is another method of testing for overexpression of the HER2 gene that uses fluorescent pieces of DNA that attach only to the HER2 gene copies in cells, which can then be counted under a special microscope. FISH tests include PathVysion®, HER2 FISH pharmDx™, and INFORM®. The FISH technique is more expensive than IHC and takes longer to get the results, but it is also thought to be more accurate. The result is expressed as a ratio of the number of copies of the HER2 receptors to the control rather than as a score. The result is reported as a number with the remainder of the ratio expression implied. For example, the report may indicate a ratio of 2.2 [: 1].

In SSF11, code the local doctor's interpretation of the FISH test, if available; otherwise, look at the results on the lab report. For FISH, the definition of positive, negative or borderline varies from lab to lab. The code structure for this field is similar to other lab tests requiring an interpretation. If a FISH test was performed and the results are interpreted in the chart, record as positive, negative or borderline. If the test results are in the chart but there is no interpretation and no laboratory guideline given, code SSF11 as 999.

Site-Specific Factor 13 – Chromogenic In Situ Hybridization (CISH) Interpretation

CISH results is reported in SSF 13 (interpretation). CISH is the most recent technique for determining HER2 status, and may be called SPOT-Light® on the report. It has only been approved in the United States since July of 2008. CISH works in a manner similar to FISH, by using small DNA probes to count the number of HER2 genes in breast cancer cells. But this test looks for color changes (not fluorescence) and doesn't require a special microscope, which makes it less expensive. In addition, unlike other tests, it can be used on tissue samples that have been stored in the lab. CISH is in widespread use in Canada, and because of its advantages, CISH may replace FISH testing in the US.

CISH results are expressed as the mean (average) number of HER-2/neu gene copies per cell. In other words, CISH is the ratio of the number of gene copies detected, divided by the number of tumor cell nuclei counted; for example, 253 gene copies divided by 60 nuclei counted = 4.22.

Record the interpretation of the CISH test in SSF13, which has a similar code structure to the HER2 IHC and HER2 FISH interpretation fields. For CISH, the definition of positive, negative or borderline varies from lab to lab. If a CISH test was performed and the results are interpreted in the chart, code as positive, negative or borderline. Usually, the results will be either positive or negative, because if the result of counting the mean number of gene copies per cell from 30 cells is between 4.0 and 6.0, another 30 cells are counted and the mean from those 60 cells is interpreted according to the following scoring guideline:

Non-amplification: 1–5 signals/nucleus in tumor cells. Result: negative.

Amplification: > 5 signals/nucleus, or cluster of amplified signals/nucleus in >50% of tumor cells. Result: positive.

Site-Specific Factor 14 – Result of Other or Unknown Test

Site-specific factor 14 documents other types of HER2 testing, in other words, not IHC, FISH, or CISH. The most likely scenario will be a statement in the CAP Protocol or elsewhere in the chart that the patient is HER2 positive or HER2 negative, with no indication of how this information was determined and no test results in the chart. This may be particularly true for cases diagnosed or treated outside the reporting facility or cases being reported by freestanding radiation therapy or ambulatory surgery centers. Other possibilities are SISH (silver in-situ hybridization) test and RISH (rapid in situ hybridization against mRNA), which are still experimental. The code structure is the same as the IHC, FISH and CISH test interpretation fields. Code a statement of HER2 status (positive, negative, borderline) by the clinician/pathologist in this field when there is no information about the specific HER2 test in the chart.

Site-Specific Factor 15 - Summary Result of Testing

Site-specific factor 15 can be derived from SS Factors 9, 11, 13, and 14. When there is only one test done (IHC, FISH, or CISH), repeat the result of that test in this field. When more than one HER2 test is done, code the final result in this field. If the results of one test are available and a second test is known to have been performed but the results are not available, use code 997. To determine which result to code in this field, use the following guidelines:

a. Gene-amplification tests (in situ hybridization) are considered to be a more reliable test of the over-expression of the HER2 gene. Thus, if both an IHC and a gene-amplification test (FISH, CISH, etc.) were done, code the result of the gene-amplification test in site-specific factor 15, except as noted below.

b. If the gene-amplification test was given first and the result was borderline/equivocal and an IHC was done to clarify these equivocal results, code the result of the IHC.

c. Code 988 should not be used by any registry in the US or Canada, as this field is required by all standards setters.

Site-Specific Factor 16 – Combinations of ER, PR, and HER2 Results

This is another summary field that allows researchers to rapidly identify those women who are "triple negative"-ER negative, PR negative and HER2 negative-a group comprising approximately 15% of all breast cancer cases. Younger women, African American women, and Hispanic women are more likely to be triple negative than older women and Caucasians, meaning that they are less likely to respond to hormone therapy or Herceptin as part of their breast cancer treatment.

SSF16 uses information from Site-Specific Factors 1, 2, and 15. The first digit reflects the result of ER testing, the second of PR testing, and the third HER2 testing as shown in Table A.14. The values in each digit are simply 0 for a negative test result and 1 for a positive test result. Thus "triple negative" patients are coded 000 in this field. In contrast, code 111 identifies women who are "triple positive." If the result of any of the three tests is borderline/equivocal, unknown, or not performed, code as 999.

Table A.14 Layout of SSF16

1ST DIGIT	2ND DIGIT	3RD DIGIT	FOR EACH DIGIT
			0 Negative
ER	PR	HER2	1 Positive

Female Genital Organs – Placenta

Site-Specific Factor 1 – Prognostic Scoring Index (Placenta)

The Prognostic Index is a non-anatomic risk factor scoring system that adds a fourth dimension to the stage grouping of gestational trophoblastic tumors (GTT) of the placenta. The score subcategorizes GTTs into low risk or high risk based on a point system.

Code the clinician's statement of the total point value for the Prognostic Index in priority over the clinician's statement of risk.

1. Use code 000 if the clinician states no risk factors.

2. Use code 010 if the point value is between 1 and 6.

3. Use code 110 if the point value is 7 or more.

4. If there is no statement of point value, look for a statement of low risk (code 010) or high risk (code 110), or a statement of Substage A (code 050) or Substage B (code 150).

5. Use code 200 if the clinician indicates that risk factors are present but does not state whether they are low or high risk.

6. If none of these clinician statements is available, the registrar may attempt to determine the point value and risk. If any one of the factors is unknown, stop trying to assign score, unless the risk category-low or high-has already been determined with the known factors.

7. Use code 999 if risk factors are not assessed or are not documented in the medical record

Male Genital Organs – Prostate and Testis

The schemas for the male genital system have no site-specific factors in common.

Prostate

Site-Specific Factor 1 – Prostate Specific Antigen (PSA) Lab Value

Source documents: clinical laboratory report (blood or serum test), history, clinician note, pathology report

***Other names*:** Prostate specific antigen, serum PSA, total PSA

***Normal reference range*:** varies by age and race of patient. The reference range should be shown on the clinical laboratory report. In general, normal findings are 0 – 4.0 nanograms per milliliter (ng/ml).

Optimal normal range is 0 – 2.6 ng/ml. Nanograms per milliliter may be reported as micrograms per liter (µg/L or ug/L). The number to be recorded in SSF1 is the same for both measurements.

Serum PSA is the most sensitive tumor marker for monitoring individuals with prostate cancer, including progression of disease and response to therapy. Although originally not intended to be a screening test, this relatively simple blood test has become a very common method of detecting new prostate cancer in its earliest stages. PSA can be totally negative when prostate cancer is found on digital rectal exam. In such cases, PSA will not be helpful in monitoring for recurrence. Serum PSA is not the same as free PSA or precursor PSA; do not record values from either of these tests in this field.

1. Record the highest PSA value prior to, and closest to, diagnostic biopsy of prostate and initiation of treatment in the range 001 to 979. This site-specific factor is a 3 digit field with an implied decimal point between the second and third digits. If the PSA result is between 0 and 0.1 ng/ml, round up and code as 001. Results for SSF1 and SSF2 should be from the same test.
   Examples: 12.4 code as 124
   4.2 code as 042
   94 code as 940

Note: If there are PSA tests prior to diagnosis and other PSA tests after diagnosis but before treatment, use the PSA before diagnosis. If there are multiple PSA tests within three months prior to diagnosis and treatment, record the highest value. If all PSA tests are greater than 3 months, prior to diagnosis and treatment, record the most recent one.

> ***Example 1*:** PSA on January 5, 2017 is 5.8. PSA on January 29 2017 is 5.2. Biopsy February 22, 2017 is positive for adenocarcinoma. *Code the highest PSA (from January 5) as 058*.
>
> ***Example 2*:** PSA on December 19, 2016 is 44.3. PSA on March 11, 2017 is 42.8. DRE on May 1, 2017 indicated palpable nodularity in both lobes of the prostate consistent with cancer so treatment with Casodex initiated without performing a needle core biopsy. *Code the highest PSA (from March 11) as 428.*

2. A clinician may document an adjusted PSA value due to the patient taking medication for benign prostatic hypertrophy (BPH). Record the adjusted PSA value ONLY if documented by the clinician in the medical record. The registrar does not adjust the PSA value due to BPH medication use.

3. Use code 980 if the actual value of the test exceeds 98.0.
4. For site-specific factor 1 PSA Lab Value, code 988 should not be used by any registry in the US or Canada, as this field is required by all standards setters.
5. Use code 997 if the PSA was ordered but the results are not in the medical record.
6. Use code 998 if there is a statement in the medical record that the PSA was not done or was not ordered.
7. Use code 999 when there is no information in the medical record about whether a PSA was done.

Site-Specific Factor 8 – Gleason's Score on Needle Core Biopsy/Transurethral Resection of Prostate (TURP)

Source documents: pathology reports from needle biopsies or transurethral resection of prostate

The Gleason system for grading prostate cancer is the one recommended by the AJCC and College of American Pathologists. Site-specific factor 8 code information on Gleason pattern and score from core needle biopsy or transurethral resection of the prostate (TURP) *only*. This information is used for clinical stage grouping in AJCC seventh edition and in predictive nomograms, such as the Kattan nomograms and the Partin tables, which guide individual treatment decisions. (Information on Gleason pattern and score from prostatectomy or autopsy is collected in SSF 10.) The pathologist determines the Gleason patterns and score by looking at prostate tissue under the microscope. He assigns a grade to the most predominant pattern (largest surface area of involvement-more than 50% of the tissue) and a grade for the secondary pattern (second most predominant) based on published Gleason criteria. Gleason grades range from 1 (small, uniform glands) to 5 (lack of glands, sheets of cells). The cancer protocol for prostate published by the College of American Pathologists (CAP checklist or synoptic report) provides specific instructions to the pathologist for describing patterns and score from diagnostic procedures and prostatectomy specimens.

The notes above the tables in Site-Specific Factor 10 are extensive and describe how to handle situations where information about Gleason Patterns and Score may not be complete.

Gleason Score

The Gleason score is the sum of the values for the primary and secondary patterns. The score ranges from 2 (1 + 1) to 10 (5 + 5). The SSF8 code is three digits, with the Gleason score in the right-most digit(s) and leading zeros (Table I-2-27).

***Examples*:**

Gleason 3 + 3 code SSF8 as 006

Gl 4 + 3 code SSF8 as 007

Gleason 7 code SSF8 as 007

Gleason 10/10 code SSF8 as 010

No needle biopsy or TURP performed: code as 998.

Gleason 4 code SSF8 as 004 (assume a number in the range 2 to 5 is a primary pattern and that it is the score)

No Gleason information on needle biopsy or TURP: code as 999.

Note: Code 988 should not be used by any registry in the US or Canada, as this field is required by all standards setters.

Table A.15 Format for SSFs 8 and 10

1ST DIGIT	2ND AND 3RD DIGITS
0	Gleason Score 02-10

Site-Specific Factor 10 – Gleason's Score on Prostatectomy/Autopsy

Source documents: pathology report from prostatectomy or autopsy report

***Other names*:** Gleason sum, combined Gleason grade

This site-specific factor codes information on Gleason pattern score from prostatectomy or autopsy *only*. This information is used for pathologic stage grouping in AJCC seventh edition. Information on Gleason score from core needle biopsy or TURP is collected in SSF 8-see above. The pathologist's process for determining the Gleason score and examples of the codes are described in SSF 8. The same format is used for prostatectomy or autopsy information.

Note: If a tertiary pattern is documented in the prostatectomy pathology report, do not add it to SSF10.

> ***Example*:**
> No prostatectomy performed Code as 998 in SSF 10.
> Diagnosed at autopsy but no Gleason information Code as 999 in SSF 10.

Note: Code 988 should not be used by any registry in the US or Canada, as this field is required by all standards setters.

Testis

Serum Tumor Markers for Testis

Tumor markers for testicular cancer serve several purposes. Pre-orchiectomy, they help determine the histologic cell type. Post-orchiectomy, they assist in treatment management for patients with germ cell tumors, and provide an extra prognostic dimension (S) to AJCC stage grouping. For the pathologist, elevated levels of the markers alpha fetoprotein (AFP) or beta subunit of human chorionic gonadotropin (beta-hCG) may indicate the need for additional microscopic analysis of resected tissue. The serum lactate dehydrogenase (LDH) helps the clinician assess the patient's metastatic tumor burden. AFP, hCG, and LDH information is combined into the S (serum tumor marker) category in the TNM system, although each may be given an individual S value. The value used for stage group IS is calculated on the serum marker values measured post-orchiectomy (this is a change in AJCC seventh edition). To determine the S category for other stage groups, lab values for the three markers must be within the ranges below. In CS version 2, the computer algorithm compares the values coded in SSFs 7, 9 and 10 to derive an S value.

- S0 All three markers are within normal limits
- S1 All three markers are done and all three are no more than minimally elevated
- AFP <1000 ng/ml **AND** hCG <5,000 mIU/ml **AND** LDH <1.5 times N* or unknown
- S2 **ANY** marker is moderately elevated (not all three have to be done)

- AFP 1000-10,000 ng/ml **OR** hCG 5,000-50,000 mIU/ml **OR** LDH 1.5-10 times N* S3 **ANY** marker is highly elevated (not all three have to be done)
- AFP > 10,000 ng/ml **OR** hCG >50,000 mIU/ml **OR** LDH >10 times N*
- N = upper limit of normal

Note: According to AJCC, the S category can be determined for both AJCC sixth and seventh editions even if the LDH value is unknown when either the AFP or hCG is moderately or highly elevated.

Lactate dehydrogenase: LDH, LDH Value, LDH Upper Limit or Normal

Source documents: clinical laboratory report; may be included in a liver or hepatic panel/profile, a cardiac panel, or a general metabolic panel of tests.

***Other names*:** LD, Lactate dehydrogenase, lactase dehydrogenase, lactic acid dehydrogenase.

***Normal Reference Range*:** varies widely by laboratory, patient age, and the units of measurement. Examples of reference range lab values—

Lab A: Total LDH 7 1 – 207 U/L
Lab B: Total LDH 3 0 0 – 600 U/L
Lab C: Total LDH 45 – 90 U/L
Lab D: Total LDH 150 – 250 U/L

When cells (normal or tumor) are damaged or destroyed, an enzyme called lactate dehydrogenase (LDH) is released into the bloodstream. LDH is an indirect indication of possible tumor burden or damage to an organ, which may be caused by metastatic involvement of liver or lung, or a myocardial infarction. The total LDH should be the test value that is coded, but there are five fractions of LDH that measure tissue specific cellular damage: LD1 and LD2: heart, red blood cells and kidneys; LD3: lung; LD4 and LD5: liver, skin and skeletal muscles. LDH is elevated in 60% of patients with non-seminomatous germ cell tumors of the testis. LDH is not a screening test, nor is it diagnostic of melanoma, ocular adnexal lymphoma, or testicular cancer.

Site-Specific Factor 16 - Serum Lactate Dehydrogenase (LDH) Post-Orchiectomy Lactate Dehydrogenase (LDH) Range (Testis)

Record the code describing the range of the highest LDH value prior to treatment, based on the reference range used by the lab. To calculate whether the lab result is in a particular range, multiply the lab's upper limit of normal (usually stated on the report) times the stated multiplier.

***Example*:** Test result is 155. *Normal range—*
Lab A: 105-333 IU/L
Lab B: 46-100 IU/L
Lab C: 45-90 IU/L

For Labs A and B, that result is within the normal range (code 000).

For Lab C, the test result is elevated (upper limit of normal for Lab C is 90). Calculate 1.5 times the upper limit of normal for Lab C (1.5 x 90 = 135). For Lab C, this test result would be coded as 020 for testis, between 1.5 and 10 times the upper limit of normal.

Note: LDH may not be done if the primary is localized. If so, code as 999.

Central Nervous System

Brain, CNS Other, Intracranial Gland

Central nervous system sites include all parts of the brain, meninges, spinal cord, and the pituitary and pineal glands and craniopharyngeal duct. There is no TNM staging for any of these primary sites, but there is a chapter for brain and spinal cord in the seventh edition of the *AJCC Cancer Staging Manual*.

Site-Specific Factor 1 – World Health Organization (WHO) Grade Classification (Brain, CNSOther, IntracranialGland)

***Source documents*:** pathology report

The World Health Organization (WHO) has promoted a histologic grading classification for central nervous system tumors since 1979. The most recent version was published in 2007 as part of the WHO classification of central nervous system tumors. Tumor grade is the most important prognostic indicator for response to therapy and outcomes for brain and spinal cord tumors. According to WHO, the classification is more of a "malignancy scale" than a strict histologic grading system. Therefore, the WHO grade is different from the ICD-O grade/differentiation value that is stored with the morphology code. Do not use WHO grade to code the sixth digit of the ICD-O morphology code. WHO grade ranges from I (low proliferative potential and possibly surgically curable-essentially benign behavior) through IV (cytologically malignant, mitotically active neoplasms that are rapidly fatal). Most CNS tumors are assigned a WHO grade, so there is usually a one-for-one correspondence between the ICD-O morphology code and the WHO grade.

Code the WHO grade as documented in the pathology report: Grade I – code 010; Grade II – code 020; Grade III – code 030; Grade IV – code 040. Do not convert terminology such as well-, moderately-, or poorly differentiated to code this field.

a. Code 988 should not be used by any registry in the US or Canada, as this field is required by all standards setters.

b. Use code 998 if there was no histologic examination of the primary site (clinical diagnosis).

c. Use code 999 if the WHO grade is unknown, not stated, or not documented in the medical record.

Note: Do not use WHO grade information to code the fields Grade Path Value and Grade Path System.

Gastrointestinal Stromal Tumors (GIST)

Esophagus, Stomach, Small intestine, Appendix, Colon, Rectum, Peritoneum-omentum and mesentery

Gastrointestinal stromal tumors (GISTs) are a rare type of soft tissue sarcoma (mesenchymal tumor). They are different from carcinomas of the gastrointestinal tract because they develop in the muscle layer and grow outward. These tumors were first described as a distinct entity in 1998 and codes were added to ICD-O-3 in 2000. GIST is an umbrella term covering most mesenchymal tumors of the stomach and intestine. Most tumors diagnosed as leiomyosarcomas a decade ago are now referred to as GISTs.

GISTs are believed to develop from the interstitial cells of Cajal that regulate peristalsis. Because the staging of GISTs is based on the size of the primary tumor and the mitotic count, a new chapter was added to the seventh edition of the AJCC Cancer Staging Manual (Chapter 16).

About 55% of GISTs occur in the stomach, followed by 30% in the small intestine. Other sites are much less frequent. Even in the stomach, GISTs are only 1-3% of all gastric malignancies. In the small intestine, GISTS are about 20% of all malignancies. About 35-50% of gastrointestinal stromal tumors are malignant. The GIST chapter of the AJCC Cancer Staging Manual can be used to code benign, borderline, and malignant GISTs, but **only malignant** GISTs should be reported to population-based cancer registries. Benign and borderline GISTS may be reportable-by-agreement in facility-based registries.

Mitotic Count

*See **Mitotic Count** in Site Specific Notes Common to Several Primary Sites/Histologies on page 297.*

Mitotic count is a site-specific factor for a number of primary sites. For GIST, the standard measurement is the total number of mitoses per 50 high power fields (HPF at 40 times magnification) or per 5 square millimeters.

For esophagus, stomach, and small intestine, mitotic count is collected in SSF 6.
For appendix, colon, and rectum, mitotic count is collected in SSF 11.
For peritoneum mitotic count is collected in SSF 5.

The following stratification table can help determine if the tumor is benign, borderline or malignant. Review the table with the facility pathologist(s) to make sure they agree. When sending a GIST abstract to the TCR, include the word “malignant” with the pathology report.

Table A.16 Recurrence Risk Stratification in GIST*

Group	Size (cm)	Mitotic Count (/50 HPF)	Stomach and Omentum	Jejunum/Ileum (incl esoph, mesentery, peritoneum)	Colon, Rectum
1	≤ 2	≤ 5/50 hpf	No risk of recur	None	None
2	> 2 ≤ 5	≤ 5/50 hpf	Very low	Low	Low
3a	> 5 ≤ 10	≤ 5/50 hpf	Low	Moderate	High
3b	> 10	≤ 5/50 hpf	Moderate	High	High
4	≤ 2	> 5/50 hpf	Unknown risk	Unknown risk	High
5	> 2 ≤ 5	> 5/50 hpf	Moderate	High	High
6a	> 5 ≤ 10	> 5/50 hpf	High	High	High
6b	> 10	> 5/50 hpf	High	High	High

No risk = /0 Benign Tumor
Low to moderate risk = /1 Borderline (uncertain behavior)
High = /3 Malignant

*Adapted from Miettinen M, Lasota J. Gastrointestinal stromal tumors: pathology and prognosis at different sites. Semin. Diagn. Pathol. 2006: 23; 70-83.

Neuroendocrine Tumors (NETs)

Stomach, Colon, Rectum

Neuroendocrine tumors (NETs) originate in the diffuse neuroendocrine system from cells that produce small amounts of hormones in response to signals from the nervous system. There are neuroendocrine cells in many body systems, including respiratory tract, lung, skin (Merkel cell carcinoma), gastrointestinal tract, and endocrine glands. Neuroendocrine cells regulate neighboring cells. NETs are also called carcinoids, but the preferred terminology is well-differentiated neuroendocrine tumor. In the gastrointestinal system, abnormal production of hormones can cause unusual symptoms, such as flushing, fatty diarrhea (steatorrhea), and dumping syndrome.

Neuroendocrine tumors in general are rare, so they are not well understood and there may be difficulty in diagnosing them. Gastrointestinal NETs can grow slowly for many years before producing symptoms leading to diagnosis. Malignant NETs tend to be more aggressive than carcinomas and metastasize earlier. When they metastasize, the most common site is liver, but NETs will also metastasize to lymph nodes and bone. Small NETs less than 1 cm in size are unlikely to spread, but a tumor larger than 2 cm has a 95% chance of developing metastases. The principle criteria for staging NETs are size of tumor and depth of invasion.

Well-differentiated or low grade neuroendocrine carcinoma (ICD-O-3 morphology code 8240; also called carcinoid, NOS) is most common in the appendix and rectum, and uncommon in the colon. Enterochromaffin (EC) cell carcinoid (8241) is most common in the appendix. Entero-Chromaffin-Like (ECL) cell tumor (8242) is most common in the gastric fundus or body. Neuroendocrine tumor (8246) is a broad term covering carcinoids and some adenocarcinomas. Atypical carcinoid (8249) but is uncommon in the gastrointestinal tract. The NET schemas for stomach, small intestine, colon, rectum, and ampulla of Vater include malignant gastrinomas, which are found in the duodenum and ileum as well as the stomach, TNM has an specific chapter for NET (Chapter 17).

Carcinoid Tumors of the Appendix and NETs of the pancreas are found in chapter 13 and 24 of the TNM 7th edition, repectively.

B

APPENDIX B:
REPORTING LAW AND RULES

THE LAW

HEALTH AND SAFETY CODE
TITLE 2. HEALTH
SUBTITLE D. PREVENTION, CONTROL, AND REPORTS OF DISEASES
CHAPTER 82. CANCER REGISTRY

Sec. 82.001. SHORT TITLE. This chapter may be cited as the Texas Cancer Incidence Reporting Act.
Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1991, 72nd Leg., ch. 14, Sec. 33, eff. Sept. 1, 1991.

Sec. 82.002. DEFINITIONS. In this chapter:

(1) "Cancer" includes:

(A) a large group of diseases characterized by uncontrolled growth and spread of abnormal cells;

(B) any condition of tumors having the properties of anaplasia, invasion, and metastasis;

(C) a cellular tumor the natural course of which is fatal, including malignant and benign tumors of the central nervous system; and

(D) malignant neoplasm, other than nonmelanoma skin cancers such as basal and squamous cell carcinomas.

(2) "Clinical laboratory" means an accredited facility in which:

(A) tests are performed identifying findings of anatomical changes; and

(B) specimens are interpreted and pathological diagnoses are made.

(3) "Health care facility " means:

(A) a general or special hospital as defined by Chapter 241 (Texas Hospital Licensing Law);

(B) an ambulatory surgical center licensed under Chapter 243;

(C) an institution licensed under Chapter 242; or

(D) any other facility, including an outpatient clinic, that provides diagnosis or treatment services to patients with cancer.

(4) "Health care practitioner" means:

(A) a physician as defined by Section 151.002, Occupations Code; or

(B) a person who practices dentistry as described by Section 251.003, Occupations Code.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 2001, 77th Leg., ch. 589, Sec. 1, eff. Sept. 1, 2001.

Sec. 82.003. APPLICABILITY OF CHAPTER. This chapter applies to records of cases of cancer, diagnosed on or after January 1, 1979, and to records of all ongoing cancer cases diagnosed before January 1, 1979.
Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 2001, 77th Leg., ch. 589, Sec. 2, eff. Sept. 1, 2001.

Sec. 82.004. REGISTRY REQUIRED. The department shall maintain a cancer registry for the state.
Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.
Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0252, eff. April 2, 2015.

Sec. 82.005. CONTENT OF REGISTRY. (a) The cancer registry must be a central data bank of accurate, precise, and current information that medical authorities agree serves as an invaluable tool in the early recognition, prevention, cure, and control of cancer.

(b) The cancer registry must include:

(1) a record of the cases of cancer that occur in the state; and

(2) information concerning cancer cases as the executive commissioner considers necessary and appropriate for the recognition, prevention, cure, or control of cancer.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 2001, 77th Leg., ch. 589, Sec. 3, eff. Sept. 1, 2001.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0253, eff. April 2, 2015.

Sec. 82.006. EXECUTIVE COMMISSIONER AND DEPARTMENT POWERS. (a) To implement this chapter, the executive commissioner may adopt rules that the executive commissioner considers necessary.

(b) To implement this chapter, the department may:

(1) execute contracts considered necessary;

(2) receive the data from medical records of cases of cancer that are in the custody or under the control of clinical laboratories, health care facilities, and health care practitioners to record and analyze the data directly related to those diseases;

(3) compile and publish statistical and other studies derived from the patient data obtained under this chapter to provide, in an accessible form, information that is useful to physicians, other medical personnel, and the general public;

(4) comply with requirements as necessary to obtain federal funds in the maximum amounts and most advantageous proportions possible;

(5) receive and use gifts made for the purpose of this chapter; and

(6) limit cancer reporting activities under this chapter to specified geographic areas of the state to ensure optimal use of funds available for obtaining the data.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 2001, 77th Leg., ch. 589, Sec. 4, eff. Sept. 1, 2001.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0254, eff. April 2, 2015.

Sec. 82.007. REPORTS. (a) The department shall publish an annual report to the legislature of the information obtained under this chapter.

(b) The department, in cooperation with other cancer reporting organizations and research institutions, may publish reports the department determines are necessary or desirable to carry out the purpose of this chapter.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1991, 72nd Leg., ch. 14, Sec. 34, eff. Sept. 1, 1991.

Sec. 82.008. DATA FROM MEDICAL RECORDS. (a) To ensure an accurate and continuing source of data concerning cancer, each health care facility, clinical laboratory, and health care practitioner shall furnish to the department, on request, data the executive commissioner considers necessary and appropriate that is derived from each medical record pertaining to a case of cancer that is in the custody or under the control of the health care facility, clinical laboratory, or health care practitioner. The department may not request data that is more than three years old unless the department is investigating a possible cancer cluster. At the request and with the authorization of the

applicable health care facility, clinical laboratory, or health care practitioner, data may be furnished to the department through a health information exchange as defined by Section 182.151.

(b) A health care facility, clinical laboratory, or health care practitioner shall furnish the data requested under Subsection (a) in a reasonable format prescribed by department rule and within six months of the patient's admission, diagnosis, or treatment for cancer unless a different period is prescribed by the United States Department of Health and Human Services.

(c) The data required to be furnished under this section must include patient identification and diagnosis.

(d) The department may access medical records that would identify cases of cancer, establish characteristics or treatment of cancer, or determine the medical status of any identified patient from the following sources:

(1) a health care facility or clinical laboratory providing screening, diagnostic, or therapeutic services to a patient with respect to cancer; or

(2) a health care practitioner diagnosing or providing treatment to a patient with cancer, except as described by Subsection (g).

(e) The executive commissioner shall adopt procedures that ensure adequate notice is given to the health care facility, clinical laboratory, or health care practitioner before the department accesses data under Subsection (d).

(f) A health care facility, clinical laboratory, or health care practitioner that knowingly or in bad faith fails to furnish data as required by this chapter shall reimburse the department or its authorized representative for the costs of accessing and reporting the data. The costs reimbursed under this subsection must be reasonable, based on the actual costs incurred by the department or by its authorized representative in the collection of data under Subsection (d), and may include salary and travel expenses. The department may assess a late fee on an account that is 60 days or more overdue. The late fee may not exceed one and one-half percent of the total amount due on the late account for each month or portion of a month the account is not paid in full. A health care facility, clinical laboratory, or health care practitioner may request that the department conduct a hearing to determine whether reimbursement to the department under this subsection is appropriate.

(g) The department may not require a health care practitioner to furnish data or provide access to records if:

(1) the data or records pertain to cases reported by a health care facility providing screening, diagnostic, or therapeutic services to cancer patients that involve patients referred directly to or previously admitted to the facility; and

(2) the facility reported the same data the practitioner would be required to report.

(h) The data required to be furnished under this section may be shared with cancer registries of health care facilities subject to the confidentiality provisions in Section 82.009.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1991, 72nd Leg., ch. 14, Sec. 35, eff. Sept. 1, 1991; Acts 1997, 75th Leg., ch. 343, Sec. 1, eff. May 27, 1997; Acts 1999, 76th Leg., ch. 1411, Sec. 23.01, eff. Sept. 1, 1999; Acts 2001, 77th Leg., ch. 589, Sec. 5, eff. Sept. 1, 2001. Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0255, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1085 (H.B. 2641), Sec. 5, eff. September 1, 2015.

Sec. 82.009. CONFIDENTIALITY. (a) Reports, records, and information obtained under this chapter are confidential and are not subject to disclosure under Chapter 552, Government Code, are not subject to subpoena, and may not otherwise be released or made public except as provided by this section or Section 82.008(h). The reports, records, and information obtained under this chapter are for the confidential use of the department and the persons or public or private entities that the department determines are necessary to carry out the intent of this chapter.

(b) Medical or epidemiological information may be released:

(1) for statistical purposes in a manner that prevents identification of individuals, health care facilities, clinical laboratories, or health care practitioners;

(2) with the consent of each person identified in the information; or

(3) to promote cancer research, including release of information to other cancer registries and appropriate state and federal agencies, under rules adopted by the executive commissioner to ensure confidentiality as required by state and federal laws.

(c) A state employee may not testify in a civil, criminal, special, or other proceeding as to the existence or contents of records, reports, or information concerning an individual whose medical records have been used in submitting data required under this chapter unless the individual consents in advance.

(d) Data furnished to a cancer registry or a cancer researcher under Subsection (b) or Section 82.008(h) is for the confidential use of the cancer registry or the cancer researcher, as applicable, and is subject to Subsection (a).

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 1995, 74th Leg., ch. 76, Sec. 5.95(90), eff. Sept. 1, 1995; Acts 1997, 75th Leg., ch. 343, Sec. 2, eff. May 27, 1997; Acts 1999, 76th Leg., ch. 1411, Sec. 23.02, eff. Sept. 1, 1999; Acts 2001, 77th Leg., ch. 589, Sec. 6, eff. Sept. 1, 2001.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0256, eff. April 2, 2015.

Sec. 82.010. IMMUNITY FROM LIABILITY. The following persons subject to this chapter that act in compliance with this chapter are not civilly or criminally liable for furnishing the information required under this chapter:

(1) a health care facility or clinical laboratory;

(2) an administrator, officer, or employee of a health care facility or clinical laboratory;

(3) a health care practitioner or employee of a health care practitioner; and

(4) an employee of the department.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989. Amended by Acts 2001, 77th Leg., ch. 589, Sec. 7, eff. Sept. 1, 2001.

Sec. 82.011. EXAMINATION AND SUPERVISION NOT REQUIRED. This chapter does not require an individual to submit to any medical examination or supervision or to examination or supervision by the department.

Acts 1989, 71st Leg., ch. 678, Sec. 1, eff. Sept. 1, 1989.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 3.0257, eff. April 2, 2015.

THE RULES

Texas Administrative Code
Title 25. Health Services
Part 1. Department of State Health Services
Chapter 91. Cancer
Subchapter A. Cancer Registry
Effective Date: April 2, 2017

§91.1. Purpose.

This subchapter implements the Texas Cancer Incidence Reporting Act, Health and Safety Code, Chapter 82. This legislation concerns the reporting of cases of cancer for the recognition, prevention, cure or control of those diseases, and to facilitate participation in the national program of cancer registries established by 42 United States Code, §§280e - 280e-4. Nothing in this subchapter shall preempt the authority of facilities or individuals providing diagnostic or treatment services to patients with cancer to maintain their own cancer registries.

§91.2. Definitions.

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Act--The Texas Cancer Incidence Reporting Act, Texas Health and Safety Code, Chapter 82.

(2) Cancer--Includes a large group of diseases characterized by uncontrolled growth and spread of abnormal cells; any condition of tumors having the properties of anaplasia, invasion, and metastasis; a cellular tumor the natural course of which is fatal, including intracranial and central nervous system malignant, borderline, and benign tumors as required by the national program of cancer registries; and malignant neoplasm, other than non-melanoma skin cancers such as basal and squamous cell carcinomas.

(3) Cancer Reporting Handbook--The Texas Cancer Registry's manual for reporting entities that documents reporting procedures and format.

(4) Clinical laboratory--An accredited facility in which tests are performed identifying findings of anatomical changes; specimens are interpreted and pathological diagnoses are made.

(5) Confidential cancer data--Information that includes items that may identify an individual, and is subject to Health and Safety Code, §82.009.

(6) Department--Department of State Health Services.

(7) Health care facility--A general or special hospital as defined by the Health and Safety Code, Chapter 241; an ambulatory surgical center licensed under the Health and Safety Code, Chapter 243; an institution licensed under the Health and Safety Code, Chapter 242; or any other facility, including an outpatient clinic, that provides diagnostic or treatment services to patients with cancer.

(8) Health care practitioner--A physician as defined by Occupations Code, §151.002 or a person who practices dentistry as described by the Occupations Code, §251.003.

(9) Quality assurance--Operational procedures by which the accuracy, completeness, and timeliness of the information reported to the department can be determined and verified.

(10) Report--Information provided to the department that notifies the appropriate authority of the occupancy of a specific cancer in a person, including all information required to be provided to the department.

(11) Reporting Entity--A reporting entity may include a health care facility, clinical laboratory, health care practitioner, or a health information exchange as defined by Health and Safety Code, §182.151.

(12) Research--A systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.

(13) Statistical cancer data--Aggregate presentation of individual records on cancer cases excluding patient identifying information.

(14) Texas Cancer Registry--The cancer incidence reporting system administered by the Department of State Health Services.

§91.3. Who Reports and Access to Records.

(a) Each health care facility, clinical laboratory or health care practitioner shall report to the department, by methods specified in §§91.4 - 91.7 of this title (relating to Cancer Registry), required data from each medical record pertaining to a case of cancer in its custody or under its control except for cases to which subsection (d) of this section would apply.

(b) A health care facility or clinical laboratory providing screening, diagnostic or therapeutic services to patients with cancer shall grant the department or its authorized representative access to but not removal of all medical records which would identify cases of cancer, establish characteristics or treatment of cancer, or determine the medical status of any identified cancer patient.

(c) A health care practitioner providing diagnostic or treatment services to patients with cancer shall grant the department or its authorized representative access to but not removal of all medical records which would identify cases of cancer, establish characteristics or treatment of cancer, or determine the medical status of any identified cancer patient except for cases to which subsection (d) of this section would apply.

(d) The department may not require a health care practitioner to furnish data or provide access to records if:

(1) the data or records pertain to cases reported by a health care facility providing screening, diagnostic, or therapeutic services to cancer patients that involve patients referred directly to or previously admitted to the facility; and

(2) the facility reported the same data the practitioner would be required to report.

(e) Health care facilities, clinical laboratories, and health care practitioners are subject to federal law known as the Health Insurance Portability and Accountability Act of 1996 found at Title 42 United States Code §1320d et seq.; the federal privacy rules adopted in Title 45 Code of Federal Regulations (C.F.R.) Parts 160 and 164; and applicable state medical records privacy laws. Because state law requires reporting of cancer data, persons subject to this chapter are permitted to provide the data to the department without patient consent or authorization under 45 C.F.R. §164.512(a) relating to uses and disclosures required by law and §164.512(b)(1) relating to disclosures for public health activities. Both of these exceptions to patient consent or authorization are recognized in the state law.

§91.4. What to Report.

(a) Reportable conditions.

(1) The cases of cancer to be reported to the Texas Cancer Registry are as follows:

(A) all neoplasms with a behavior code of two or three in the most current edition of the International Classification on Diseases for Oncology (ICD-O) of the World Health Organization with the exception of those designated by the Texas Cancer Registry as non-reportable in the Cancer Reporting Handbook; and

(B) all benign and borderline intracranial and central nervous system neoplasms as required by the national program of cancer registries.

(2) Codes and taxa of the most current edition of the International Classification of Diseases, Clinical Modification of the World Health Organization which correspond to the Texas Cancer Registry's reportable list are specified in the Cancer Reporting Handbook.

(b) Reportable information.

(1) Except as provided in paragraph (2) of this subsection and health care practitioners in §91.5(c) of this title (relating to When to Report), those data required to be reported for each cancer case shall include:

(A) name, address, zip code, and county of residence;

(B) social security number, date of birth, gender, race and ethnicity, marital status, birthplace, and primary payer at time of diagnosis, to the extent such information is available from the medical record;

(C) information on industrial and occupational history, smoking status, height and weight to the extent such information is available from the medical record;

(D) diagnostic information including the cancer site and laterality, cell type, tumor behavior, markers, grade and size, stage of disease, date of diagnosis, diagnostic confirmation method, sequence number, and other primary tumors;

(E) first course of cancer-related treatment, including dates and types of procedures;

(F) text information to support cancer diagnosis, stage and treatment codes;

(G) health care facility or practitioner related information including reporting institution number, casefinding source, type of reporting source, medical record number, registry number, tumor record number, class of case, date of first contact, date of last contact, vital status, facility referred from, facility referred to, managing physician, follow-up physician, date abstracted, abstractor, and electronic record version; and

(H) clinical laboratory related information including laboratory name and address, pathology case number, pathology report date, pathologist, and referring physician name and address.

(2) The department or its authorized representative may exempt a reporting entity from providing specific reportable data items delineated in paragraph (1) of this subsection to the extent that those data to be exempted are not collected by the reporting entity.

(3) Except as provided in §91.6(b) of this title (relating to How to Report), each report shall:

(A) be electronically readable and contain all data items required in paragraph (1) of this subsection;

(B) be fully coded and in a format prescribed by the Texas Cancer Registry;

(C) meet all quality assurance standards utilized by the Texas Cancer Registry;

(D) in the case of individuals who have more than one form of cancer, be submitted separately for each primary cancer diagnosed;

(E) be submitted to the Texas Cancer Registry electronically; and

(F) be transmitted by secure means at all times to protect the confidentiality of the data.

§91.5. When to Report.

(a) All reports shall be submitted to the department within six months of the patient's admission, initial diagnosis, or treatment for cancer.

(b) Data shall be submitted no less than quarterly by health care facilities with annual caseloads of 400 or less. Monthly submissions are required for all other health care facilities.

(c) Data shall be submitted no less than quarterly by health care practitioners initially diagnosing a patient with cancer and performing the in-house pathological tests for that patient. Otherwise, data shall be submitted within 2 months of the request to a health care practitioner by the department or its authorized representative for a report or subset of a report on a patient diagnosed or treated elsewhere and for whom the same cancer data has not been reported.

(d) Data shall be submitted no less than quarterly by clinical laboratories.

§91.6. How to Report.

(a) Reports of cancer from health care facilities, clinical laboratories and health care practitioners shall be submitted to the Texas Cancer Registry electronically using a secure electronic process as defined by the department. At the request and with the authorization of the applicable health care facility, clinical laboratory, or health care practitioner, data may be furnished to the Texas Cancer Registry through a health information exchange.

(b) The Texas Cancer Registry may accept the submission of paper copies of medical records from a health care facility, pathology reports from a clinical laboratory and reports or subsets of reports from a health care practitioner under the following conditions.

(1) The department, or its authorized representative, shall determine that such paper submissions are more expedient than electronic reporting.

(2) The acceptance of paper submissions from a health care facility, clinical laboratory or health care practitioner shall be approved by the department or its authorized representative.

(3) The department, or its authorized representative, may approve acceptance of paper submissions from defined groups or types of health care facilities, clinical laboratories or health care practitioners.

(4) All records and reports provided to the Texas Cancer Registry pursuant to this subsection must be transmitted by secure means at all times to protect the confidentiality of the data.

§91.7. Where to Report.

Data reports should be submitted to the Texas Cancer Registry as specified in the Cancer Reporting Handbook.

§91.8. Compliance.

(a) Each health care facility, clinical laboratory, or health care practitioner that reports to the department, by methods specified in §§91.4 - 91.7 of this title (relating to Cancer Registry), is considered compliant.

(b) A person will be notified in writing if the person has not reported in compliance with this chapter within 30 days following the end of the required monthly or quarterly reporting timeframe and will be given an opportunity to take corrective action within 60 days from the date of the notification letter. A second notification letter will be sent 30 days after the date of the original notification letter if no corrective action has been taken.

(c) If a person is non-compliant and takes no corrective action within 60 days of the original notification letter, the department or its authorized representative may access the information from the health care facility, clinical laboratory or health care practitioner as provided in §91.3 of this title (relating to Who Reports, Access to Records) and report it in the appropriate format.

(1) The health care facility, clinical laboratory or health care practitioner shall be notified at least two weeks in advance before a scheduled arrival for collection of the information.

(2) A health care facility, clinical laboratory or health care practitioner that knowingly or in bad faith fails to furnish data as required by this chapter shall reimburse the department or its authorized representative for its cost to access and report the information. The costs must be reasonable, based on the actual costs incurred by the department or by its authorized representative in the collection of the data and may include salary and travel expenses. It is presumed that a health care facility, clinical laboratory or health care practitioner acted knowingly or in bad faith if it failed to take corrective action within 60 days of the date of the original notification letter.

(3) A health care facility, clinical laboratory or health care practitioner may request the department to conduct a hearing under the department's fair hearing rules to determine whether reimbursement to the department is appropriate.

(d) Any health care facility, clinical laboratory or health care practitioner which is required to reimburse the department or its authorized representative for the cost to access and report the information pursuant to subsection (c)(2) of this section shall provide payment to the department or its authorized representative within 60 days of the day this payment is demanded. In the event any health care facility, clinical laboratory or health care practitioner fails to make payment to the department or its authorized representative within 60 days of the day the payment is demanded, the department or its authorized representative may, at its discretion, assess a late fee not to exceed 1-1/2 % per month of the outstanding balance.

§91.9. Confidentiality and Disclosure.

(a) Pursuant to the Act, Chapter 82, §82.009, all data obtained is for the confidential use of the department and the persons or entities, public or private, that the department determines are necessary to carry out the intent of the Act.

(b) Limited release of the data is allowed by the Act, §82.008(h) and §82.009(b).

(c) Any requests for confidential or statistical cancer data shall be made in accordance with §91.11 or §91.12 of this title (relating to Cancer Registry).

(d) The Texas Cancer Registry is subject to state law that requires compliance with portions of the federal law and regulations cited in §91.3(e) of this title (relating to Who Reports, Access to Records). The department is authorized to use and disclose, for purposes described in the Act, cancer data without patient consent or authorization under 45 C.F.R §164.512(a) relating to uses and disclosures required by law, §164.512(b)(1) and (2) relating to uses and disclosures for public health activities, and §164.512(i) relating to uses and disclosures for research purposes.

§91.10. Quality Assurance.

The department shall cooperate and consult with persons required to comply with this chapter so that such persons may provide timely, complete, and accurate data. The department will provide:

(1) reporting training, technical assistance, on-site case-finding studies, and reabstracting studies;

(2) quality assessment reports to ascertain that the computerized data utilized for statistical information and data compilation is accurate; and

(3) educational information on cancer morbidity and mortality statistics available from the Texas Cancer Registry and the department.

§91.11. Requests for Statistical Cancer Data.

(a) Statistical cancer data previously analyzed are available upon written or oral request to the Texas Cancer Registry. All other requests for statistical cancer data shall be in writing and directed to: Texas Cancer Registry, Mail Code 1928, Department of State Health Services, P.O. Box 149347, Austin, Texas 78714-9347 or CancerData@dshs.state.tx.us.

(b) To ensure that the proper data are provided, the request shall include, but not be limited to, the following information:

(1) name, address, and telephone number of the person requesting the information;

(2) type of data needed and for what years (e.g. lung cancer incidence rates, Brewster County, 1998 - 2002); and

(3) name and address of person(s) to whom data and billings are to be submitted (if applicable).

§91.12. Requests and Release of Confidential Cancer Data.

(a) Data requests for research.

(1) Requests for confidential cancer data shall be in writing and directed to: Texas Cancer Registry, Mail Code 1928, Department of State Health Services, P.O. Box 149347, Austin, Texas 78714-9347 or CancerData@dshs.state.tx.us.

(2) Written requests for confidential cancer data shall meet the submission requirements of the department's Institutional Review Board (IRB) before release.

(3) The Texas Cancer Registry may release confidential cancer data to state, federal, local, and other public agencies and organizations if approved by the IRB.

(4) The Texas Cancer Registry may release confidential cancer data to private agencies, organizations, and associations if approved by the IRB.

(5) The Texas Cancer Registry may release confidential cancer data to any other individual or entities for reasons deemed necessary by the department to carry out the intent of the Act if approved by the IRB.

(b) Data requests for non-research purposes.

(1) The Texas Cancer Registry may provide reports containing confidential cancer data back to the respective reporting entity from records previously submitted to the Texas Cancer Registry from each respective reporting entity for the purposes of case management and administrative studies. These reports will not be released to any other entity.

(2) The Texas Cancer Registry may release confidential cancer data to other areas of the department, provided that the disclosure is required or authorized by law. All communications of this nature shall be clearly labeled "Confidential" and will follow established departmental internal protocols and procedures.

(3) The Texas Cancer Registry may release confidential cancer data to state, federal, local, and other public agencies and organizations in accordance with subsection (a) of this section.

(4) The Texas Cancer Registry may release confidential cancer data to any other individual or entities for reasons deemed necessary to carry out the intent of the Act and in accordance with subsection (a) of this section.

(5) An individual who submits a valid authorization for release of an individual cancer record shall have access to review or obtain copies of the information described in the authorization for release.

Texas Cancer Incidence Reporting Act and Reporting Rules also available on the web at:
https://www.dshs.texas.gov/tcr/lawrules.aspx

The Texas Cancer Registry Rule can be found at the Texas Administrative Code webpage:
http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=91&rl=4

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APPENDIX C:
FIPS COUNTY CODES

FIPS COUNTY CODES - TEXAS COUNTIES

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APPENDIX D: CONFIDENTIAL CANCER REPORTING FORM

Appendix D Confidential Cancer Reporting Form

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E

APPENDIX E: COMMON ACCEPTABLE ABBREVIATIONS

Common Acceptable Abbreviations
(In order of Abbreviation)

When abbreviating words in an address, refer to the Address Abbreviations section of the National Zip Code and Post Office Directory, published by the U.S. Postal Service. For short names of antineoplastic drugs, consult SEER*RX Interactive Antineoplastic Drugs Database: https://seer.cancer.gov/seertools/seerrx/.

ABBREVIATION	DESCRIPTION
A	Allergy
A	Annum
A	Anode
A	Anterior
A	Aortic
A	Artery
A	Axial
AA	Aplastic anemia
AB	Abort (miscarry)
AB	About
AB	Antibody
AB	Asthmatic bronchitis
ABD, ABDOM	Abdomen
ABG	Arterial Blood Gas
ABN	Abnormal
ABP	Arterial blood pressure
ABST	Abstract
AC	Adrenal cortex
AC	Air contrast
AC	Anterior chamber
ACH	Adrenal cortical hormone
ACID PHOS	Acid phosphatase
ACID P'TASE	Acid phosphatase
A-COLON	Ascending Colon
ACTH	Adrenocorticotrophic hormone
ADENOCA	Adenocarcinoma
ADH	Antidiuretic hormone (vasopressin)
ADJ	Adjacent
ADL	Activities of Daily Living
ADM	Admission

ABBREVIATION	DESCRIPTION
ADM	Admit
ADR	Adverse drug reaction
AFF	Afferent
AFF	Affirmative
AFP	Alpha-fetoprotein
AG	Atrial gallop
AG	Antigen
AG	Argentum (silver, chemical symbol for)
AGL	Acute granulocytic leukemia
A/G RATIO	Albumin-globulin ratio
AGNO3	Silver Nitrate
AIDS	Acquired immunodeficiency syndrome
AIL	Angioimmunoblastic lymphadenopathy
AILD	Angioimmunoblastic lymphadenopathy with dysprotinemia
AIN	Anal intraepithelial neoplasia
AK(A)	Above knee (amputation)
AKA	Also known as
ALB	Albumin
ALCL	Anaplastic large cell lymphoma
ALK PHOS	alkaline phosphatase
ALL	Acute lymphocytic leukemia
AMA	Against medical advice
AMB	ambulatory
AMKL	Acute megakaryocytic leukemia
AML	Acute myelogenous leukemia
AMP	Amputation
ANAP	Anaplastic
ANAT	Anatomy
ANO	Axillary node dissection
ANED	Alive no evidence of disease
ANES(TH)	Anesthesia, anesthetic
ANT	Anterior
ANTE	Before
A&P	Auscultation & percussion
AP	Abdominal perineal
AP	Anteroposterior

ABBREVIATION	DESCRIPTION
AP	Anterior pituitary
AP&LAT	Anteroposterior & lateral
ARC	Aids Related Complex
ARMS	Alveolar Rhabdomyosarcoma
APP	Appendix
APPROX	Approximately
ASP	Aspiration
AUT	Autopsy
AV	Arteriovenous
AX	Axilla(ry)
B	Bacillus
B	Black
B	Blue
B	Born
B	Brother
BA	Bachelor of Arts
BA	Barium (chemical symbol for)
BA	Bronchial asthma
BALT	Bronchial-associated lymphoid tissue
BAS	Basal
BASOS	Basophil(s) (granular leukocyte)
BBB	Blood-brain block
BBB	Bundle-branch block
BBT	Basal body temperature
BC	Birth control
BC	Bone conduction
BC	Buccocervical
BCC	Basal cell carcinoma
B-CELLS	Special lymphocytes formed in bone marrow (derived from bursa of Fabricius)
BCG	Bacillus Calmette-Guerin
BD	Bile duct
BE	Barium enema
B/F	Black female
BIO	Twice a day
BIL	Bilateral
BK(A)	Below knee (amputation)

ABBREVIATION	DESCRIPTION
BM	Bone marrow
BM	Bowel movement
B/M	Black male
BMR	Basal metabolic rate
BMT	Bone marrow transplant
BP	Blood pressure
BPH	Benign prostatic hypertrophy/hyperplasia
BRB(PR)	Bright Red Blood (per Rectum)
BRM	Biological response modifier
BSC	Bone scan
BSE	Breast self-examination
BS	Bowel Sounds
BS, BRS	Breath Sounds
BSO	Bilateral salpingo-oophorectomy
BT	Brain tumor
BUN	Blood urea nitrogen
BUS	Bartholin's, urethral & Skene's glands
BX	Biopsy
C	Centigrade
Ca	Ca-Journal of the American Cancer Society
C1-C7	Cervical vertebrae
CA	Calcium
CA	Carcinoma
CAT	Computerized axial tomography
CBC	Complete blood count
CBD	Common bile duct
CC	Chief complaint
CC	Cubic centimeter
CHEMO	Chemotherapy
CHF	Congestive heart failure
CHR	Chronic
CIG	Cigarettes
CIN	Cervical intraepithelial neoplasia
CIS	Carcinoma-in situ
CLL	Chronic lymphocytic leukemia
CLR	Clear

ABBREVIATION	DESCRIPTION
CM	Centimeter
CM	Costal margin
CML	Chronic myeloid/myelocytic leukemia
CMML	Chronic myelomonocytic leukemia
CMV	Cytomegalovirus
CNS	Central nervous system
C/O	Complaining of
CO2	Carbon dioxide
Co60	Cobalt 60
Cont	Continue
Contra	Contralateral
COR	Heart
CPK	Creatine Phosphokinase
CR	Complete remission
CRF	Chronic renal failure
CS	Cesium
CS	Collaborative Stage
CSF	Cerebrospinal fluid
CSF	Colony-stimulating factor
C-SPINE	Cervical spine
CTCL	Cutaneous T cell lymphoma
CTR	Certified Tumor Registrar
CT SC, CAT Scan	Computerized (axial) tomography scan
CVA	Cerebrovascular accident
CVA	Costovertebral angle
C/W	Consistent with
CX	Cervix
CXR	Chest x-ray
CYSTO	Cystoscopy
CYTO	Cytology
D1, D2 ETC	First dorsal vertebra, second, etc.
D&C	Dilatation and curettage
DC	Discharge
DC	Discontinued
DCIS	Ductal carcinoma in situ
D-Colon	Descending Colon

ABBREVIATION	DESCRIPTION
DECR (or <)	Decreased
DERM	Dermatology
DD	Discharge diagnosis
DDX	Differential diagnosis
DERM	Dermatology
DIAM	Diameter
DIFF	Differentiated, differential
DIS, DISCH	Disease; Discharge
DLS	Date last seen
DNA	Deoxyribonucleic acid
DNR	Do not resuscitate
DO	Doctor of Osteopathy
DOA	Dead on arrival
DOB	Date of birth
DOD	Date of death
DOE	Dyspnea on exertion
DP	Dorsalis Pedis
DR	(Medical) doctor
DRE	Digital Rectal Exam
DS	Discharge
DTR	Deep tendon reflex
DX	Diagnosis
ECF	Extended care facility
ECG, EKG	Electrocardiogram
EEG	Electroencephalogram
EENT	Eyes, ears, nose, & throat
EGD	Esophagogastroduodenoscopy
EMG	Electromyogram
ENL	Enlarged
ENT	Ear, nose & throat
EPA	Erect (standing), posterior, anterior
ER(A)	Estrogen receptor (assay)
ERCP	Endoscopic retrograde cholangiopancreatography
EST	Electroshock therapy
ETOH	Alcohol
EUA	Exam under anesthesia

ABBREVIATION	DESCRIPTION
EVAL	Evaluation
EXAM	Examination
EXC	Excision
EXP LAP	Exploratory laparotomy
EXT	Extend, extension
EXT	External; Extremity
F	Fahrenheit
FAB	French American and British Classification Scheme for Leukemia
FB	Fingerbreadth
FBS	Fasting blood sugar
FDA	Food and Drug Administration in USA
FIGO	International Federation of Gynecology and Obstetrics
F(M)H	Family (medical) history
FLURO	Fluoroscopy
FNA	Fine Needle Aspiration
FOM	Floor of mouth
FP	Flat plate
FS	Frozen Section
FU	Follow up
FUO	Fever unknown origin
FX	Fracture
FX	Frozen section
GA	Gastric analysis
GB	Gallbladder
GBM	Glioblastoma multiforme
GCT	Germ cell tumor
GE	Gastroenterostomy
GE	Gastroesophageal
GEN	Generalized
GI	Gastrointestinal
GM	Gram
GP	General practitioner
GR	Grade, grain(s)
GU	Genitourinary
GYN	Gynecology
HB	Hemoglobin

ABBREVIATION	DESCRIPTION
HCG	Human Chorionic Gonadotropin
HCL	Hairy cell leukemia
HCT	Hematocrit
HCVD	Hypertensive cardiovascular disease
HD	Heart disease
HD	Heart disease
HEENT	Head, eyes, ears, nose & throat
HGB	Hemoglobin
HIV	Human immunodeficiency virus
HN2	Nitrogen mustard
H2O	Water
H/O	History of
HORM	Hormone
HOSP	Hospital
H&P	History and physical
HPF	High power field
HPI	History of present illness
HPV	Human papilloma virus
HR(S)	Hour(s)
HRT	Hormone Replacement therapy
HTLV-III	Human T-Lymphotrophic virus type III
HVD	Hypertensive vascular disease
HX	History
HYST	Hysterectomy
I	Iodine
IARC	International Agency for Research on Cancer
ICD-O-1	International Classification of Diseases for Oncology, 1st Ed., 1976
ICD-O-2	International Classification of Diseases, for Oncology, 2nd Ed., 1992
ICD-O-3	International Classification of Diseases, for Oncology, 3rd Ed., 2000
ICF	Intercellular fluid
ICM	Intercostal margin
ICS	Intercostal space
ICU	Intensive care unit
IG	Immunoglobulin
IM	Intramuscular
IMA	Internal mammary artery

ABBREVIATION	DESCRIPTION
IMP	Impression
INCL	Includes, including
INCR	Increase
INF	Inferior
INF	Infraction
INF	Infusion
INFILT	Infiltrating
INJ	Injection
INT MED	Internal medicine
INPT, IP	Inpatient
INV	Invade(s)/invading/invasion
INVL	Involve(s)/involvement
IPPB	Intermittent positive pressure breathing
IPSI	Ipsilateral
IRREG	Irregular
IT	Intrathecal
IV	Intravenous
IVC	Inferior vena cava
IVP	Intravenous pyelogram
IVU	Intravenous Urography
JVD	Jugular venous distention
K	Potassium
KG	Kilogram
KJ	Knee jerk
KK	Knee kick
KUB	Kidneys, ureters, bladder
KV	Kilovolt
L	Left
L	Liter
L	Lower
L1-L5	Lumbar vertebrae
LAD	Lymphadenopathy
LAP	Laparotomy
LAT	Lateral
LAV	Lymphadenopathy-associated virus
LCIS	Lobular carcinoma in-situ

ABBREVIATION	DESCRIPTION
LCM	Left costal margin
LDH	Lactic dehydrogenase
LE	Lower extremity; Lupus erythematosus
LFT	Liver function test
LG	Large
LIF	Left iliac fossa
LINAC	Linear accelerator
LIQ	Lower inner quadrant (breast)
LKS(B)	Liver, kidney, spleen, (bladder)
LLE	Left lower extremity
LLL	Left lower lobe (lung)
LLQ	Left lower quadrant (abdomen)
LMD	Local medical doctor
LMP	Last menstrual period
LN(S)	Lymph node(s)
LND	Lymph Node Dissection
LOP	Lower outer quadrant (breast)
LP	Lumbar puncture
LPF	Lower power field
LPN	Licensed practical nurse
LS	Lumbosacral
LSK, LKS	Liver, spleen, kidneys
LSO	Left salpingo-oophorectomy
L-SPINE	Lumbar spine
LT	Left
LUE	Left upper extremity
LUL	Left upper lobe (lung)
LUQ	Left upper quadrant (abdomen)
L&W	Living and well
M	Monocytes, meter
MAB	Monoclonal antibody
MAL	Malignant
MALT	mucosal-associated lymphoid tissue
MALIG	Malignant
MAND	Mandible
MAST	Mastectomy

ABBREVIATION	DESCRIPTION
M-CSF	Macrophage Colony-Stimulating Factor
MC	Millicurie
MCH	Mean corpuscular hemoglobin
MCHC	Mean corpuscular hemoglobin count
MCL	Mid clavicular line
MCV	Mean corpuscular volume
MD	Medical doctor
MD	Moderately differentiated
MED	Medicine
MOS	Myelodysplastic syndrome
MET, METS	Metastatic, metastases
MEV	Million electron volts
MH	Marital history
MH	Mental health
MI	Myocardial infarction
MIN	Minimum
MG	Milligram
MICRO	Microscopic
ML	Middle lobe
ML	Milliliter
MM	Millimeter
MOD	Moderate
MOD DIFF	Moderately differentiated
MO	Month
MPNST	Malignant peripheral nerve sheath tumor
MRI	Magnetic resonance imaging
MRM	Modified radical mastectomy
MSL	Mid sternal line
MULT	Multiple
MX	Microscopic
MX	Maxilla(ry), maximum
NA	Not applicable
NBS	Normal bowel sounds
NEC	Not elsewhere classified
NED	No evidence of disease
NEG or -	Negative

ABBREVIATION	DESCRIPTION
NEMD	No Evidence of Metastatic Disease
NERD	No evidence of recurrent disease
NEURO	Neurology
NHL	Non Hodgkin lymphoma
NK	Natural killer
NL	Normal
NOS	Not otherwise specified
NR	Not recorded
NR	Not reportable
NSCLC	Non-small cell lung carcinoma
NSF	N significant findings
NTP	Normal temperature and pressure
N&V	Nausea and vomiting
NVD	neck vein distention
OB	Obstetrics
OBST	Obstructed (ing, ion)
OD	Right eye (oculus dexter)
OH	Occupational history
OP	Operation
OP	Outpatient
OPD	Outpatient clinic; department
OPHTH	Ophthalmology
OP RPT	Operative Report
OR	Operating room
ORTH	Orthopedics
OS	Bone
OS	Left eye (oculus sinister)
OS	Mouth
OS	Opening
OSTEO	Osteomyelitis
OT	Occupational therapy
OTO	Otology
OU	Each eye (oculus uterque)
OV	Office visit
OZ	Ounce
P	Pulse

ABBREVIATION	DESCRIPTION
P&A	Percussion and auscultation
PA	Posteroanterior
PA	Pulmonary artery
PA	Physician assistant
PALP	Palpable, palpated, palpation
PAP	Papanicolaou smear
PAP	Papillary
PAR	Post anesthesia room
PARA	Number of pregnancies resulting in viable infants
PATH	Pathology
PCV	Packed cell volume
PD	Poorly differentiated
PDR	Physician's Desk Reference
PE	Physical examination
PED	Pediatrics
PEG	Pneumoencephalography
PEG	Percutaneous gastrostomy tube
PERC	Percutaneous
PET	Positron emission tomography
PH	Past or personal history
PI	Present illness
PID	Pelvic inflammatory disease
PIN	Prostatic intraepithelial neoplasia
PLT	Platelets
PM	Post mortem (after death)
PMD	Personal (primary) medical doctor
PMH	Past medical history
PND	Postnasal drip
PNET	Peripheral neuroectodermal tumor (bone tumors)
PNET	Primitive neuroectodermal tumor (CNS tumors)
PO, POSTOP	Postoperative(ly)
POD	Postoperative day
POOR DIFF	Poorly differentiated
POS or +	Positive
POSS	Possible
POST	Posterior

ABBREVIATION	DESCRIPTION
POST	Postmortem examination
POSTOP	Postoperative(ly)
PPD	Purified protein derivative (Tuberculin skin test)
PPD	Packs per day
PR	Partial response
PR(A)	Progesterone receptor (assay)
PREOP	Preoperative(ly)
PTA	Prior to Admission
PROB	Probable(ly)
PSA	Prostate specific antigen
PT	Patient
PT	Physiotherapy
PTA	Prior to examination
PUO	Pyrexia of undetermined origin
PULM	Pulmonary
Q	Quadrant
QID	Four times a day
R	Roentgen
R	Respiration
R	Right
RA	Radium
RAD	Radiation
RAD	Radiation Absorbed Dose
RAD	Radical
RAEB (-T)	Refractory anemia with excess blasts (in transformation)
RAIU	Radioactive iodine (I 131) uptake
RARS	Refractory anemia with ringed sideroblasts
RBC	Red blood cells
RCM	Right costal margin
RCS	Reticulum cell sarcoma
REG	Radioencephalogram
RES	Reticuloendothelial system
RESEC	Resection
RESP	Respiratory
RH	Rhesus (monkey) factor in blood
RIA	Radioimmunoassay

ABBREVIATION	DESCRIPTION
RIF	Right iliac fossa
RIQ	Right inner quadrant (abdomen)
RLE	Right lower extremity
RLL	Right lower lobe (lung)
RLQ	Right lower quadrant
RML	Right middle lobe (lung)
RMS	Rhabdomyosarcoma
RN	Registered nurse
RNP	Registered nurse practitioner
RNA	Ribonucleic acid
RO, R/O	Rule out
ROF	Review of outside films
ROM	Range of motions
ROS	Review of slides
ROS	Review of outside slides
ROS	Review of Systems
ROQ	Right outer quadrant (abdomen)
RSO	Right salpingo-oophorectomy
R-S cells	Reed-Sternberg cells
RT	Radiation therapy
RT	Right
RUE	Right upper extremity
RUL	Right upper lobe
RUQ	Right upper quadrant
R-V	Rectovaginal
RX	Treatment
S1S5	Sacral vertebra
SALT	Skin-associated lymphoid tissue
SARC	Sarcoma
SB	Small bowel
SBE	Subacute bacterial endocarditis
SCC	Squamous cell carcinoma
S-COLON	Sigmoid Colon
SEER	Surveillance Epidemiology and End Results
SGOT	Serum glutamic oxaloacetic
SGPT	Serum glutamic pyruvic transaminase

ABBREVIATION	DESCRIPTION
SS	Social Security
SH	Serum hepatitis
SM	Small
SMA	Sequential multiple analysis (Biochem profile)
SML BWL	Small bowel
SNF	Skilled nursing facility
SO	Salpingo-oophorectomy
SOB	Shortness of breath
SOL	Solution
S/P	Status post
SPEC	Specimen
SP GR	Specific gravity
S-Q, SQ	Subcutaneous
SQ, SQUAM	Squamous
SQ CELL CA	Squamous cell carcinoma
SR	Sedimentation rate
S-SPINE	Sacral spine
STAPH	Staphylococcus
STAT	Immediately (statim)
STREP	Streptococcus
STSG	Split thickness skin graft
SUBCU	Subcutaneous
SUB-Q, SUBQ	Subcutaneous
SURG	Surgery, surgical
SUSP	Suspicious/Suspected
SVC	Superior vena cava
SX	Symptoms
SYMP	Symptoms
T	Temperature
T	Thoracic
TA	Toxin-antitoxin
T1-T2	Thoracic vertebra
T&A	Tonsillectomy and adenoidectomy
TAH	Total abdominal hysterectomy
TAH-BSO	Total abdominal hysterectomy-bilateral salpingo oophorectomy
TB, TBC	Tuberculosis

ABBREVIATION	DESCRIPTION
TCC	Transitional cell carcinoma
T-COLON	Transverse Colon
TD	Tumor dose
TID	Three times a day
TNM	Tumor, Nodes, Metastasis
TP	Total protein
TPN	Total parenteral nutrition
TPR	Temperature, pulse and respiration
TS	Tumor size
TSH	Thyroid stimulating hormone
T-SPINE	Thoracic spine
TUR	Transurethral resection
TURB	Transurethral resection-Bladder
TURP	Transurethral resection-Prostate
TVH	Total vaginal hysterectomy
TX	Treatment
U	Unit
UCHD	Usual childhood diseases
UE	Upper extremity
UGI	Upper gastrointestinal
UIQ	Upper inner quadrant (breast)
ULCC	Undifferentiated large cell carcinoma
UMB	Navel (umbilicus)
UNDIFF	Undifferentiated
UOQ	Upper outer quadrant (abdomen)
UR	Urine
URI	Upper respiratory infection
UROL	Urology
UTI	Urinary tract infection
VAG	Vagina, Vaginal
VAG HYST	Vaginal hysterectomy
VAIN	Vaginal intraepithelial neoplasia
VASC	Vascular
VD	Venereal Disease
VIN	Vulvar intraepithelial neoplasia
VS	Vital signs

ABBREVIATION	DESCRIPTION
W/	With
WBC	White blood cells
W/D	Well developed
WD, WELL DIFF	Well differentiated
W/F	White female
W/M	White male
WN	Well nourished
WNL	Within normal limits
W/O	Without
WT	Weight
W/U	Work-up
XR	X-ray
Y/O	Year old
YR	Year

Symbols

@ At
/ Comparison
< Decrease, Less than
= Equals
> Increase, More than
- Negative
Number*
+ Positive
# Pounds**
x Times

*If it appears before a numeral
**If it appears after a numeral

F

APPENDIX F:
COMPARISON OF DATA SETS

COMPARISON OF DATA SETS

Definitions:

Required Data Set (R): Commission-approved programs must record the required data set items using the codes and definitions specified in the FORDS manual.

Supplementary Data Set (S): The supplementary data set contains additional data items that are important for the efficient operation of a cancer registry.

Surveillance, Epidemiology, and End Results Program (SEER): Required data elements for a central registry affiliated with the National Cancer Institute's SEER Program.

National Program of Cancer Registries (NPCR): Refers to requirements and recommendations of the NPCR regarding data items that should be collected or computed by NPCR state registries.

Commission on Cancer (CoC): Refers to requirements and recommendations of the Commission on Cancer of ACoS.

Texas Cancer Registry (TCR): Refers to the requirements and recommendations of the Texas Cancer Registry.

Exchange Elements for Hospital to Central and Central to Central: Items required for facilities reporting to central registries (labeled Hosp>Central), and items that central registries should use when sending cases to other central registries (labeled Central>Central).

Codes for Recommendations:

(Left blank indicates that this data field is not currently collected by the TCR and other entities.)

- No recommendations

C Collect

D Derived

D* Derived, when available

D+ Derived; central registries may collect either SEER Summary Stage 2000 or Collaborative Stage

DH Historically derived and currently transmitted

R Required

R# Required; central registries may code available data using either SEER or CoC data items and associated rules

R#* Required, when available; central registries may code available data using SEER or CoC data items and associated rules

R$ Requirements differ by year

R* Required, when available

R^ Required, these text requirements may be met with one or several text block fields

R+ Required, central registries may collect either SEER Summary Stage 2000 or Collaborative Stage

RC Collected by SEER from CoC-accredited hospitals

RH Historically collected and currently transmitted

RH* Historically collected and currently transmitted when available

RN Collect according to NPCR stage transition schedule

RS Required, site specific

RS# Required, site specific; central registries may code available data using either SEER or CoC data items and associated rules

RS* Required, site specific; when available

Ret. Retired

Rev. Revised

S Supplementary/recommended

T Data is vital to complete exchange record

T* Transmit data if available for any case in exchange record

TH Only certain historical cases may require these fields

TH* Only certain historical cases may require these fields; transmit data if available for any case in exchange record

√ Populated by TCR

The following table is derived from **Chapter VIII: Required Status Table** of the NAACCR *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary*, which can be found at: http://datadictionary.naaccr.org/?c=8.

Table F.1 Comparison of Data Sets

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP > CENTRAL	CENTRAL > CENTRAL	
	10	Record Type	√	R	•	R	•	R	T	T	NAACCR
	20	Patient ID Number	√	R	•	•	R	R	•	T	Reporting Registry
	21	Patient System ID-Hosp	•	•	•	•	•	•	T	•	NAACCR
	30	Registry Type	•	•	•	•	•	•	•	T	NAACCR
Ret.	35	FIN Coding System									
	37	Reserved 00									
	40	Registry ID	R	R	•	•	R	R	T	T	NAACCR
	45	NPI-Registry ID	•	•	•	•	R*	•	•	•	CMS
Rev.	50	NAACCR Record Version	R	R	•	R	R	R	T	T	NAACCR
	60	Tumor Record Number	•	•	•	•	S	S	T	T	NAACCR
	70	Addr at DX-City	R	R	R	R	R	•	T	T	COC
Rev.	80	Addr at DX-State	R	R	R	R	R	R	T	T	COC
	90	County at DX	R	R	R	R	R	R	T	T	FIPS/SEER
New	94	County at DX Geocode1990		D	•	•	D	R	•	•	NAACCR
New	95	County at DX Geocode2000		D	•	•	D	R	•	•	NAACCR
New	96	County at DX Geocode2010		D	•	•	D	R	•	•	NAACCR
New	97	County at DX Geocode2020		•	•	•	D	R	•	•	NAACCR
	100	Addr at DX-Postal Code	R	R	R	R	R	•	T	T	COC
	102	Addr at DX-Country	•	•	R	R	R	•	•		NAACCR
	110	Census Tract 1970/80/90	D	RH*	•	•	RH	RH	•	T*	SEER
	120	Census Cod Sys 1970/80/90	D	RH*	•	•	RH	RH	•	T*	SEER
Rev.	130	Census Tract 2000	D	RH	•	•	RH	RH	•	T*	NAACCR
	135	Census Tract 2010	D	R	•	•	R	R	•	•	NAACCR
Ret.	140	Census Tract Cod Sys-Alt									
Rev.	145	Census Tract Poverty Indicator		R	•	•	D	R			NAACCR
	150	Marital Status at DX	•	•	•	•	R	R	•	•	SEER

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP > CENTRAL	CENTRAL > CENTRAL	
	160	Race 1	R	R	R	R	R	R	T	T	SEER/COC
	161	Race 2	R	R	R	R	R	R	T	T	SEER/COC
	162	Race 3	R	R	R	R	R	R	T	T	SEER/COC
	163	Race 4	R	R	R	R	R	R	T	T	SEER/COC
	164	Race 5	R	R	R	R	R	R	T	T	SEER/COC
	170	Race Coding Sys-Current	•	•	R	R	•	•	T	T	NAACCR
	180	Race Coding Sys-Original	•	•	R	R	•	•	T	T	NAACCR
	190	Spanish/Hisp Origin	R	R	R	R	R	R	T	T	SEER/COC
	191	NHIA Derived Hisp Origin	D	D	•	•	D	R	•	•	NAACCR
	192	IHS Link	√	R*	•	•	•	R	•	•	NPCR
	193	Race NAPIIA (derived API)	D	R	•	•	D	R	•	•	NAACCR
	200	Computed Ethnicity	R	R	•	•	D	R	•	•	SEER
	210	Computed Ethnicity Source	R	R	•	•	R	R	•	•	SEER
	220	Sex	R	R	R	R	R	R	T	T	SEER/COC
	230	Age at Diagnosis	√	R	R	R	R	R	•	•	SEER/COC
	240	Date of Birth	R	R	R	R	R	R	T	T	SEER/COC
	241	Date of Birth Flag	D	R	R	R	R	R	T	T	NAACCR
Rev.	250	Birthplace	RH*	RH*	•	•	•	•	T*	T	SEER/COC
Rev.	252	Birthplace-State	R*	R*	R	R	R	R	•	•	NAACCR
Rev.	254	Birthplace-Country	R*	R*	R	R	R	R	•	•	NAACCR
Ret.	260	Religion									
	270	Occupation Code-Census 1970-2000	√	R*	•	•	•	•	•	•	Census/ NPCR
	272	Census Ind Code 2010	R*	R*	•	•	•	•	•	•	Census/ NPCR
	280	Industry Code-Census 1970-2000	√	R*	•	•	•	•	•	•	Census/ NPCR
	282	Census Occ Code 2010	R*	R*	•	•	•	•	•	•	Census/ NPCR
	290	Occupation Source	√	R*	•	•	•	•	•	•	NPCR
	300	Industry Source	√	R*	•	•	•	•	•	•	NPCR
	310	Text-Usual Occupation	R	R*	•	•	•	•	T*	T*	NPCR
	320	Text-Usual Industry	R	R*	•	•	•	•	T*	T*	NPCR

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP > CENTRAL	CENTRAL > CENTRAL	
	330	Occup/Ind Coding System 70-00	√	R*	•	•	•	•	•	•	NPCR
Ret.	340	Tobacco History									
Ret.	350	Alcohol History									
Ret.	360	Family History of Cancer									
	362	Census Tract Block Group 2000	D	•	•	•	S	•	•	•	Census
	363	Census Block Group 2010	•	•	•	•	R	•	•	•	Census
	364	Census Tr Cert 1970/80/90	D	RH*	•	•	RH	RH	•	•	SEER
Rev.	365	Census Tr Certainty 2000	D	RH	•	•	RH	RH	•	•	NAACCR
	366	GIS Coordinate Quality	R*	R*	•	•	S	•	•	•	NAACCR
	367	Census Tr Certainty 2010	D	R	•	•	R	R	•	•	NAACCR
	368	CensusBlockGroup 70/80/90	•	•	•	•	S	•	•	•	Census
	370	Reserved 01									
	380	Sequence Number-Central	R	R	•	•	R	R	•	T	SEER
	390	Date of Diagnosis	R	R	R	R	R	R	T	T	SEER/COC
	391	Date of Diagnosis Flag	D	R	•	•	R	R	T	T	NAACCR
	400	Primary Site	R	R	R	R	R	R	T	T	SEER/COC
	410	Laterality	R	R	R	R	R	R	T	T	SEER/COC
	419	Morph-Type & Behav ICD-O-2	•	•	•	•	•	•	•	•	
	420	Histology(92-00) ICD-O-2	RH	RH	RH	RH	RH	RH	TH	TH	SEER/COC
	430	Behavior (92-00) ICD-O-2	RH	RH	RH	RH	RH	RH	TH	TH	SEER/COC
Rev.	439	Date of Mult Tumors Flag	•	•	RH	RH	RH	RH	•	•	NAACCR
	440	Grade	R	R	R	R	R	R	T	T	SEER/COC
Rev.	441	Grade Path Value		RH*	RH	RH	RH	RH	T*	T*	AJCC
Rev.	442	Ambiguous Term DX	•	•	RH	RH	RH	RH	•	•	SEER
Rev.	443	Date of Conclusive DX	•	•	RH	RH	RH	RH	•	•	SEER
Rev.	444	Mult Tum Rpt as One Prim	•	•	RH	RH	RH	RH	•	•	SEER
Rev.	445	Date of Multiple Tumors	•	•	RH	RH	RH	RH	•	•	SEER

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP > CENTRAL	CENTRAL > CENTRAL	
Rev.	446	Multiplicity Counter	•	•	RH	RH	RH	RH	•	•	SEER
Ret.	447	Number of Tumors/ Hist									
Rev.	448	Date Conclusive DX Flag	•	•	RH	RH	RH	RH	•	•	NAACCR
Rev.	449	Grade Path System		RH*	RH	RH	RH	RH	T*	T*	AJCC
	450	Site Coding Sys-Current	• D	R	R	R	•	•	T	T	NAACCR
	460	Site Coding Sys-Original	•	•	R	R	•	•	T	T	NAACCR
	470	Morph Coding Sys-Current	• D	R	R	R	•	•	T	T	NAACCR
	480	Morph Coding Sys-Origin 1	•	•	R	R	•	•	T	T	NAACCR
	490	Diagnostic Conf	R	R	R	R	R	R	T	T	SEER/COC
	500	Type of Reporting Source	R	R	•	•	R	R	T	T	SEER
	501	Casefind. Source	R*	R*	•	•	•	•	T*	T*	NAACCR
Ret.	510	Screening Date									
Ret.	520	Screening Result									
	521	Morph Type & Behav ICD-O-3	•	•	•	•	•	•	•	•	
	522	Histologic Type ICD-O-3	R	R	R	R	R	R	T	T	SEER/COC
	523	Behavior Code ICD-O-3	R	R	R	R	R	R	T	T	SEER/COC
	530	Reserved 02									
Ret.	538	Reporting Hospital FAN									
	540	Reporting Facility	R	R	R	R	R	•	T	•	COC
	545	NPI-Reporting Facility	D	R*	R	R	R*	•	•	•	CMS
	550	Accession Number-Hosp	R	•	R	R	R	•	T*	•	COC
	560	Sequence Number-Hospital		•	R	R	R	•	T	•	COC
	570	Abstracted By	R	•	R	R	R	•	•	•	COC
	580	Date of 1st Contact	R	R	R	R	•	•	T	•	COC
	581	Date of 1st Contact Flag	D	R	R	R	•	•	T	•	NAACCR
	590	Date of Inpatient Adm	•	•	•	•	•	•	•	•	NAACCR

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP > CENTRAL	CENTRAL > CENTRAL	
	591	Date of Inpt Adm Flag	•	•	•	•	•	•	•	•	NAACCR
	600	Date of Inpatient Disch	•	•	•	•	•	•	•	•	NAACCR
	601	Date of Inpt Disch Flag	•	•	•	•	•	•	•	•	NAACCR
	605	Inpatient Status	•	•	•	•	•	•	•	•	NAACCR
	610	Class of Case	R	R	R	R	RC	•	T	•	COC
Ret.	620	Year First Seen This CA									
	630	Primary Payer at DX	R*	R*	R	R	R	R	•	•	COC
Ret.	640	Inpatient/ Output Status									
Ret.	650	Present. at CA Conf									
Ret.	660	Date of CA Conference									
Ret.	665	RX Hosp-ASA Class	•	•	•	•	•	•	•	•	
	668	RX Hosp-Surg App 2010	•	•	R	R	•	•	T*	•	COC
	670	RX Hosp-Surg Prim Site	•	•	R	R	R	•	T*	•	COC
	672	RX Hosp-Scope Reg LN Sur	•	•	R	R	R	•	T*	•	COC
	674	RX Hosp-Surg Oth Reg/Dis	•	•	R	R	R	•	T*	•	COC
	676	RX Hosp-Reg LN Removed	•	•	RH	RH	•	•	T*	•	COC
Ret.	678	RX Hosp-Surg Timing									
	680	Reserved 03									
	690	RX Hosp-Radiation	•	•	•	•	RH	•	TH*	•	SEER
	700	RX Hosp-Chemo	•	•	R	R	R	•	T*	•	COC
	710	RX Hosp-Hormone	•	•	R	R	R	•	T*	•	COC
	720	RX Hosp-BRM	•	•	R	R	R	•	T*	•	COC
	730	RX Hosp-Other	•	•	R	R	R	•	T*	•	COC
	740	RX Hosp-DX/ Stg Proc	•	•	R	R	•	•	•	•	COC
Ret.	742	RX Hosp-Screen/ BX Proc1									
Ret.	743	RX Hosp-Screen/ BX Proc2									
Ret.	744	RX Hosp-Screen/ BX Proc3									

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP > CENTRAL	CENTRAL > CENTRAL	
Ret.	745	RX Hosp-Screen/ BX Proc4									
	746	RX Hosp-Surg Site 98-02	•	•	RH	RH	RH	•	TH*	•	COC
	747	RX Hosp-Scope Reg 98-02	•	•	RH	RH	RH	•	TH*	•	COC
	748	RX Hosp-Surg Oth 98-02	•	•	RH	RH	RH	•	TH*	•	COC
	750	Reserved 04									
New	752	Tumor Size Clinical	•	•	•	•	R	R	•	•	SEER
New	754	Tumor Size Pathologic	•	•	•	•	R	R	•	•	SEER
New	756	Tumor Size Summary	R	R	R	R	S	S			NPCR/CoC
Rev.	759	SEER Summary Stage 2000	RH	R	R	R	R+	R+	TH*	TH*	SEERv
	760	SEER Summary Stage 1977	RH	RH	RH	RH	•	S	TH*	TH*	SEER
Ret.	770	Loc/Reg/ Distant Stage									
	779	EOD 10-Dig									
	780	EOD-Tumor Size	RH	•	RH	RH	RH	RH	TH*	TH*	SEER/COC
	790	EOD-Extension	•	•	•	•	RH	RH	TH*	TH*	SEER
	800	EOD-Extension Prost Path	•	•	•	•	RH	RH	TH*	TH*	SEER
	810	EOD-Lymph Node Involv	•	•	•	•	RH	RH	TH*	TH*	SEER
	820	Regional Nodes Positive	R	R	R	R	R	R	T*	T*	SEER/COC
	830	Regional Nodes Examined	R	R	R	R	R	R	T*	T*	SEER/COC
	840	EOD-Old 13 Digit	•	•	•	•	RH	RH	•	•	SEER
	850	EOD-Old 2 Digit	•	•	•	•	RH	RH	•	•	SEER
	860	EOD-Old 4 Digit	•	•	•	•	RH	RH	•	•	SEER
	870	Coding System for EOD	•	•	•	•	RH	RH	•	TH*	SEER
Rev.	880	TNM Path T	R	R	R	R	R	R	T*	T*	AJCC
Rev.	890	TNM Path N	R	R	R	R	R	R	T*	T*	AJCC
Rev.	900	TNM Path M	R	R	R	R	R	R	T*	T*	AJCC
Rev.	910	TNM Path Stage Group	R	R	R	R	S	S	T*	T*	AJCC
Rev.	920	TNM Path Descriptor	R	R	R	R	R	R	T*	T*	COC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP > CENTRAL	CENTRAL > CENTRAL	
Rev.	930	TNM Path Staged By	•	•	R	R	R	R	T*	T*	COC
Rev.	940	TNM Clin T	R	R	R	R	R	R	T*	T*	AJCC
Rev.	950	TNM Clin N	R	R	R	R	R	R	T*	T*	AJCC
Rev.	960	TNM Clin M	R	R	R	R	R	R	T*	T*	AJCC
Rev.	970	TNM Clin Stage Group	R	R	R	R	S	S	T*	T*	AJCC
Rev.	980	TNM Clin Descriptor	R	R	R	R	R	R	T*	T*	COC
Rev.	990	TNM Clin Staged By	•	•	R	R	R	R	T*	T*	COC
Ret.	1000	TNM Other T									
Ret.	1010	TNM Other N									
Ret.	1020	TNM Other M									
Ret.	1030	TNM Other Stage Group									
Ret.	1040	TNM Other Staged By									
Ret.	1050	TNM Other Descriptor									
Rev.	1060	TNM Edition Number	R	R	R	R	R	R	T*	T*	COC
Ret.	1070	Other Staging System									
Ret.	1080	Date of 1st Positive BX									
Ret.	1090	Site of Distant Met 1									
Ret.	1100	Site of Distant Met 2									
Ret.	1110	Site of Distant Met 3									
New	1112	Mets at DX-Bone	•	•	R	R	R	R			SEER
New	1113	Mets at DX-Brain	•	•	R	R	R	R			SEER
New	1114	Mets at Dx-Distant LN	•	•	R	R	R	R			SEER
New	1115	Mets at DX-Liver	•	•	R	R	R	R			SEER
New	1116	Mets at DX-Lung	•	•	R	R	R	R			SEER
New	1117	Mets at DX-Other	•	•	R	R	R	R			SEER
	1120	Pediatric Stage	•	•	•	•	•	•	•	•	COC
	1130	Pediatric Staging System	•	•	•	•	•	•	•	•	COC
	1140	Pediatric Staged By	•	•	•	•	•	•	•	•	COC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP > CENTRAL	CENTRAL > CENTRAL	
	1150	Tumor Marker 1	•	•	RH	RH	RH	RH	TH*	TH*	SEER
	1160	Tumor Marker 2	•	•	RH	RH	RH	RH	TH*	TH*	SEER
	1170	Tumor Marker 3	•	•	RH	RH	RH	RH	TH*	TH*	SEER
	1180	Reserved 05									
	1182	Lymph-vascular Invasions	R	R	R	R	RS	RS	T*	T*	AJCC
	1190	Reserved 06									
Rev.	1200	RX Date-Surgery	R	R	R	R	RC	RC	T*	T*	COC
Rev.	1201	RX Date-Surgery Flag	R	R	R	R	RC	RC	T*	T*	NAACCR
Rev.	1210	RX Date-Radiation	R	R	R	R	RC	RC	T*	T*	COC
Rev.	1211	RX Date-Radiation Flag	R	R	R	R	RC	RC	T*	T*	NAACCR
Rev.	1220	RX Date-Chemo	R	R	R	R	RC	RC	T*	T*	COC
Rev.	1221	RX Date-Chemo Flag	R	R	R	R	RC	RC	T*	T*	NAACCR
Rev.	1230	RX Date-Hormone	R	R	R	R	RC	RC	T*	T*	COC
Rev.	1231	RX Date-Hormone Flag	R	R	R	R	RC	RC	T*	T*	NAACCR
Rev.	1240	RX Date-BRM	R	R	R	R	RC	RC	T*	T*	COC
Rev.	1241	RX Date-BRM Flag	R	R	R	R	RC	RC	T*	T*	NAACCR
Rev.	1250	RX Date-Other	R	R	R	R	RC	RC	T*	T*	COC
Rev.	1251	RX Date-Other Flag	R	R	R	R	RC	RC	T*	T*	NAACCR
	1260	Date of Initial RX-SEER	R#	R#	•	•	R	R	T*	T*	SEER
	1261	Date of Initial RX Flag	D	R#	•	•	R	R	T*	T*	NAACCR
	1270	Date of 1st Crs RX-COC	R#	R#	R	R	•	•	T*	T*	COC
	1271	Date of 1st Crs RX Flag	R#	R#	R	R	•	•	T*	T*	NAACCR
	1280	RX Date-DX/ Stg Proc	•	•	R	R	•	•	•	•	COC
	1281	RX Date-Dx/ Stg Proc Flag	•	•	R	R	•	•	•	•	NAACCR
Rev.	1285	RX Summ-Treatment Status	R#	R#	R	R	R	R	T*	T*	SEER/COC
	1290	RX Summ-Surg Prim Site	R	R	R	R	R	R	T	T*	SEER/COC
	1292	RX Summ-Scope Reg LN Sur	R	R	R	R	R	R	T	T*	SEER/COC
	1294	RXSumm-Surg Oth Reg/Dis	R	R	R	R	R	R	T	T*	SEER/COC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP > CENTRAL	CENTRAL > CENTRAL	
	1296	RX Summ-Reg LN Examined	•	•	RH	RH	RH	RH	TH*	TH*	SEER/COC
	1300	Reserved 07									
	1310	RXSumm-Surgical Approach	•	•	RH	RH	•	•	•	•	COC
	1320	RX Summ-Surgical Margins	•	•	R	R	R	R	•	•	COC
	1330	RX Summ-Reconstruct 1st	•	•	RH	RH	RH	RH	•	•	SEER
	1340	Reason for No Surgery	R	R	R	R	R	R	T	T*	SEER/COC
	1350	RX Summ-DX/Stg Proc	•	•	R	R	•	•	•	•	COC
	1360	RX Summ-Radiation	RH	RH	•	•	R	R	TH*	TH*	SEER
Rev.	1370	RX Summ-Rad to CNS	•	•	•	•	RH	RH	•	•	SEER/COC
Rev.	1380	RX Summ-Surg/Rad Seq	R	R	R	R	R	R	T	T*	SEER/COC
Rev.	1390	RX Summ-Chemo	R	R	R	R	R	R	T*	T*	SEER/COC
Rev.	1400	RX Summ-Hormone	R	R	R	R	R	R	T*	T*	SEER/COC
Rev.	1410	RX Summ-BRM	R	R	R	R	R	R	T*	T*	SEER/COC
Rev.	1420	RX Summ-Other	R	R	R	R	R	R	T*	T*	SEER/COC
Rev.	1430	Reason for No Radiation	R	R	R	R	•	•	•	•	COC
Ret.	1440	Reason for No Chemo									
Ret.	1450	Reason for No Hormone									
	1460	RX Coding System-Current	• D	R	R	R	•	RH	T*	T*	NAACCR
Ret.	1470	Protocol Eligibility Stat									
Ret.	1480	Protocol Participation									
Ret.	1490	Referral to Support Serv									
Ret.	1500	First Course Calc Method									
	1510	Rad-Regional Dose: cGy	•	•	R	R	•	•	T	•	COC
	1520	Rad-No of Treatment Vol	•	•	R	R	•	•	T	•	COC
Ret.	1530	Rad-Elapsed RX Days									

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP > CENTRAL	CENTRAL > CENTRAL	
	1540	Rad-Treatment Volume	•	•	R	R	•	•	T	•	COC
	1550	Rad-Location of RX	•	•	R	R	•	•	T	•	COC
Ret.	1560	Rad-Intent of Treatment									
Rev.	1570	Rad-Regional RX Modality	R	R	R	R	RC	•	T	T*	COC
Ret.	1580	Rad-RX Completion Status									
Ret.	1590	Rad-Local Control Status									
Ret.	1600	Chemo Field 1									
Ret.	1610	Chemo Field 2									
Ret.	1620	Chemo Field 3									
Ret.	1630	Chemo Field 4									
Rev.	1639	RX Summ-Systemic/Surg Seq	R	R	R	R	R	R	T	T	COC
	1640	RX Summ-Surgery Type	•	•	•	•	RH	RH	•	•	SEER
Ret.	1642	RX Summ-Screen/BX Proc1									
Ret.	1643	RX Summ-Screen/BX Proc2									
Ret.	1644	RX Summ-Screen/BX Proc3									
Ret.	1645	RX Summ-Screen/BX Proc4									
	1646	RX Summ-Surg Site 98-02	•	•	RH	RH	RH	RH	TH*	TH*	SEER/COC
	1647	RX Summ-Scope Reg 98-02	•	•	RH	RH	RH	RH	TH*	TH*	SEER/COC
	1648	RX Summ-Surg Oth 98-02	•	•	RH	RH	RH	RH	TH*	TH*	SEER/COC
	1650	Reserved 08									
	1660	Subsq RX 2nd Course Date	•	•	•	•	•	•	•	•	COC
	1661	Subsq RX 2nd Crs Date Flag	•	•	•	•	•	•	•	•	NAACCR
	1670	Subsq RX 2nd Course Codes	•	•	•	•	•	•	•	•	
	1671	Subsq RX 2nd Course Surg	•	•	•	•	•	•	•	•	COC
	1672	Subsq RX 2nd Course Rad	•	•	•	•	•	•	•	•	COC
	1673	Subsq RX 2nd Course Chemo	•	•	•	•	•	•	•	•	COC
	1674	Subsq RX 2nd Course Horm	•	•	•	•	•	•	•	•	COC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP > CENTRAL	CENTRAL > CENTRAL	
	1675	Subsq RX 2nd Course BRM	•	•	•	•	•	•	•	•	COC
	1676	Subsq RX 2nd Course Oth	•	•	•	•	•	•	•	•	COC
	1677	Subsq RX 2nd-Scope LN SU	•	•	•	•	•	•	•	•	COC
	1678	Subsq RX 2nd-Surg Oth	•	•	•	•	•	•	•	•	COC
	1679	Subsq RX 2nd-Reg LN Rem	•	•	•	•	•	•	•	•	COC
	1680	Subsq RX 3rd Course Date	•	•	•	•	•	•	•	•	COC
	1681	Subsq RX 3rd Crs Date Flag	•	•	•	•	•	•	•	•	NAACCR
	1690	Subsq RX 3rd Course Codes	•								
	1691	Subsq RX 3rd Course Surg	•	•	•	•	•	•	•	•	COC
	1692	Subsq RX 3rd Course Rad	•	•	•	•	•	•	•	•	COC
	1693	Subsq RX 3rd Course Chemo	•	•	•	•	•	•	•	•	COC
	1694	Subsq RX 3rd Course Horm	•	•	•	•	•	•	•	•	COC
	1695	Subsq RX 3rd Course BRM	•	•	•	•	•	•	•	•	COC
	1696	Subsq RX 3rd Course Oth	•	•	•	•	•	•	•	•	COC
	1697	Subsq RX 3rd-Scope LN Su	•	•	•	•	•	•	•	•	COC
	1698	Subsq RX 3rd-Surg Oth	•	•	•	•	•	•	•	•	COC
	1699	Subsq RX 3rd-Reg LN Rem	•	•	•	•	•	•	•	•	COC
	1700	Subsq RX 4th Course Date	•	•	•	•	•	•	•	•	COC
	1701	Subsq RX 4th Crs Date Flag	•	•	•	•	•	•	•	•	NAACCR
	1710	Subsq RX 4th Course Codes	•	•	•	•	•	•	•	•	
	1711	Subsq RX 4th Course Surg	•	•	•	•	•	•	•	•	COC
	1712	Subsq RX 4th Course Rad	•	•	•	•	•	•	•	•	COC
	1713	Subsq RX 4th Course Chemo	•	•	•	•	•	•	•	•	COC
	1714	Subsq RX 4th Course Horm	•	•	•	•	•	•	•	•	COC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP > CENTRAL	CENTRAL > CENTRAL	
	1715	Subsq RX 4th Course BRM	•	•	•	•	•	•	•	•	COC
	1716	Subsq RX 4th Course Oth	•	•	•	•	•	•	•	•	COC
	1717	Subsq RX 4th-Scope LN Su	•	•	•	•	•	•	•	•	COC
	1718	Subsq RX 4th-Surg Oth	•	•	•	•	•	•	•	•	COC
	1719	Subsq RX 4th-Reg LN Rem	•	•	•	•	•	•	•	•	COC
Ret.	1720	Subsq RX 5th Course Date									
Ret.	1730	Subsq RX 5th Course Codes									
Ret.	1731	Subsq RX 5th Course Surg									
Ret.	1732	Subsq RX 5th Course Rad									
Ret.	1733	Subsq RX 5th Course Chemo									
Ret.	1734	Subsq RX 5th Course Horm									
Ret.	1735	Subsq RX 5th Course BRM									
Ret.	1736	Subsq RX 5th Course Oth									
Ret.	1737	Subsq RX 5th-Scope LN Su									
Ret.	1738	Subsq RX 5th-Surg Oth									
Ret.	1739	Subsq RX 5th-Reg LN Rem									
	1740	Reserved 09									
	1741	Subsq RX-Reconstruct Del	•	•	•	•	•	•	•	•	COC
	1750	Date of Last Contact	R	R	R	R	R	R	T	T	SEER/COC
	1751	Date of Last Contact Flag	D	R	R	R	R	R	T	T	NAACCR
	1760	Vital Status	R	R	R	R	R	R	T	T	SEER/COC
	1770	Cancer Status	•	•	R	R	•	•	•	•	COC
	1780	Quality of Survival	•	•	•	•	•	•	•	•	COC
New	1782	Surv-Date Active Followup	•	•	•	•	D	R	•	•	
New	1783	Surv-Flag Active Followup	•	•	•	•	D	R	•	•	
New	1784	Surv-Mos Active Followup	•	•	•	•	D	R	•	•	

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP > CENTRAL	CENTRAL > CENTRAL	
New	1785	Surv-Date Presumed Alive	•	•	•	•	D	R	•	•	
New	1786	Surv-Flag Presumed Alive	•	•	•	•	D	R	•	•	
New	1787	Surv-Mos Presumed Alive	•	•	•	•	D	R	•	•	
New	1788	Surv-Date DX Recode	•	•	•	•	D	R	•	•	
	1790	Follow-Up Source	R*	R*	R	•	•	•	T*	•	COC
	1791	Follow-up Source Central	D	R	•	•	•	•	•	T*	NAACCR
	1800	Next Follow-Up Source	•	•	R	•	•	•	•	•	COC
	1810	Addr Current-City	•	•	R	•	R	•	T*	•	COC
	1820	Addr Current-State	•	•	R	•	R	•	T*	•	COC
	1830	Addr Current-Postal Code	•	•	R	•	R	•	T*	•	COC
	1832	Addr Current-Country	•	•	R	•	R	•	•	•	NAACCR
	1835	Reserved 10									
	1840	County-Current	•	•	•	•	•	•	•	•	NAACCR
	1842	Follow-Up Contact-City	•	•	•	•	•	•	T*	•	SEER
	1844	Follow-Up Contact-State	•	•	•	•	•	•	T*	•	SEER
	1846	Follow-Up Contact-Postal	•	•	•	•	•	•	T*	•	SEER
	1847	FollowUp Contact-Country	•	•	•	•	•	•	•	•	NAACCR
	1850	Unusual Follow-Up Method	•	•	•	•	•	•	•	•	NAACCR
	1860	Recurrence Date-1st	•	•	R	R	RC	•	T*	•	COC
	1861	Recurrence Date-1st Flag	•	•	R	R	RC	•	T*	•	NAACCR
Ret.	1870	Recurrence Distant Sites									
Ret.	1871	Recurrence Distant Site 1									
Ret.	1872	Recurrence Distant Site 2									
Ret.	1873	Recurrence Distant Site 3									
	1880	Recurrence Type-1st	•	•	R	R	RC	•	T*	•	COC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP > CENTRAL	CENTRAL > CENTRAL	
Ret.	1890	Recurrence Type-1st-Oth									
	1900	Reserved 11									
	1910	Cause of Death	√	R	•	•	R	R	•	T	SEER
	1920	ICD Revision Number	√	R	•	•	R	R	•	T	SEER
	1930	Autopsy	•	•	•	•	•	•	•	•	NAACCR
	1940	Place of Death	√	RH	•	•	•	•	T*	T*	NPCR
Rev.	1942	Place of Death-State	R	R	•	•	R	R	•	•	NAACCR
Rev.	1944	Place of Death-Country	R*	R*	•	•	R	R	•	•	NAACCR
	1960	Site (73-91) ICD-O-1	•	•	•	•	RH	RH	•	•	SEER
	1970	Morph (73-01) ICD-O-1	•	•	•	•	•	•	•	•	
	1971	Histology(73-91) ICD-O-1	•	•	•	•	RH	RH	•	•	SEER
	1972	Behavior (73-91) ICD-O-1	•	•	•	•	RH	RH	•	•	SEER
	1973	Grade (73-91) ICD-O-1	•	•	•	•	RH	RH	•	•	SEER
	1980	ICD-O-2 Conversion Flag	•	•	RH	RH	R	R	T*	T*	SEER
	1981	Over-ride SS/Nodes Pos	•	•	•	•	R	R	T*	T*	NAACCR
	1982	Over-ride SS/TNM-N	•	•	•	•	R	R	T*	T*	NAACCR
	1983	Over-ride SS/ TNM-M	•	•	•	•	R	R	T*	T*	NAACCR
Ret.	1984	Over-ride SS/Dis Met1									
	1985	Over-ride Acsn/Class/Seq	•	•	R	R	•	•	T*	T*	COC
	1986	Over-ride HospSeq/ DxConf	•	•	R	R	•	•	T*	T*	COC
	1987	Over-ride COC-Site/Type	•	•	R	R	•	•	T*	T*	COC
	1988	Over-ride HospSeq/ Site	•	•	R	R	•	•	T*	T*	COC
Rev.	1989	Over-ride Site/ TNM-StgGrp	R	R	R	R	•	•	T*	T*	COC
	1990	Over-ride Age/ Site/ Morph	D	R	R	R	R	R	T*	T*	SEER
	2000	Over-ride SeqNo/DxConf	D	R	•	•	R	R	T*	T*	SEER
	2010	Over-ride Site/ Lat/ SeqNo	D	R	•	•	R	R	T*	T*	SEER
	2020	Over-ride Surg/ DxConf	D	R	R	R	R	R	T*	T*	SEER

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP > CENTRAL	CENTRAL > CENTRAL	
	2030	Over-ride Site/Type	D	R	R	R	R	R	T*	T*	SEER
	2040	Over-ride Histology	D	R	R	R	R	R	T*	T*	SEER
	2050	Over-ride Report Source	D	R	•	•	R	R	T*	T*	SEER
	2060	Over-ride Ill-define Site	D	R	•	•	R	R	T*	T*	SEER
	2070	Over-ride Leuk, Lymphoma	D	R	R	R	R	R	T*	T*	SEER
	2071	Over-ride Site/ Behavior	D	R	R	R	R	R	T*	T*	SEER
	2072	Over-ride Site/ EOD/DX Dt	D	•	•	•	R	R	T*	T*	SEER
	2073	Over-ride Site/Lat/ EOD	D	•	•	•	R	R	T*	T*	SEER
	2074	Over-ride Site/ Lat/ Morph	D	R	R	R	R	R	T*	T*	SEER
	2080	Reserved 13									
	2081	CRC CHECK SUM	•	•	•	•	S	S	•	•	NAACCR
	2085	Date Case Initiated	•	•	•	•	•	•	•	•	NAACCR
	2090	Date Case Completed	R	•	•	•	•	•	•	•	NAACCR
Rev.	2092	Date Case Complete-COC	•	•	D	D	•	•	•	•	COC
Rev.	2100	Date Case Last Changed	√	•	D	D	•	•	•	•	NAACCR
	2110	Date Case Report Exported	√	R	•	•	•	•	T	•	NPCR
	2111	Date Case Report Received	√	R	•	•	•	•	•	•	NPCR
	2112	Date Case Report Loaded	√	R	•	•	•	•	•	•	NPCR
	2113	Date Tumor Record Available	R	R	•	•	•	•	•	•	NPCR
Ret.	2114	Future Use Timeliness 1									
Ret.	2115	Future Use Timeliness 2									
	2116	ICD-O-3 Conversion Flag	D	R	•	•	R	R	T	T	SEER/COC
	2120	SEER Coding Sys-Current	•	•	•	•	•	R	T*	T*	NAACCR
	2130	SEER Coding Sys-Original	•	•	•	•	•	R	T*	T*	NAACCR
	2140	COC Coding Sys-Current	•	•	R	R	•	•	T*	T*	COC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP > CENTRAL	CENTRAL > CENTRAL	
	2150	COC Coding Sys-Original	•	•	R	R	•	•	T*	T*	COC
Ret.	2160	Subsq Report for Primary									
	2161	Reserved 18									
	2170	Vendor Name	√	•	R	R	•	•	T	T	NAACCR
	2180	SEER Type of Follow-Up	•	•	•	•	R	R	•	•	SEER
	2190	SEER Record Number	•	•	•	•	•	R	•	•	SEER
	2200	Diagnostic Proc 73-87	•	•	•	•	RH	RH	•	•	SEER
	2210	Reserved 14							•	•	
	2220	State/Requestor Items	•	•	•	•	•	•	•	•	Varies
	2230	Name-Last	R	R	R	•	R	•	T	T	COC
	2240	Name-First	R	R	R	•	R	•	T	T	COC
	2250	Name-Middle	R	R	R	•	R	•	T*	T*	COC
	2260	Name-Prefix	•	•	•	•	•	•	•	•	NAACCR
	2270	Name-Suffix	•	•	•	•	R	•	T*	T*	NAACCR
	2280	Name-Alias	R	R	•	•	R	•	T*	T*	NAACCR
	2290	Name-Spouse/ Parent	•	•	•	•	•	•	•	•	NAACCR
	2300	Medical Record Number	R	R	R	•	R	•	T	•	COC
	2310	Military Record No Suffix	•	•	•	•	•	•	•	•	COC
	2320	Social Security Number	R	R	R	•	R	•	T	T	COC
	2330	Addr at DX-No & Street	R	R	R	•	R	•	T	T	COC
	2335	Addr at DX-Suppl	R	R	R*	•	R	•	T*	T*	COC
	2350	Addr Current-No & Street	•	R*	R	•	R	•	T*	T*	COC
	2352	Latitude	D	R*	•	•	S	•	•	•	NAACCR
	2354	Longitude	D	R*	•	•	S	•	•	•	NAACCR
Rev.	2355	Addr Current-Suppl	•	•	R*	•	R*	•	T*	•	COC
	2360	Telephone	•	•	R	•	R	•	T*	T*	COC
Ret.	2370	DC State									
	2380	DC State File Number	R	R	•	•	R*	•	•	T*	State
Rev.	2390	Name-Maiden	R √	R	•	•	R	•	T*	T*	NAACCR
	2392	Follow-Up Contact-No & St	•	•	•	•	•	•	•	•	SEER
	2393	Follow-Up Contact-Suppl	•	•	•	•	•	•	•	•	SEER

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP > CENTRAL	CENTRAL > CENTRAL	
	2394	Follow-Up Contact-Name	•	•	•	•	•	•	•	•	SEER
	2400	Reserved 15									
	2410	Institution Referred From	•	•	•	•	•	•	T*	•	COC
	2415	NPI-Inst Referred From	•	•	R	•	•	•	•	•	CMS
	2420	Institution Referred To	•	•	•	•	•	•	T*	•	COC
	2425	NPI-Inst Referred To	•	•	R	•	•	•	•	•	CMS
Ret.	2430	Last Follow-Up Hospital									
Rev.	2440	Following Registry	•	•	•	•	RH	•	•	•	COC
Rev.	2445	NPI-Following Registry	•	•	•	•	RH*	•	•	•	CMS
	2450	Reserved 16									
	2460	Physician-Managing	•	•	•	•	•	•	•	•	NAACCR
	2465	NPI-Physician-Managing	•	•	R	•	•	•	•	•	CMS
	2470	Physician-Follow-Up	R	•	•	•	R	•	T*	T*	COC
	2475	NPI-Physician-Follow-Up	•	•	R	•	R*	•	•	•	CMS
	2480	Physician-Primary Surg	•	•	•	•	•	•	•	•	COC
	2485	NPI-Physician-Primary Surg	•	•	R	R	•	•	•	•	CMS
	2490	Physician 3	•	•	•	•	•	•	•	•	COC
	2495	NPI-Physician 3	•	•	R	R	•	•	•	•	CMS
	2500	Physician 4	•	•	•	•	•	•	•	•	COC
	2505	NPI-Physician 4	•	•	R	R	•	•	•	•	CMS
	2510	Reserved 12									
	2520	Text-DX Proc-PE	R^	R^	•	•	R	•	T*	T*	NPCR
	2530	Text-DX Proc-X-ray/scan	R^	R^	•	•	R	•	T*	T*	NPCR
	2540	Text-DX Proc-Scopes	R^	R^	•	•	R	•	T*	T*	NPCR
	2550	Text-DX Proc-Lab Tests	R^	R^	•	•	R	•	T*	T*	NPCR
	2560	Text-DX Proc-Op	R^	R^	•	•	R	•	T*	T*	NPCR
	2570	Text-DX Proc-Path	R^	R^	•	•	R	•	T*	T*	NPCR
	2580	Text-Primary Site Title	R	R^	•	•	R	•	T*	T*	NPCR

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP > CENTRAL	CENTRAL > CENTRAL	
	2590	Text-Histology Title	R	R^	•	•	R	•	T*	T*	NPCR
	2600	Text-Staging	R	R^	•	•	R	•	T*	T*	NPCR
	2610	RX Text-Surgery	R	R^	•	•	R	•	T*	T*	NPCR
	2620	RX Text-Radiation (Beam)	R	R^	•	•	R	•	T*	T*	NPCR
	2630	RX Text-Radiation Other	R	R^	•	•	R	•	T*	T*	NPCR
	2640	RX Text-Chemo	R	R^	•	•	R	•	T*	T*	NPCR
	2650	RX Text-Hormone	R	R^	•	•	R	•	T*	T*	NPCR
	2660	RX Text-BRM	R	R^	•	•	R	•	T*	T*	NPCR
	2670	RX Text-Other	R	R^	•	•	R	•	T*	T*	NPCR
	2680	Text-Remarks	•	•	•	•	R	•	T*	T*	NPCR
	2690	Text-Place of Diagnosis	•	•	•	•	•	•	•	•	NPCR
	2700	Reserved 17									
	2730	CS PreRX Tumor Size	•	•	•	•	•	•	•	•	AJCC
	2735	CS PreRx Extension	•	•	•	•	•	•	•	•	AJCC
	2740	CS PreRX Tum Sz/Ext Eval	•	•	•	•	•	•	•	•	AJCC
	2750	CS PreRx Lymph Nodes	•	•	•	•	•	•	•	•	AJCC
	2755	CS PreRx Reg Nodes Eval	•	•	•	•	•	•	•	•	AJCC
	2760	CS PreRx Mets at Dx	•	•	•	•	•	•	•	•	AJCC
	2765	CS PreRX Mets Eval	•	•	•	•	•	•	•	•	AJCC
	2770	CS PostRx Tumor Size	•	•	•	•	•	•	•	•	AJCC
	2775	CS Post Rx Extension	•	•	•	•	•	•	•	•	AJCC
	2780	CS Post Rx Lymph Nodes	•	•	•	•	•	•	•	•	AJCC
	2785	CS PostRx Mets Dx	•	•	•	•	•	•	•	•	AJCC
	2800	CS Tumor Size	RH	RH	RH	RH	S	S	T	T	AJCC
	2810	CS Extension	RH	RH	RH	RH	S	S	T	T	AJCC
	2820	CS Tumor Size/Ext Eval	RH	RH	RH	RH	S	S	T*	T*	AJCC
	2830	CS Lymph Nodes	RH	RH	RH	RH	S	S	T	T	AJCC
	2840	CS Reg Nodes Eval	RH*	RH*	RH	RH	S	S	T*	T*	AJCC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP > CENTRAL	CENTRAL > CENTRAL	
	2850	CS Mets at DX	RH	RH	RH	RH	S	S	T	T	AJCC
	2851	CS Mets at Dx-Bone	•	•	RH	RH	RH	RH	T*	T*	AJCC
	2852	CS Mets at Dx-Brain	•	•	RH	RH	RH	RH	T*	T*	AJCC
	2853	CS Mets at Dx-Liver	•	•	RH	RH	RH	RH	T*	T*	AJCC
	2854	CS Mets at Dx Lung	•	•	RH	RH	RH	RH	T*	T*	AJCC
	2860	CS Mets Eval	RH*	RH*	RH	RH	S	S	T*	T*	AJCC
	2861	CS Site-Specific Factor 7	RH	RH	RS	RS	RS	RS	T*	T*	AJCC
	2862	CS Site-Specific Factor 8	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
	2863	CS Site-Specific Factor 9	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
Rev.	2864	CS Site-Specific Factor 10	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
	2865	CS Site-Specific Factor 11	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
Rev.	2866	CS Site-Specific Factor 12	RH	RH	RS	RS	RS	RS	T*	T*	AJCC
	2867	CS Site-Specific Factor 13	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
	2868	CS Site-Specific Factor 14	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
	2869	CS Site-Specific Factor 15	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
	2870	CS Site-Specific Factor 16	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
	2871	CS Site-Specific Factor 17	RH	RH	RS	RS	RS	RS	T*	T*	AJCC
	2872	CS Site-Specific Factor 18	•	•	RS	RS	RS	RS	T*	T*	AJCC
	2873	CS Site-Specific Factor 19	•	•	RS	RS	RS	RS	T*	T*	AJCC
	2874	CS Site-Specific Factor 20	•	•	RS	RS	RS	RS	T*	T*	AJCC
	2875	CS Site-Specific Factor 21	•	•	RS	RS	RS	RS	T*	T*	AJCC
	2876	CS Site-Specific Factor 22	•	•	RS	RS	RS	RS	T*	T*	AJCC
	2877	CS Site-Specific Factor 23	•	•	RS	RS	RS	RS	T*	T*	AJCC
	2878	CS Site-Specific Factor 24	•	•	RS	RS	RS	RS	T*	T*	AJCC
	2879	CS Site-Specific Factor 25	RS	RS	RS	RS	RS	RS	T*	T*	AJCC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP > CENTRAL	CENTRAL > CENTRAL	
	2880	CS Site-Specific Factor 1	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
	2890	CS Site-Specific Factor 2	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
	2900	CS Site-Specific Factor 3	RH	RH	RS	RS	RS	RS	T*	T*	AJCC
	2910	CS Site-Specific Factor 4	RH	RH	RS	RS	RS	RS	T*	T*	AJCC
	2920	CS Site-Specific Factor 5	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
	2930	CS Site-Specific Factor 6	RS	RS	RS	RS	RS	RS	T*	T*	AJCC
	2935	CS Version Input Original	D	R	R	R	D	R	•	•	AJCC
	2936	CS Version Derived	RH	RH	DH	DH	D*	S	•	•	AJCC
	2937	CS Version Input Current	D	R	R	R	S	S	T*	T*	AJCC
Rev.	2940	Derived AJCC-6 T	•	•	DH	DH	D*	S	T*	T*	AJCC
Rev.	2950	Derived AJCC-6 T Descript	•	•	DH	DH	D*	S	T*	T*	AJCC
Rev.	2960	Derived AJCC-6 N	•	•	DH	DH	D*	S	T*	T*	AJCC
Rev.	2970	Derived AJCC-6 N Descript	•	•	DH	DH	D*	S	T*	T*	AJCC
Rev.	2980	Derived AJCC-6 M	•	•	DH	DH	D*	S	T*	T*	AJCC
Rev.	2990	Derived AJCC-6 M Descript	•	•	DH	DH	D*	S	T*	T*	AJCC
Rev.	3000	Derived AJCC-6 Stage Group	•	•	DH	DH	D*	S	T*	T*	AJCC
Rev.	3010	Derived SS1977	D	•	DH	DH	D*	S	T*	T*	AJCC
Rev.	3020	Derived SS2000	D+	RH	DH	DH	D+	R+	T*	T*	AJCC
Rev.	3030	Derived AJCC-Flag		•	DH	DH	D*	S	T*	T*	AJCC
Rev.	3040	Derived SS1977-Flag	^	•	DH	DH	D*	S	T*	T*	AJCC
Rev.	3050	Derived SS2000-Flag	^	RH	DH	DH	D*	S	T*	T*	AJCC
	3100	Archive FIN	•	•	R	R	•	•	•	•	COC
	3105	NPI-Archive FIN	•	•	R	R	•	•	•	•	CMS
	3110	Comorbid/ Complication 1	•	•	R	R	•	•	T*	•	COC
	3120	Comorbid/ Complication 2	•	•	R	R	•	•	T*	•	COC
	3130	Comorbid/ Complication 3	•	•	R	R	•	•	T*	•	COC

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP > CENTRAL	CENTRAL > CENTRAL	
	3140	Comorbid/ Complication 4	•	•	R	R	•	•	T*	•	COC
	3150	Comorbid/ Complication 5	•	•	R	R	•	•	T*	•	COC
	3160	Comorbid/ Complication 6	•	•	R	R	•	•	T*	•	COC
	3161	Comorbid/ Complication 7	•	•	R	R	•	•	T*	•	COC
	3162	Comorbid/ Complication 8	•	•	R	R	•	•	T*	•	COC
	3163	Comorbid/ Complication 9	•	•	R	R	•	•	T*	•	COC
	3164	Comorbid/ Complication 10	•	•	R	R	•	•	T*	•	COC
Rev.	3165	ICD Revision Comorbid	•	•	•	•	•	•	T*	•	COC
Rev.	3170	RX Date-Mst Defn Srg	R	R	R	R	•	•	T*	•	COC
Rev.	3171	RX Date Mst Defn Srg Flag	R	R	R	R	•	•	T*	•	NAACCR
	3180	RX Date-Surg Disch	•	•	R	R	•	•	•	•	COC
	3181	RX Date Surg Disch Flag	•	•	R	R	•	•	•	•	NAACCR
	3190	Readm Same Hosp 30 Days	•	•	R	R	•	•	•	•	COC
	3200	Rad-Boost RX Modality	•	•	R	R	RC	•	T*	T*	COC
	3210	Rad-Boost Dose cGy	•	•	R	R	•	•	•	•	COC
	3220	RX Date Rad Ended	•	•	R	R	•	•	•	•	COC
	3221	RX Date Rad Ended Flag	•	•	R	R	•	•	•	•	NAACCR
	3230	RX Date Systemic	•	•	R	R	RC	RC	T*	T*	COC
	3231	RX Date Systemic Flag	•	•	R	R	RC	RC	T*	T*	NAACCR
Rev.	3250	RX Summ-Transplnt/Endocr	R	R	R	R	R	R	T*	T*	COC
Ret.	3260	Pain Assessment									
	3270	RX Summ-Palliative Proc	•	•	R	R	•	•	T*	•	COC
	3280	RX Hosp-Palliative Proc	•	•	R	R	•	•	T*	•	COC
	3300	RuralUrban Continuum 1993	D	D	•	•	•	•	•	•	NAACCR
	3310	RuralUrban Continuum 2003	D	D	•	•	•	•	•	•	NAACCR

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP > CENTRAL	CENTRAL > CENTRAL	
New	3312	RuralUrban Continuum 2013		D	•	•	D	R	•	•	NAACCR
Rev.	3400	Derived AJCC-7 T	RH*	RH*	DH	DH	D*	S	T*	T*	AJCC
Rev.	3402	Derived AJCC-7 T Descrip	RH*	RH*	DH	DH	D*	S	T*	T*	AJCC
Rev.	3410	Derived AJCC-7 N	RH*	RH*	DH	DH	D*	S	T*	T*	AJCC
Rev.	3412	Derived AJCC-7 N Descrip	RH*	RH*	DH	DH	D*	S	T*	T*	AJCC
Rev.	3420	Derived AJCC-7 M	RH*	RH*	DH	DH	D*	S	T*	T*	AJCC
Rev.	3422	Derived AJCC-7 M Descrip	RH*	RH*	DH	DH	D*	S	T*	T*	AJCC
Rev.	3430	Derived AJCC-7 Stage Grp	RH*	RH*	DH	DH	D*	S	T*	T*	AJCC
	3440	Derived PreRx-7 T	•	•	•	•	•	•	•	•	AJCC
	3442	Derived PreRx-7 T Descrip	•	•	•	•	•	•	•	•	AJCC
	3450	Derived PreRx-7 N	•	•	•	•	•	•	•	•	AJCC
	3452	Derived PreRx-7 N Descrip	•	•	•	•	•	•	•	•	AJCC
	3460	Derived PreRx-7 M	•	•	•	•	•	•	•	•	AJCC
	3462	Derived PreRx-7 M Descrip	•	•	•	•	•	•	•	•	AJCC
	3470	Derived PreRx-7 Stage Grp	•	•	•	•	•	•	•	•	AJCC
	3480	Derived PostRx-7 T	•	•	•	•	•	•	•	•	AJCC
	3482	Derived PostRx-7 N	•	•	•	•	•	•	•	•	AJCC
	3490	Derived PostRx-7 M	•	•	•	•	•	•	•	•	AJCC
	3492	Derived PostRx-7 Stge Grp	•	•	•	•	•	•	•	•	AJCC
	3600	Derived Neoadjuv Rx Flag	•	•	•	•	•	•	T*	T*	AJCC
New	3605	Derived SEER Path Stg Grp	•	•	•	•	D	R	•	•	SEER
New	3610	Derived SEER Clin Stg Grp	•	•	•	•	D	R	•	•	SEER
New	3614	Derived SEER Cmb Stg Grp	•	•	•	•	D	R	•	•	SEER
New	3616	Derived SEER Combined T	•	•	•	•	D	R	•	•	SEER

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP > CENTRAL	CENTRAL > CENTRAL	
New	3618	Derived SEER Combined N	•	•	•	•	D	R	•	•	SEER
New	3620	Derived SEER Combined M	•	•	•	•	D	R	•	•	SEER
New	3622	Derived SEER Cmb T Src	•	•	•	•	D	R	•	•	SEER
New	3624	Derived SEER Cmb N Src	•	•	•	•	D	R	•	•	SEER
New	3626	Derived SEER Cmb M Src	•	•	•	•	D	R	•	•	SEER
New	3650	NPCR Derived Clin Stg Grp		R	•	•	•	•	•	•	NPCR
New	3655	NPCR Derived Path Stg Grp		R	•	•	•	•	•	•	NPCR
	3700	SEER Site-Specific Fact 1	•	•	•	•	•	•	•	•	SEER
	3702	SEER Site-Specific Fact 2	•	•	•	•	•	•	•	•	SEER
	3704	SEER Site-Specific Fact 3	•	•	•	•	•	•	•	•	SEER
	3706	SEER Site-Specific Fact 4	•	•	•	•	•	•	•	•	SEER
	3708	SEER Site-Specific Fact 5	•	•	•	•	•	•	•	•	SEER
	3710	SEER Site-Specific Fact 6	•	•	•	•	•	•	•	•	SEER
Rev.	3720	NPCR Specific Field	•	R	•	•	•	•	•	•	NPCR
	3750	Over-ride CS 1	•	•	RH	RH	R	R	•	•	AJCC
	3751	Over-ride CS 2	•	•	RH	RH	R	R	•	•	AJCC
	3752	Over-ride CS 3	•	•	RH	RH	R	R	•	•	AJCC
	3753	Over-ride CS 4	•	•	RH	RH	R	R	•	•	AJCC
	3754	Over-ride CS 5	•	•	RH	RH	R	R	•	•	AJCC
	3755	Over-ride CS 6	•	•	RH	RH	R	R	•	•	AJCC
	3756	Over-ride CS 7	•	•	RH	RH	R	R	•	•	AJCC
	3757	Over-ride CS 8	•	•	RH	RH	R	R	•	•	AJCC
	3758	Over-ride CS 9	•	•	RH	RH	R	R	•	•	AJCC
	3759	Over-ride CS 10	•	•	RH	RH	R	R	•	•	AJCC
	3760	Over-ride CS 11	•	•	RH	RH	R	R	•	•	AJCC
	3761	Over-ride CS 12	•	•	RH	RH	R	R	•	•	AJCC
	3762	Over-ride CS 13	•	•	RH	RH	R	R	•	•	AJCC
	3763	Over-ride CS 14	•	•	RH	RH	R	R	•	•	AJCC
	3764	Over-ride CS 15	•	•	RH	RH	R	R	•	•	AJCC
	3765	Over-ride CS 16	•	•	RH	RH	R	R	•	•	AJCC
	3766	Over-ride CS 17	•	•	RH	RH	R	R	•	•	AJCC
	3767	Over-ride CS 18	•	•	RH	RH	R	R	•	•	AJCC
	3768	Over-ride CS 19	•	•	RH	RH	R	R	•	•	AJCC
	3769	Over-ride CS 20	RH	RH	RH	RH	R	R	•	•	AJCC/NPCR

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP > CENTRAL	CENTRAL > CENTRAL	
Rev.	3780	Secondary Diagnosis 1	•	•	R	R	•	•	T*		CoC
Rev.	3782	Secondary Diagnosis 2	•	•	R	R	•	•	T*		CoC
Rev.	3784	Secondary Diagnosis 3	•	•	R	R	•	•	T*		CoC
Rev.	3786	Secondary Diagnosis 4	•	•	R	R	•	•	T*		CoC
Rev.	3788	Secondary Diagnosis 5	•	•	R	R	•	•	T*		CoC
Rev.	3790	Secondary Diagnosis 6	•	•	R	R	•	•	T*		CoC
Rev.	3792	Secondary Diagnosis 7	•	•	R	R	•	•	T*		CoC
Rev.	3794	Secondary Diagnosis 8	•	•	R	R	•	•	T*		CoC
Rev.	3796	Secondary Diagnosis 9	•	•	R	R	•	•	T*		CoC
Rev.	3798	Secondary Diagnosis 10	•	•	R	R	•	•	T*		CoC
	7010	Path Reporting Fac ID 1	•	•	•	•	•	•	•	•	HL7
	7011	Path Reporting Fac ID 2	•	•	•	•	•	•	•	•	HL7
	7012	Path Reporting Fac ID 3	•	•	•	•	•	•	•	•	HL7
	7013	Path Reporting Fac ID 4	•	•	•	•	•	•	•	•	HL7
	7014	Path Reporting Fac ID 5	•	•	•	•	•	•	•	•	HL7
	7090	Path Report Number 1	•	•	•	•	•	•	•	•	HL7
	7091	Path Report Number 2	•	•	•	•	•	•	•	•	HL7
	7092	Path Report Number 3	•	•	•	•	•	•	•	•	HL7
	7093	Path Report Number 4	•	•	•	•	•	•	•	•	HL7
	7094	Path Report Number 5	•	•	•	•	•	•	•	•	HL7
	7100	Path Order Phys Lic No 1	•	•	•	•	•	•	•	•	HL7
	7101	Path Order Phys Lic No 2	•	•	•	•	•	•	•	•	HL7
	7102	Path Order Phys Lic No 3	•	•	•	•	•	•	•	•	HL7
	7103	Path Order Phys Lic No 4	•	•	•	•	•	•	•	•	HL7

NOTE	ITEM #	ITEM NAME	TCR	NPCR	COC		SEER		EXCHANGE ELEMENTS		SOURCE OF STANDARD
					C	T	C	T	HOSP > CENTRAL	CENTRAL > CENTRAL	
	7104	Path Order Phys Lic No 5	•	•	•	•	•	•	•	•	HL7
	7190	Path Ordering Fac No 1	•	•	•	•	•	•	•	•	HL7
	7191	Path Ordering Fac No 2	•	•	•	•	•	•	•	•	HL7
	7192	Path Ordering Fac No 3	•	•	•	•	•	•	•	•	HL7
	7193	Path Ordering Fac No 4	•	•	•	•	•	•	•	•	HL7
	7194	Path Ordering Fac No 5	•	•	•	•	•	•	•	•	HL7
	7320	Path Date Spec Collect 1	•	•	•	•	•	•	•	•	HL7
	7321	Path Date Spec Collect 2	•	•	•	•	•	•	•	•	HL7
	7322	Path Date Spec Collect 3	•	•	•	•	•	•	•	•	HL7
	7323	Path Date Spec Collect 4	•	•	•	•	•	•	•	•	HL7
	7324	Path Date Spec Collect 5	•	•	•	•	•	•	•	•	HL7
	7480	Path Report Type 1	•	•	•	•	•	•	•	•	HL7
	7481	Path Report Type 2	•	•	•	•	•	•	•	•	HL7
	7482	Path Report Type 3	•	•	•	•	•	•	•	•	HL7
	7483	Path Report Type 4	•	•	•	•	•	•	•	•	HL7
	7484	Path Report Type 5	•	•	•	•	•	•	•	•	HL7

G

APPENDIX G: REPORTABLE LIST

REPORTABLE LIST

This listing provides documentation of all conditions the TCR considers reportable. Note the following changes:

Reportable conditions from both the *International Classification of Diseases for Oncology, Second Edition (ICD-O-2)* and the *Third Edition (ICD-O-3)* are included in the listing.

- Reportable conditions and terms with behavior changed from /1 (borderline) in *ICD-O-2* to /3 (malignant) in *ICD-O-3 are included*. These conditions are reportable only when diagnosed on or after January 1, 2001.
- Several terms changed behavior from /3 (malignant) in *ICD-O-2* to /1 (borderline) in *ICD-O-3*. These conditions are reportable only when diagnosed prior to January 1, 2001, and are identified in *[brackets and italics]*.
- New terms and synonyms for existing ICD-O codes were added.
- Terms **bolded** and followed by an asterisk (*) indicate new terms in ICD-O-3 effective for January 1, 2015. For coding instructions for these new terms refer to list below. No new terms were added for 2017.
- 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 24 in the Casefinding Section of the Cancer Reporting Handbook 2016. If the behavior is malignant (2 or 3) the terms are reportable for any site.
- Terms followed by asterisks (***) indicate new terms in ICD-O-3 effective for January 1, 2016 after discontinuation of Collaborative Stage. For these new terms refer to the list below.

Adamantinoma (long bones, malignant, tibial only)
Adenoacanthoma
Adenocarcinofibroma
Adenocarcinoma
Adenocarcinoma, pancreatobilliary-type***
Adenofibroma (malignant endometrioid only)
Adenoma**
Adenoma (carcinoid bronchial and cylindroid bronchial only)
Adenosarcoma
AIN III (anal intraepithelial neoplasia, grade III)
ALK positive large B-cell lymphoma
Ameloblastoma (malignant only)
Androblastoma (malignant only)
Anemia, refractory
Angioendotheliomatosis
Angiolipoma**
Angiomyosarcoma

Angiosarcoma
Argentaffinoma (malignant only)
Arrhenoblastoma (malignant only)
Astroblastoma
Astrocytoma**
Astroglioma
B lymphoblastic leukemia/lymphoma,
Blastoma
Cancer
Carcinoid, malignant (stromal, argentaffin tumor NOS, enterochromaffin-like cell NOS, and tubular)
Carcinofibroma
Carcinoma
Carcinomatosis
Carcinosarcoma
CASTLE (Carcinoma showing thymus-like element)
Chloroma
Cholangiocarcinoma
Chondroblastoma
Chondrosarcoma
Chordoma
Choriocarcinoma
Chorioepithelioma
Chorionepithelioma
Chronic lymphoproliferative disorder of NK-cells
Class IV cytology
Class V cytology
Comedocarcinoma
CPNET (central primitive neuroectodermal, NOS)
Craniopharyngioma**
Cylindroma (exclude eccrine dermal, and skin)
Cyst (dermoid with malignant transformation only or dermoid with secondary tumor)
Cystadenocarcinofibroma
Cystadenocarcinoma
Cystadenofibroma (malignant endometrioid only)
[Cystadenoma (diagnosis date prior to January 1, 2001);
mucinous, borderline malignancy
papillary, borderline malignancy
papillary mucinous, borderline malignancy
papillary pseudomucinous, borderline malignancy
papillary serous, borderline malignancy
pseudomucinous, borderline malignancy
serous, borderline malignancy]
Cystic pancreatic endocrine neoplasm (CPEN)*
Cystosarcoma phyllodes (malignant only)
Cytopenia, refractory with multilineage dysplasia
Dermatofibrosarcoma
Diktyoma (exclude benign)
DIN III (ductal intraepithelial neoplasia, grade III)
Disease (include only):

alpha heavy chain
Bowen
Chronic myeloproliferative
Di Guglielmo
Franklin
Gamma heavy chain
Heavy chain NOS
Hodgkin
immunoproliferative [NOS and small
intestinal only]
Letterer-Siwe
Mast cell, systemic tissue
Mu heavy chain
Myeloproliferative, chronic, NOS
Paget [exclude of bone]
Sezary
Disorder, myeloproliferative, chronic
Disorder, primary cutaneous CD30+ T-cell lymphoproliferative
Dysgerminoma
Ectomesenchymoma
Endometriosis, stromal
Ependymoblastoma
Ependymoma**
Epithelioma (NOS, basal cell, malignant, and squamous cell only)
Erythremia (acute and chronic only)
Erythroleukemia
Erythroplasia, Queyrat
Esthesioneuroblastoma
Esthesioneurocytoma
Esthesioneuroepithelioma
Fibroblastic reticular cell tumor
Fibrochondrosarcoma
Fibrodentinosarcoma
Fibroepithelioma, of Pinkus type or NOS
Fibrolipoma**
Fibroliposarcoma
Fibroma, NOS**
Fibromyxosarcoma
Fibro-odontosarcoma
Fibrosarcoma
Fibroxanthoma (malignant only)
Gangliocytoma**
Ganglioglioma**
Ganglioneuroblastoma
Ganglioneuroma**
Gastrinoma (malignant only)
Gemistocytoma
Germinoma
GIST-Gastrointestinal stromal tumor (malignant only)

Glioblastoma
Gliofibroma**
Glioma**
Gliomatosis cerebri
Gliosarcoma
Glomangiosarcoma
Glucagonoma (malignant)*
Granuloma (Hodgkin only)
Hemangioblastoma**
Hemangioendothelioma**
Hemangioma**
Hemangiopericytoma**
Hemangiosarcoma
Hepatoblastoma
Hepatocarcinoma
Hepatocholangiocarcinoma
Hepatoma (exclude benign)
Hidradenocarcinoma
Hidradenoma (malignant only)
Histiocytoma (malignant fibrous only)
Histiocytosis (malignant, and acute progressive X only)
Histiocytosis, Langerhans cell, disseminated or generalized
Hutchinson melanotic freckle (melanoma in situ only)
Hydroa vaccinforme-like lymphoma
Hypernephroma
Immunocytoma
Insulinoma (malignant only)
Intravascular large B-cell lymphoma
Langerhans cell histiocytosis, NOS
Langerhans cell histiocytosis, multifocal
Langerhans cell histiocytosis, unifocal
Large B-cell lymphoma arising in HHV8-associated multicentric Castleman disease
LCIS, NOS (lobular carcinoma in situ)
Leiomyoma (NOS)**
Leiomyomatosis (NOS)**
Leiomyosarcoma
Lentigo maligna
Leukemia
LIN III
Linitis plastica
Lipoma (atypical or NOS)**
Liposarcoma (exclude well differentiated liposarcoma, superficial)
LN2 (of breast also called lobular neoplasia, grade 2 only)
Lymphangioendothelioma (malignant only)
Lymphangiosarcoma
Lymphoblastoma
Lymphoepithelioma
Lymphoma
Lymphosarcoma

Macroglobulinemia, Waldenstrom
Malignancy
Malignant
Malignant Poorly Differentiated neuroendocrine tumors
Mastocytoma (malignant only)
Mastocytosis (malignant only)
Medulloblastoma
Medulloepithelioma
Medullomyoblastoma
Melanocytoma, meningeal
Melanoma (exclude juvenile)
Melanocytoma, meningial**
Melanocytosis, diffuse**
Melanomatosis, meningeal
Melanosis (precancerous only)
Meningioma**
Meningiomatosis**
Mesenchymoma (malignant only)
Mesonephroma (exclude benign)
Mesothelioma (exclude benign and cystic)
Metaplasia, agnogenic myeloid
Microglioma
Micropapillary carcinoma, NOS***
Mixed acinar ductal carcinoma***
Mixed phenotype acute leukemia
MPNST, NOS (malignant peripheral nerve sheath tumor)
Multiple neurofibromatosis
Mycosis Fungoides
Myeloid and lymphoid neoplasms
Myelodysplastic/Myeloproliferative neoplasm
Myelofibrosis (acute, chronic idiopathic, with myeloid metaplasia or as a result of myeloproliferative disease only)
Myeloma
Myelomatosis
Myelosclerosis (megakaryocytic, acute, malignant or with myeloid metaplasia)
Myelosis
Myoblastoma (malignant granular cell only)
Myoepithelioma (malignant only)
Myosarcoma
Myosis, stromal NOS or endolymphatic stromal
Myxoliposarcoma
Myxosarcoma
Neoplasia, ductal intraepithelial, grade 3 (of breast, also called DIN III)
Neoplasia, intratubular germ cell
Neoplasia, lobular, grade 2 of breast only (also called LN2)
Neoplasia, squamous intraepithelial, grade 3 (of anus, vulva and vagina only- also called, AIN III, VIN III and VAIN III)
Neoplasm (malignant only)
Neoplasm**

Nephroblastoma
Nephroma (exclude mesoblastic)
Neurilemmoma**
Neurilemmosarcoma
Neuroblastoma
Neurocytoma**, olfactory
Neuroepithelioma
Neurofibroma**
Neurofibromatosis (NOS)**
Neurofibrosarcoma
Neuroma (NOS)**
Neurosarcoma
Neurothekeoma**
Nevus (malignant blue only)
Non-invasive mucinous cystic neoplasm (MCN) of the páncreas with high-grade displasia*
Odontosarcoma
Oligoastrocytoma, mixed
Oligodendroblastoma
Oligodendroglioma
Orchioblastoma
Osteochondrosarcoma
Osteoclastoma (malignant only)
Osteofibrosarcoma
Osteosarcoma
Pancreatoblastoma
Pancreatobilliary-type carcinoma***
Panmyelosis, acute only
Papillary tumor of the pineal region***
Papilloma**
Papulosis, lymphomatoid
Paraganglioma **
Paragranuloma, Hodgkin
Perineural MPNST
Perineurioma**
Pheochromoblastoma
Pheochromocytoma (malignant only)
Pilomatrixoma (malignant only)
Pilomyxoid astrocytoma***
Pinealoma (NOS)**
Pineoblastoma
Pineocytoma**
Pituitary Adenoma
Plasmacytoma
Plasmablastic lymphoma
PNET (primitive neuroectodermal tumor)
Pneumoblastoma
Polycythemia (proliferative, rubra vera, or vera)
Polyembryoma
Polymorphic PTLD

Polyposis (malignant lymphomatous only)
Porocarcinoma
Poroma, eccrine (malignant only)
PPNET (peripheral primitive neuroectodermal tumor)
Preleukemia
Primary cutaneous follicle centre lymphoma
Primary cutaneous gamma-delta T-cell lymphoma
Prolactinoma**
Pseudomyxoma peritonei
Queyrat erythroplasia
Rathke Pouch Tumor
Refractory neutropenia
Refractory thrombocytopenia
Reticuloendotheliosis
Reticulosarcoma
Reticulosis (histiocytic medullary, malignant, pagetoid, and polymorphic only)
Retinoblastoma
Rhabdomyoma (NOS)**
Rhabdomyosarcoma
Rhabdosarcoma
Sarcoma (exclude well differentiated liposarcoma, superficial)
Sarcomatosis (meningeal only)
Schwannoma
Secondary Neuroendocrine tumors
Seminoma
Serrated adenocarcinoma*
SETTLE (spindle epithelial tumor with thymus-like element)
Solid pseudopapillary neoplasm of the pancreas *
Somatostatinoma (malignant only)
Spermatocytoma
Spiradenoma (malignant only)
Spongioblastoma
Spongioneuroblastoma
Stromatosis, endometrial
Struma (malignant ovarii and Wuchernde Langhans only)
Subependymoma**
Subependymoma-ependymoma, mixed
Sympathicoblastoma
Syndrome,
- 5q deletion with Myelodysplastic (5q-) syndrome
- Hypereosinophilic
- Myelodysplastic
  - NOS
  - with 5q deletion syndrome
  - therapy-related, NOS
  - therapy-related, alkylating agent related
  - therapy-related, epidopophyllotoxin related
- Preleukemic
- Sezary

Synovioma (NOS and malignant only)
Syringoma chondroid, (malignant only)
Systemic EBV positive T-cell Lymphoproliferative disease of childhood
T-cell/histiocyte rich large B-cell lymphoma
T-cell large granular lymphocytic leukemia
T lymphoblastic leukemia/lymphoma
Teratoblastoma, malignant
Teratocarcinoma
Teratoma**
Thecoma (malignant only)
Thrombocythemia (essential, essentialhemorrhagic, idiopathic, or idiopathic hemorrhagic)
Thymoma (malignant or type C only)
Tumor (include only):
- adenocarcinoid
- adrenal cortical (malignant only)
- alpha cell (malignant only)
- Askin
- Bednar
- beta cell (malignant only)
- Brenner (malignant only)
- Burkitt
- carcinoid, NOS (except of appendix)
- carcinoid (malignant only)
- cells**
- desmoplastic small round cell
- dysembryoplastic neuroepithelial**
- embolus
- endodermal sinus
- epithelial**
- Ewing
- fibrous, solitary**
- follicular dendritic cell
- fusiform cell type (malignant only)
- G cell (malignant only)
- gastrin cell (malignant only)
- gastrointestinal stromal (malignant only)
- germ cell
- giant cell (malignant only)
- glomus (malignant only)
- granular cell**
- granulosa cell (malignant or sarcomatoid only)
- Grawitz
- interstitial cell (malignant only)
- intravascular bronchial alveolar
- Klatskin
- Krukenberg
- Leydig cell (malignant only)
- malignant (any type)
- mast cell (malignant only)

Merkel cell
mesenchymal (malignant only)
mesodermal, mixed
metastatic
mixed pineal
mixed salivary gland type (malignant only)
[mucinous, of low malignant potential; *diagnosis date prior to January 1, 2001]*
mucocarcinoid
Mullerian mixed
neuroectodermal (exclude melanotic)
nonencapsulating sclerosing
odontogenic (malignant only)
olfactory, neurogenic
Pancoast
[papillary mucinous, of low malignant potential; diagnosis date prior to January 1, 2001]
[papillary serous, of low malignant potential; diagnosis date prior to January 1, 2001]
peripheral neuroectodermal or peripheral primitive neuroectodermal, NOS
peripheral nerve sheath (malignant only)
phyllodes (malignant only)
pineal parenchymal of intermediate differentiation
Pinkus
plasma cell
polyvesicular vitelline
primitive neuroectodermal
rhabdoid, NOS
rhabdoid/teratoid, atypical
round cell, desmoplastic, small
Schminke
Secondary
[serous, NOS, of low malignant potential serous, papillary, of low malignant potential diagnosis date prior to January 1, 2001]
Sellar region granular cell tumor
Sertoli-Leydig cell (poorly differentiated, with heterologous elements, sarcomatoid (malignant only)
sinus, endodermal
small cell type (malignant only)
smooth muscle (NOS)**
soft tissue**
spindle cell type (malignant only)
spindle epithelial with thymus-like element or thymus-like differentiation
steroid cell (malignant only)
sweat gland (malignant only)
teratoid/rhabdoid, atypical
transitional pineal
Triton, malignant
trophoblastic, epithelioid
vitelline, polyvesicular
Wilms
yolk sac or yolk sac, hepatoid
Ulcer, rodent

VAIN III (vaginal intraepithelial neoplasia, grade 3)
VIN III (vulvar intraepithelial neoplasia, grade 3)
Vipoma (malignant only)
Xanthoastrocytoma, pleomorphic

Resource: Jean-Baptiste R, Gebhard IK (eds.). Series IV: Cancer Case Ascertainment. Procedure Guidelines for Cancer Registries. Springfield, IL: North American Association of Central Cancer Registries, February 2002.
http://www.naaccr.org/LinkClick.aspx?fileticket=fsZdXjDtP78%3d&tabid=130&mid=470

In 2015 TCR updated the list to include new reportable diagnosis. No new terms were added in 2016

H

APPENDIX H:
QUICK REFERENCE

Texas Cancer Registry
Handbook Quick Reference Sheet

The Sample Abstract Form can be found in Appendix D in the 2017 CRH (pg 332).

Data Field 540 REPORTING FACILITY NUMBER (pg 55)**:** 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 55)**:** Enter code for the source documents and/or facility used to abstract the case.
1 - Hospital inpatient; Managed health plans with comprehensive, unified medical records
2 - Radiation Treatment Centers or Medical Oncology Centers (Facility or Private)
3 - Laboratory Only (Facility or Private)
4 - Physician's Office/Private Medical Practitioner
5 - Nursing/Convalescent Home, Hospice
6 - Autopsy Only
7 - Death Certificate Only
8 – Other hospital outpatient units/surgery centers
Note: *Assign codes in priority order: 1, 2, 8, 4, 3, 5, 6 and 7 (if more than one source is used)*

Data Field 580 DATE OF ADMIT/FIRST CONTACT/ADMIT (YYYYMMDD) (pg 58)**:** 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 59): The first four digits identify the calendar year the patient was first seen at the facility with a reportable diagnosis. The following five digits identify the numerical order in which the case was entered into the registry. Each year's accession/registry number will start with **00001**.mk

Data Field 2300 MEDICAL RECORD NUMBER (pg 59)**:** 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 60)**:** Divides data into analytical and non-analytical categories.

Data Field 2230 PATIENT LAST NAME (pg 65)**:** 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 65)**:** 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 66)**:** 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 66)**:** 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 66): Enter an alternative name or "AKA" used by the patient, if known. If unknown, leave blank.

Data Field 2330 STREET ADDRESS (pg 67)**:** 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 69)**:** 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 70)**:** 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 70)**:** 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 73)**:** 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: https://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 74 & APPENDIX C) Enter the three digit Federal Information Processing Standards code found in Appendix C. Code "998" for out-of-state or foreign residents. If address is not available enter "999".

Data Field 102 ADDRESS AT DX-COUNTRY: (pg 75) Enter the appropriate alpha-3-digit code for the country of residence. Use codes issued by the United States Postal Service. Use USA for United States.

Data Field 2320 PATIENT SSN (pg 75)**:** 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 76)**:** DOB must be coded. Enter year, month and day of patient's birth. **Unknown date of birth will not be accepted**

Data Field 252 PLACE OF BIRTH-STATE (pg 77): Record the patient's state of birth (if available) using the US Postal Service. If the state of birth is unknown, code to ZZ.

Data Field 254 PLACE OF BIRTH-COUNTRY (pg 77): Record the patient's country of birth (if available) using the US Postal Service. If the country of birth is unknown, code to ZZU.

Table H.1 Data Field 160 RACE CODES 1 – 5 (page 78)**:**
Enter the 2 digit code to identify the primary race of the patient.

CODE	DESCRIPTION	CODE	DESCRIPTION
01	White	17	Pakistani
02	Black	20	Micronesian, NOS
03	American Indian, Aleutian, Eskimo (includes all indigenous populations of the Western hemisphere)	21	Chamorro/Chamoru
04	Chinese	22	Guamanian, NOS
05	Japanese	25	Polynesian, NOS
06	Filipino	26	Tahitian
07	Hawaiian	27	Samoan
08	Korean	28	Tongan
10	Vietnamese	30	Melanesian, NOS
11	Laotian	31	Fiji Islander
12	Hmong	32	New Guinean
13	Kampuchean (Cambodian)	96	Other Asian, including Asian, NOS and Oriental, NOS
14	Thai	97	Pacific Islander, NOS
15	Asian Indian or Pakistani, NOS	98	Other
16	Asian Indian	99	Unknown
88	No additional races (races 2-5)		

Data Field 161, 162, 163 & 164 RACE 2, **RACE 3, RACE 4, & RACE 5** (pg 82)**:** If the patient is multi-racial, code all the races using items (RACE 2) through (RACE 5) Use code "88" for no further race documented.

Table H.2 Data Field 190 SPANISH/HISPANIC ORIGIN (pg 83): 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 available on the TCR website online appendices: https://www.dshs.texas.gov/tcr/training/handbook/Appendix-Spanish-Hispanic-Surnames.pdf

CODE	DESCRIPTION
0	Non-Spanish; non-Hispanic (includes Portuguese and Brazilian)
1	Mexican (includes Chicano, NOS)
2	Puerto Rican
3	Cuban
4	South or Central American (except Brazil)
5	Other specified Spanish/Hispanic (includes European; excludes Dominican Republic)
6	Spanish, NOS, Hispanic, NOS; Latino, NOS. There is evidence, other than surname or maiden name that the person is Hispanic, but he/she cannot be assigned to any category of 1–5.
7	Spanish surname only. The only evidence of the person's Hispanic origin is surname or maiden name and there is no other information the person is not Hispanic. Ordinarily for central registry use only.
8	Dominican Republic (effective with diagnosis on or after 1/1/2005)
9	Unknown whether Spanish or not; not stated in patient record

Table H.3 Data Field 220 PATIENT SEX CODES (pg 85):
Enter the code to identify the gender of the patient.

CODE	DESCRIPTION
1	Male
2	Female
3	Other (intersex, disorders of sexual development/DSD)
4	Transsexual, NOS
5	Transsexual, natal male
6	Transsexual, natal female
9	Not Stated/Unknown

Data Field 320 TEXT USUAL INDUSTRY (pg 86) 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 87): 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 88) 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 88)**:** 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.tmb.state.tx.us/page/look-up-a-license.

Table H.4 Data Field 560 SEQUENCE NUMBER (pg 89): Indicates the chronological sequence of this reportable neoplasm IN THE PATIENT'S LIFETIME. Each PRIMARY tumor is assigned a different number.

Sequence Number: Malignant Neoplasms

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

Sequence Number: Non-Malignant Neoplasms

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

Data Field 2220 OTHER PRIMARY TUMORS (SITE, MORPHOLOGY, AND DATE) (pg 90)**:** Complete **if the patient has other reportable tumors during their lifetime.** Record the site, morphology, and date of any other primaries. DO NOT INCLUDE SECONDARY/METASTATIC LESIONS.

Table H.5 Data Field 630 PRIMARY PAYER AT DX (pg 91): Record patient's insurance.

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

Data Fields 3780, 3782, 3784, 3786, 3788, 3790, 3792, 3794, 3796 and 3798 _SECONDARY DIAGNOSIS (pg 94)**:** Use only ICD-10-CM codes. Secondary diagnoses are found on the discharge abstract or coding summary. Information from the billing department at your facility may be consulted when a discharge abstract is not available. Code the secondary diagnoses in the sequence in which they appear on the discharge abstract or are recorded by the billing department at your facility. **Do not leave the first data item blank.** If fewer than 10 secondary diagnoses are listed, then code the diagnoses listed, and leave the remaining *Secondary Diagnosis* data items blank. For non-analytic cases code the first data item 00000 and leave the remaining data items blank.

Table H.6 Data Field 9970 SOURCE COMORBIDITY/SECONDARY DIAGNOSIS (pg 95)**:** Do not leave this data item blank. If no comorbid condition or complications are identified in the patient's record use code 0.

CODE	DESCRIPTION
0	No comorbid condition or complication identified/Not Applicable
1	Collected from facility face sheet
2	Linkage to facility/hospital discharge data set
3	Linkage to Medicare/Medicaid data set
4	Linkage with another claims data set
5	Combination of two or more sources above
9	Other source

Data Field 9960 HEIGHT (pg 96)**:** Enter height as a 2 digit number measured in inches. Round all inches values to the nearest whole number; values with decimal place x.5 and greater should be rounded up (code 62.5 inches as 63 inches). **Do not leave this field blank. If the information is not available use code 99 (Unknown).**

Data Field 9961 WEIGHT (pg 96)**:** Enter the weight as a 3 digits number measured in pounds. Round values to the nearest whole number. Values with decimal place x.5 should be rounded up (Code 155.5 pounds as 156). Code a weight of less than 100 pounds with a leading 0 (Code 95 pounds as 095) **Do not leave this field blank. If the information is not available use code 999 (Unknown).**

Table H.7 Non-NAACCR Standard Data Fields 9965 (TOBACCO USE CIGARETTES), 9966 (TOBACCO USE OTHER SMOKE), 9967 (TOBACCO USE SMOKELESS), and 9968 (TOBACCO USE NOS) (pg 97-99): Record the patient's past or current use of tobacco. Record from sections such as Nursing Interview Guide, Vital Stats, or Nursing Assessment section.

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

Data Field 390 DATE OF INITIAL DIAGNOSIS (YYYYMMDD) (pg 101)**:** 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 2017 code 201706) 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 104)**:** 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 104)**:** The International Classification of Diseases for Oncology, (ICD-O) 3rd Edition is to be used for coding and reporting the morphology and behavior of tumors diagnosed on or after January 1, 2001. **Adequate documentation of tumor cell type must be provided** in the **FINAL DIAGNOSIS** section of the reporting form to support coding. Use all pathology reports available; generally tissue from a resection or excision is most representative of the tumor's histology.

Note: *Refer to Multiple Primary/Histology Rules (MP/H) for cases diagnosed on or after 1/1/2007: https://seer.cancer.gov/tools/mphrules/download.html*

Refer to the SEER website for hematopoietic and lymphoid malignancies. Click on the following link for the Database and Manual: https://seer.cancer.gov/seertools/hemelymph/

Data Field 400 PRIMARY SITE (pg 109)**:** 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 116): 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.

Note: Changes in determining grade have been implemented for cases diagnosed 2014 and forward.

For instructions on how to grade for solid tumors refer to page 117.

For coding instructions on how to grade for hematopoietic and lymphoid neoplasms refer to page 116.

Refer to **page 119** of the CRH for special grade systems rules for Prostate, Breast, Kidney Parenchyma, and Sarcoma primaries.

Table H.8 Data Field 410 LATERALITY (pg 125): Enter the code to identify the laterality of a paired site.

CODE	DESCRIPTION
0	Not a paired site
1	Right origin of primary
2	Left origin of primary
3	Only one side involved, right or left origin of primary not indicated
4	Bilateral involvement at time of diagnosis, lateral origin unknown for a single primary; or: Both ovaries simultaneously involved with a single histology, Bilateral retinoblastomas, and Bilateral Wilms' tumors. **Note**: If both lungs have nodules or tumors and the lung of origin is not known, assign code 4
5	Paired site: midline tumor
9	Unknown site; paired site, lateral origin unknown

Data Field 2580 & 2590 FINAL DIAGNOSIS- MORPHOLOGY/BEHAVIOR, GRADE, PRIMARY SITE, AND LATERALITY DOCUMENTATION (pg 129): Record the morphology/behavior, grade, primary site, and laterality descriptions.

Table H.9 Data Field 1182 LYMPH-VASCULAR INVASION (pg 130): Indicates presence or absence of tumor cells in lymphatic channels.

CODE	DESCRIPTION
0	Lymph-vascular invasion not present (absent)/Not identified
1	Lymph-vascular invasion present/Identified
8	Not applicable
9	Unknown if lymph-vascular invasion present Indeterminate

Data Field 490 DIAGNOSTIC CONFIRMATION (pg 131): 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. Different coding instructions are given for solid tumors (pg 131) and hematopoietic and lymphoid neoplasms (pg 134).

Table H.10 DIAGNOSTIC CONFIRMATION FOR SOLID TUMORS

CODE	DESCRIPTION	DEFINITION
MICROSCOPICALLY CONFIRMED		
1	Positive histology	Histological confirmation (tissue microscopically examined). In situ behavior must be microscopically confirmed.
2	Positive cytology	Cytological confirmation (no tissue microscopically examined; fluid cells microscopically examined). Includes pap smears, bronchial brushings, FNA and peritoneal fluid, cervical and vaginal smears, diagnoses based on paraffin block specimens from concentrated spinal, pleural or peritoneal fluid.
4	Positive microscopic confirmation, method not specified	Microscopic confirmation is all that is known. It is unknown if the cells were from histology or cytology.
NOT MICROSCOPICALLY CONFIRMED		
5	Positive laboratory test/marker study	A clinical diagnosis of cancer is based on laboratory tests/marker studies that are clinically diagnostic for cancer but there is no histologic confirmation. This includes alpha-fetoprotein for liver cancer. Elevated PSA is non-diagnostic of cancer. However if the physician uses the PSA as a basis for diagnosing prostate cancer with no other work-up, code to 5. (FORDS Manual page 130).
6	Direct visualization without microscopic confirmation	The tumor was visualized during a surgical/endoscopic procedure only with no tissue resected for microscopic exam.
7	Radiography and other imaging techniques without microscopic confirmation	The malignancy was reported by the physician from an imaging technique report only.
8	Clinical diagnosis only (other than 5, 6, or 7)	The physician documented the tumor in the medical record. **Note:** Refer to the *Ambiguous Terminology List* in the MP/H Rules for cases diagnosed on or after 1/1/2007.
CONFIRMATION UNKNOWN		
9	Unknown whether or not microscopically confirmed	There is a statement of tumor in the medical record, but there is no indication of how it was diagnosed. Includes death certificate only cases.

Table H.10 DIAGNOSTIC CONFIRMATION FOR SOLID TUMORS

CODE	DESCRIPTION	DEFINITION
MICROSCOPICALLY CONFIRMED		
1	Positive histology	Histological confirmation (tissue microscopically examined). In situ behavior must be microscopically confirmed.
2	Positive cytology, no positive histology	Cytological confirmation (no tissue microscopically examined; fluid cells microscopically examined). Includes pap smears, bronchial brushings, FNA and peritoneal fluid, cervical and vaginal smears, diagnoses based on paraffin block specimens from concentrated spinal, pleural or peritoneal fluid.
4	Positive microscopic confirmation, method not indicated	Diagnosis is stated to be microscopically confirmed but the method is not specified.
NOT MICROSCOPICALLY CONFIRMED		
5	Positive laboratory test/marker study	A clinical diagnosis of cancer is based on laboratory tests/marker studies that are clinically diagnostic for cancer but there is no histologic confirmation. This includes alpha-fetoprotein for liver cancer. Elevated PSA is non-diagnostic of cancer. If the physician uses the PSA as a basis for diagnosing prostate cancer with no other work-up, code to 5. (Adapted from SEER).
6	Direct visualization without microscopic confirmation	The tumor was visualized during a surgical/endoscopic procedure, with no specimen for microscopic exam.
7	Radiography and other imaging techniques without microscopic confirmation	The physician diagnosed the tumor from an imaging technique only.
8	Clinical diagnosis only (other than 5, 6, or 7)	The physician documented the tumor in the medical record. **Note:** Refer to the *Ambiguous Terminology List* in the MP/H Rules for cases diagnosed on or after 1/1/2007.
CONFIRMATION UNKNOWN		
9	Unknown whether or not microscopically confirmed	There is a statement of tumor in the medical record, but there is no indication of how it was diagnosed. Includes death certificate only cases.

Table H.11 DIAGNOSTIC CONFIRMATION FOR HEMATOPOIETIC OR LYMPHOID TUMORS (9590-9992)

CODE	DESCRIPTION	DEFINITION
MICROSCOPICALLY CONFIRMED		
1	Positive histology	Tissue from lymph node(s), organ(s) or other tissue specimens from biopsy, frozen section, surgery or autopsy; Bone marrow specimens (aspiration and biopsy); Peripheral blood smear can be used as histological diagnoses for all hematopoietic histologies (9590/3-9992/3) For **leukemia** only (9800/3-9948/3), positive histology also includes • Complete blood count (CBC) • White blood count (WBC) Neoplasm microscopically confirmed **AND** • Immunophenotyping, genetic testing or JAK2 **not** done **OR** • Immunophenotyping, genetic testing or JAK2 done but **negative** (non-diagnostic) for the neoplasm being abstracted **OR** • Immunophenotyping, genetic testing or JAK2 done but **not listed** in the Definitive Diagnostic Methods in the Heme DB ○ In situations like this, the immunophenotyping, genetic testing, or JAK2 may have been done to **rule out** other neoplasms that are clonally similar to the neoplasm being abstracted. Usually the provisional diagnosis will include two or more neoplasms **Example**: Bone marrow positive for myeloproliferative neoplasm, probable essential thrombocythemia. JAK2 done and is negative. The JAK2 did not confirm the essential thrombocythemia. Code the myeloproliferative neoplasm (9975/3) with diagnostic confirmation code 1 (positive bone marrow biopsy only). **Example:** Acute Myeolomonocytic Leukemia (9867/3) CD 10 (+). CD 10 (+) is not listed under Immunophenotyping for this histology, diagnostic confirmation shlud be 1 Use for historical cases not already in the database if information states that there was histologic confirmation.
2	Positive cytology, no positive histology	This code is rarely used for Hematopoietic and Lymphoid neoplasms. This code includes examination of fluid such as spinal fluid, peritoneal fluid, or pleural fluid. This code also includes paraffin block specimens from concentrated spinal fluid, peritoneal fluid, or pleural fluid. When a small-gauge needle (fine needle aspirations or FNA), or other method is used to obtain a specimen and there is not enough tissue to do a histologic examination the report will be a cytology report rather than a pathology report.

CODE	DESCRIPTION	DEFINITION
3	Positive histology PLUS: • Positive immunophenotyping AND/OR • Positive genetic studies (**Effective for cases diagnosed 1/1/2010 and later**)	This code can only be used when there is histologic confirmation (including ambiguous terminology and provisional diagnosis) (Code 1) **and** • Immunophenotyping, genetic testing, or JAK2 is listed in the **Definitive Diagnostic Methods** in the Heme DB **AND** a) Immunophenotyping, genetic testing, or JAK2 is **positive** for the neoplasm being abstracted ***(confirms disease)*** **OR** b) Immunophenotyping, genetic testing, or JAK2 identified a ***more specific histology*** (not preceded by ambiguous terminology) **Note:** ***Do not use*** code 3 for positive immunophenotyping or genetic testing identifying a more specific histology when preceding by ambiguous terminology. ***Example (identifying a more specific histology:*** Bone Marrow biopsy (+) for Acute Myeloid Leukemia (9861/3). Genetic testing (+) for AML with inv (16) (p13.1q22) (9871/3) code diagnostic confirmation code 3, positive histology and positive genetic testing.
4	Positive microscopic confirmation, method not specified	This code is rarely used for Hematopoietic Lymphoid neoplasms The diagnosis is stated to be microscopically confirmed but the method is not specified or unknown.
NOT MICROSCOPICALLY CONFIRMED		
5	Positive laboratory test/marker study	This code is rarely used for Hematopoietic and Lymphoid neoplasms. If there no provisional diagnosis or clinical suspicion of cancer, immunophenotyping or genetic testing would not be done. **Example**: CT scan consistent with multiple myeloma (9732/3). Twenty-four hour urine protein elevated with the presence of Bence-Jones kappa. Code 5 for diagnosis based on the positive Bence-Jones, which is listed as one of the diagnostic confirmation methods in the Heme DB and is also a lab test. Code 1 and 3 do not apply because there is no histologic confirmation and positive immunophenotyping and or genetic studies in this example.
6	Direct visualization without microscopic confirmation	This code is rarely used for hematopoietic and lymphoid neoplasms. The operative report may state that the patient had lymphoma but no biopsy or cytology was done or the the diagnosis is determined by gross autopsy findings (no tissue or cytologic confirmation).
7	Radiography and other imaging techniques without microscopic confirmation	This code is rarely used for Hematopoietic and Lymphoid neoplasms. Assign code 7 when the diagnosis is confirmed by radiology or other imaging techniques only.

CODE	DESCRIPTION	DEFINITION
8	Clinical diagnosis only (other than 5, 6, or 7)	While clinical diagnosis is seldom used for solid tumors, it is a valid diagnostic method for certain hematopoietic neoplasms. The Heme DB will list Clinical Diagnosis as the definitive diagnostic method for certain hematopoietic neoplasms. For these neoplasms, the biopsy, immunophenotyping, and genetic testing do not confirm the neoplasm. The diagnosis is determined based on the physician's clinical expertise, combined with the information from the biopsy, equivocal or negative tests, and the clinical symptoms. This is called a "diagnosis of exclusion" because the physician's judgment and the work-up literally exclude all other possible diagnoses, leaving one diagnosis. **Example**: Bone marrow biopsy shows anemia NOS; physician notes states the patient's overall clinical presentation of hypercalcemia, fever, and anemia is consistent with Myelodysplastic Syndrome, NOS (9989/3). Code Diagnostic Confirmation 8, clinical diagnosis only.
CONFIRMATION UNKNOWN		
9	Unknown whether or not microscopically confirmed	There is a statement of tumor in the medical record, but there is no indication of how it was diagnosed. Includes death certificate only cases.

Data Field 2600 SUMMARY STAGE DOCUMENTATION (pg 141)**:** 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. Stage documentation should include all information available through completion of surgery(ies) in the first course of treatment or within **4 months** of diagnosis in the absence of disease progression, whichever is longer. These findings may be obtained from diagnostic reports of radiology, endoscopy, surgery, and laboratory tests prior to treatment. Document both the date and the source of the staging information.

Data Fields 2520, 2530, 2540, 2550, 2560, 2570 DOCUMENTATION OF CANCER DIAGNOSIS, EXTENT OF DISEASE, AND TREATMENT (pg 141)**:** Text information to support cancer diagnosis, stage, and treatment codes **MUST BE PROVIDED BY ALL FACILITIES**. Document all types of the **first course** of definitive treatment administered, regardless of where the treatment was received, in chronological order.

Data Field 756 TUMOR SIZE SUMMARY (pg 148):
This data item records the most accurate measurement of a solid primary tumor, usually measured on the surgical resection specimen. Tumor size is one indication of the extent of disease. As such, it is used by both clinicians and researchers. Tumor size that is independent of stage is also useful for quality assurance efforts.

Tumor size code 999 is used when size is unknown or not applicable. Sites/morphologies where tumor size is not applicable:

- Hematopoietic, Reticuloendothelial, and Myeloproliferative neoplasms (histology codes 9590- 9992)
- Kaposi Sarcoma
- Melanoma Choroid
- Melanoma Ciliary Body
- Melanoma Iris
- Unknown Primary

Note: See Chapter V, Unresolved Issues,
http://www.naaccr.org/Applications/ContentReader/Default.aspx
for a discussion of coding differences between CoC and SEER.

Data Field 820 REGIONAL LYMPH NODES POSITIVE (pg 152)**:** Record the total number of regional lymph nodes pathologically examined and found to be positive. The number of regional lymph nodes positive is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment.

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

***Examples*:**

Brain
Intracranial Gland
Reticuloendotheliosis
Placenta
Leukemia, Lymphoma
Myeloma and Plasma Cell Disorder
Other and Ill-Defined Primaries, Unknown Primaries

Data Field 830 REGIONAL LYMPH NODES EXAMINED (pg 156)**:** 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

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

Data Fields 2880, 2890, 2900, , 2920, 2930, 2862, 2863, 2864, 2865, 2867, 2868, 2869, 2870, 2879 CS SITE-SPECIFIC FACTORS (pg 159)**:** 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 some of 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.

Table H.12 Data Field 760 Summary Stage 1977 (pg 160): To be used with cases diagnosed/admitted prior to 2001. Summary Stage refers to the extent of disease categorized as in-situ, localized, regional, and distant.

CODE	DESCRIPTION
0	In situ
1	Localized
2	Regional, direct extension only
3	Regional, regional lymph nodes only
4	Regional, direct extension and regional lymph nodes
5	Regional, NOS
7	Distant
8	Not applicable
9	Unstaged

Note: Do not use Code “8” for Summary Stage.

Table H.13 Data Field 759 SUMMARY STAGE 2000 (pg 161): To be used with cases diagnosed/admitted January 1, 2001 and after. Summary Stage refers to the extent of disease categorized as in-situ, localized, regional, and distant.

CODE	DESCRIPTION
0	In situ
1	Localized
2	Regional, direct extension only
3	Regional, regional lymph nodes only
4	Regional, direct extension and regional lymph nodes
5	Regional, NOS
7	Distant
8	Not applicable
9	Unstaged

Note: Do not use Code “8” for Summary Stage.

Data Field 940 TNM CLINICAL T (pg 166): Clinical T reflects the tumor size and/or extension of the primary tumor prior to the start of treatment. This field is manually coded**. Documentation in the Summary Stage Text field is required to support coding.** See the ***AJCC Cancer Staging Manual*** current edition for site-specific categories for the TNM elements and stage groups. See the FORDS Manual for specifications for codes and data entry rules.

Data Field 950 TNM CLINICAL N (pg 167): Clinical N is the detailed site-specific field used to code the clinical node (N) as defined by AJCC. Clinical N indicates the presence or absence of regional lymph node metastasis and the extent of metastasis prior to the start of treatment. This field is manually coded. **. Documentation in the Summary Stage Text field is required to support coding.** See the ***AJCC Cancer Staging Manual*** current edition for site-specific categories for the TNM elements and stage groups. See the FORDS Manual for specifications for codes and data entry rules.

Data Field 960 TNM CLINICAL M (pg 168): Clinical M is the detailed site-specific field used to code the clinical metastasis (M) as defined by AJCC. Clinical M indicates the presence or absence of distant metastasis. This field is manually coded. **Documentation in the Summary Stage Text field is required to support coding.** See the ***AJCC Cancer Staging Manual*** current edition for site-specific categories for the TNM elements and stage groups. See the FORDS Manual for specifications for codes and data entry rules.

Data Field 980 TNM CLINICAL STAGE (PREFIX/SUFFIX) DESCRIPTOR (pg 169): Clinical Stage (Prefix/Suffix) Descriptor is the prefix or suffix used in conjunction with AJCC clinical TNM fields. The prefix/suffix denotes special circumstances that may affect the staging and analysis of the data and is based on the clinical T, N, and M values prior to treatment. The descriptors are adjuncts to and do not change the stage group. **Documentation in the Summary Stage Text field is required to support coding.** See the ***AJCC Cancer Staging Manual*** current edition for site-specific categories for the TNM elements and stage groups. See the FORDS Manual for specifications for codes and data entry rules.

Data Field 970 TNM CLINICAL STAGE GROUP (pg 170): Clinical Stage Group is the detailed site-specific field used to code the clinical stage group as defined by AJCC. Clinical stage group identifies the extent of disease based on the clinical T, N, and M values prior to the start of treatment. This field is manually coded. See the ***AJCC Cancer Staging Manual*** current edition for site-specific categories for the TNM elements and stage groups. See the FORDS Manual for specifications for codes and data entry rules.

Data Field 880 TNM PATHOLOGIC T (pg 171): Pathologic T is the detailed site-specific field used to code the pathologic tumor (T) as defined by AJCC. Pathologic T reflects the tumor size and/or extension of the primary tumor after completion of surgical treatment. This field is manually coded. . **Documentation in the Summary Stage Text field is required to support coding.** See the ***AJCC Cancer Staging Manual*** current edition for site-specific categories for the TNM elements and stage groups. See the FORDS Manual for specifications for codes and data entry rules.

Data Field 890 TNM PATHOLOGIC N (pg 172): Pathologic N is the detailed site-specific field used to code the pathologic node (N) as defined by AJCC. Pathologic N indicates the presence or absence of regional lymph node metastasis and the extent of metastasis after completion of surgical treatment. This field is manually coded. **Documentation in the Summary Stage Text field is required to support coding.** See the ***AJCC Cancer Staging Manual*** current edition for site-specific categories for the TNM elements and stage groups. See the FORDS Manual for specifications for codes and data entry rules.

Data Field 890 TNM PATHOLOGIC M (pg 173): Pathologic M is the detailed site-specific field used to code the pathologic metastasis (M) as defined by AJCC. Pathologic M indicates the presence or absence of distant metastasis after completion of surgical treatment. This field is manually coded. **Documentation in the Summary Stage Text field is required to support coding.** See the ***AJCC Cancer Staging Manual*** current edition for site-specific categories for the TNM elements and stage groups. See the FORDS Manual for specifications for codes and data entry rules.

Data Field 920 TNM PATHOLOGIC STAGE (PREFIX/SUFFIX) DESCRIPTOR (pg 174): Pathologic Stage (Prefix/Suffix) Descriptor is the prefix or suffix used in conjunction with AJCC pathologic TNM fields. The prefix/suffix denotes special circumstances that may affect the staging and analysis of the data and is based on the pathologic T, N, and M values after completion of surgical treatment. The descriptors are adjuncts to and do not change the stage group. **Documentation in the Summary Stage Text field is required to support coding.** See the ***AJCC Cancer Staging Manual*** current edition for site-specific categories for the TNM elements and stage groups. See the FORDS Manual for specifications for codes and data entry rules.

Data Field 910 TNM PATHOLOGIC STAGE GROUP (pg 175): Pathologic Stage Group is the detailed site-specific field used to code the pathologic stage group as defined by AJCC. Pathologic stage group identifies the extent of disease based on the pathologic T, N, and M values after completion of surgical treatment. This field is manually coded. See the ***AJCC Cancer Staging Manual*** current edition for site-specific categories for the TNM elements and stage groups. See the FORDS Manual for specifications for codes and data entry rules.

Data Field 1260 DATE OF INITIAL TREATMENT (YYYYMMDD) (pg 182)**:** Enter the date the first course of treatment (surgery, radiation, systemic or other) started at any facility. **Note: This field will no longer be derived.**

Table H.14 Data Field 1261 DATE OF INITIAL RX FLAG (pg 185): This flag explains why there is no appropriate value in the corresponding date field.

CODE	DESCRIPTION
10	No information whatsoever can be inferred from this exceptional value (unknown if therapy was administered).
11	No proper value is applicable in this context (no treatment given or autopsy only).
12	A proper value is applicable but not known.
(blank)	A valid date value is provided in item Date of Initial Treatment (NAACCR Item #1260).

Data Field 1292 SCOPE OF REGLN SURGERY (pg 185)**:** 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 190)**:** Document and enter the date of the **first** definitive cancer-directed surgery performed at any facility. If two or more cancer-directed surgeries are performed, enter the date for the first cancer-directed surgery. If surgery was done but the date is unknown record the year and month of diagnosis and leave the day blank.

Table H.15 Data Field 1201 RX DATE SURGERY FLAG (pg 191): This flag explains why there is no appropriate value in the corresponding date field.

CODE	DESCRIPTION
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any surgery performed).
11	No proper value is applicable in this context (for example, no surgery performed).
12	A proper value is applicable but not known. This event occurred, but the date is unknown and cannot be estimated (that is, surgery was performed but the date is unknown).
(blank)	A valid date value is provided in item Date of First Surgical Procedure (NAACCR Item #1200).

Data Field 3170 RX DATE MOST DEFINITIVE SURGERY YYYYMMDD (pg. 192): Document and enter the date of the most definitive surgery of the primary site performed at any facility as part of first course treatment.

Data Field 3171 RX DATE MST DEFN SRG FLAG (pg 192): This flag explains why there is no appropriate value in the corresponding date field.

CODE	DESCRIPTION
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any surgery performed).
11	No proper value is applicable in this context (for example, no surgery performed).
12	A proper value is applicable but not known. This event occurred, but the date is unknown and cannot be estimated (that is, surgery was performed but the date is unknown).
(blank)	A valid date value is provided in item Date of First Surgical Procedure (NAACCR Item #3170).

Data Field 1290 SURGERY RX CODE (pg 193)**:** Document and code the <u>most definitive</u> first course cancer-directed surgery at any facility. Cancer-directed surgery is an operative procedure that actually removes, excises, or destroys cancer tissue of the primary site. Surgery performed solely for the purpose of establishing a diagnosis/stage (exploratory surgery), the relief of symptoms (bypass surgery), or reconstruction is not considered cancer-directed surgery. Brushings, washings and aspiration of cells are not surgical procedures.

Table H.16 Data Field 1340 REASON FOR NO SURGERY (pg 195): If no cancer directed surgery to the primary site was performed record the reason.

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

Data Field 1294 RX SUMM-SURG.OTH REG/DIST RX CODE (pg 197)**:** Document and code the highest numbered code that describes the surgical resection of Regional/Distant Sites and Distant lymph nodes.

Data Fields 2610, 2630, 2640, 2650, 2660, 2670 TREATMENT DOCUMENTATION: Text field used to support codes in the treatment fields. Document all planned treatment even if it is unknown if treatment was given. List dates and types of all treatment given, even if it was done at another facility.

Data Field 1210 DATE RADIATION STARTED (YYYYMMDD) (pg 199)**:** Document and enter the date radiation began at any facility as part of the first course of treatment. Record all zeros when no radiation therapy is delivered or the cancer was diagnosed at autopsy. Record all 9's when it is unknown whether any radiation therapy was delivered.

Table H.17 Data Field 1211 DATE RADIATION FLAG (pg 200): 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 (no radiation given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown and cannot be estimated (radiation was given but the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (radiation therapy is planned as part of first course of therapy, but had not been started at the time of the most recent follow-up).
(blank)	A valid date value is provided in item Date Radiation Started (NAACCR Item #1210).

Data Field 1570 RAD-REG RX MODALITY CODE (pg 201)**:** Document and code the dominant modality of radiation therapy used to deliver the clinically most significant dose to the primary volume of interest during first course of treatment.

Table H.18 Data Field 1360 RX SUMM-RAD (pg 203): Document and code type of radiation therapy performed as part of the first course of treatment

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

Table H.19 Data Field 1380 RX SUMM-SURG/RAD SEQ (pg 207): Code the sequence of radiation and surgical procedures given as part of the first course of treatment.

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

Table H.20 Data Field 1430 REASON NO RADIATION (pg 209): Code the reason no regional radiation therapy was administered to the patient.

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

Data Field 1220 CHEMOTHERAPY DATE STARTED (YYYYMMDD) (pg 211)**:** Record the first or earliest date of chemotherapy. If no chemotherapy was given or it is unknown if chemotherapy was given, leave the field blank.

Table H.21 Data Field 1221 CHEMOTHERAPY DATE STARTED FLAG (pg 211): 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).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, chemotherapy was given but the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (chemotherapy is planned as part of first course treatment, but had not yet started at the time of the last follow-up).
(blank)	A valid date value is provided in item Date Chemotherapy Started (NAACCR Item #1220). Case was diagnosed between 2003 and 2009 and the facility did not record Date Chemotherapy Started (NAACCR Item #1220) at that time.

Data Field 1390 CHEMOTHERAPY CODE (pg 212)**:** 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 218)**:** Record the first or earliest date on which hormone therapy was given as part of first course of treatment. If no hormone therapy was given or it is unknown if hormone therapy was given, leave this field blank.

Table H. 22 Data Field 1231 RX DATE HORMONE FLAG (pg 219): 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).
12	A proper value is applicable but not known. This event occurred, but the date is unknown and cannot be estimated (hormone therapy is planned as part of first course treatment, but had not yet started at the time of the last follow-up).
15	Information is not available at this time, but it is expected that it will be available later (hormone therapy is planned as part of first course treatment, but had not yet started at the last follow-up).
(blank)	A valid date is provided in item Date Hormone Therapy Started (NAACCR Item #1230). Case was diagnosed between 2003 and 2009 and the facility did not record Date Hormone Therapy Started (NAACCR Item #1230) at that time.

Data Field 1400 RX SUMM-HORMONE (pg 220)**:** 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 224)**:** Record the date of initiation of immunotherapy or a biologic response modifier (BRM) that is part of the first course of therapy. If no immunotherapy was given or it is unknown if immunotherapy was given, leave this field blank.

Table H.23 Data Field 1241 IMMUNOTHERAPY DATE STARTED FLAG (pg 225)**:** This flag explains why there is no appropriate value in the corresponding date field.

CODE	DESCRIPTION
10	No information whatsoever can be inferred from this exceptional value (unknown if immunotherapy was given).
11	No proper value is applicable in this context (no immunotherapy given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (immunotherapy is planned as part of first course treatment, but had not yet started at the time of the last follow-up).
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). Case was diagnosed between 2003 and 2009 and the facility did not record Date Immunotherapy started (NAACCR Item #1240) at that time.

Data Field 1410 IMMUNOTHERAPY CODE (pg 226)**:** 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 229)**:** Code the type of hematologic transplant and/or endocrine procedures the patient received as part of the first course of treatment at any facility. Code 88 if the only information is that the patient was referred to a specialist for hematologic transplant or endocrine procedures. Code 00 if a transplant or endocrine procedure was not done.

Table H.24 Data Field 1639 RX SUMM—SYSTEMIC SURG SEQ (pg 232): Code the administration of systemic therapy in sequence with the first surgery performed, described in the data item **Date of First Surgical Procedure.**

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

Data Field 1250 DATE OTHER TREATMENT STARTED (YYYYMMDD) (pg 234)**:** Enter the date other treatment is delivered that is not included in surgery, radiation therapy, and systemic treatment. If no other treatment was given or it is unknown if other treatment was given, leave the field blank.

Table H.25 Data Field 1251 RX DATE OTHER FLAG (pg 235)**:** 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 (no other treatment given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown and cannot be estimated (other treatment was given but the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (radiation therapy is planned as part of first course of therapy, but had not been started at the time of the most recent follow-up).
(blank)	A valid date value is provided in item Date Other Treatment Started (NAACCR Item #1250).

Data Field 1420 OTHER TREATMENT CODE (pg 236)**:** Document and code the type of "other treatment" the patient received as part of the first course of treatment at any facility. "Other treatment" is designed to modify or control the cancer cells, but is not included in surgery, radiation, or systemic therapy.

Table H.26 Data Field 1285 RX SUMM-TREATMENT STATUS (pg 240)**:** Code whether or not first course treatment was given.

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

Data Field 1750 DATE OF LAST CONTACT OR DEATH (YYYYMMDD**)** (pg 241)**:** Enter the date the patient was last seen at your facility, date of last contact, or date of death. If patient is known to be deceased, but date of death is not available, date of last contact should be recorded in this field. In the "Other Pertinent Information" text area, document the patient is deceased and the date of death is not available.

Table H.27 Data Field 1760 VITAL STATUS (pg 241)**:** Patient's vital status as of the date recorded in the "Date of last contact/death" field.

CODE	DESCRIPTION
0	Dead
1	Alive

Data Field 1942 PLACE OF DEATH - STATE (pg 242)**:**
See Appendix B of the *SEER Program Code Manual* for numeric and alphabetic lists of places and codes: https://seer.cancer.gov/tools/codingmanuals/index.html

Table H.28 Data Field 1944 PLACE OF DEATH-COUNTRY (pg 242): Use the International Standards Organization (ISO) 3166-1 Country Three Character Codes, whenever possible, augmented by custom codes.

CODE	DESCRIPTION
USA	United States
ZZN	North America NOS
ZZC	Central America NOS
ZZX	Non-US NOS
ZZU	Unknown

Data Field 2090 DATE ABSTRACTED (YYYYMMDD) (pg 242)**:** Record year, month, and day reporting form is completed.

Data Field 570 ABSTRACTOR INITIALS (pg 243)**:** Record the initials of the abstractor.

Data Field 1060 TNM EDITION NUMBER (pg 243): TNM Edition Number indicates the edition of the AJCC manual that was used to manually code the TNM values for the patient.

CASEFINDING QUICK REFERENCE

Casefinding and Reportable List (Detailed instructions on pages 22-53)

1. Every inpatient and outpatient case with active disease and/or receiving cancer-directed therapy **must** be reported to the Department of State Health Services, Texas Cancer Registry (TCR) regardless of the state or country of residence.

2. Cases of cancer to be reported to the TCR include:

- All neoplasms with a behavior code of two or three in the International Classification of Diseases for Oncology (ICD-O) 3rd edition (with certain exceptions); and

- All benign and borderline neoplasms of the central nervous system with a morphology term and code listed in ICD-O-3 (includes brain and other CNS neoplasms)

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

3. Obtain disease indices including both inpatient and outpatient admissions after medical records are completed and coded (monthly or quarterly).

4. Check the indices against a list of cases previously reported to the TCR to identify new cases.

5. Complete an abstract for patients found on the disease index with a reportable diagnosis not previously submitted to the TCR. Patients who have been previously reported to the TCR need to be checked for possible multiple primaries. Refer to the *Multiple Primaries/Histology Rules* (MP/H) and to the *2015 Hematopoietic and Lymphoid Neoplasm Coding Manual* for assistance.

6. To prevent reporting a primary for a patient twice, compare the patient name and primary cancer site from your registry database (accession list) to the TCR facility data report. The TCR facility data report lists all the patients a facility has reported to TCR for multiple years.

7. Other department logs/records (radiation therapy logs, emergency department logs, oncology unit records, surgery logs, etc.) are to be reviewed in the same method as the disease index to insure all reportable cases are submitted to the TCR.

8. Pathology reports, including all histology, cytology, hematology and autopsy reports, should be reviewed to identify all reportable neoplasms. These should also be reviewed against a list of records submitted to the TCR.

The following lists are intended to aid the appropriate personnel in creating a disease index with the required reportable neoplasms and ICD-10-CM codes. **A DI with the reportable ICD-10-CM codes will require a 100% review.**

REPORTABLE ICD-10-CM CODES

Table H. 29 Reportable ICD-10-CM Codes (List Effective 10/01/2015 Forward)

ICD-10-CM CODE (100% Review Required)	DESCRIPTION
C00._ - C43._, C4A._, C45._ - C96._	Malignant neoplasms (excluding category C44), stated or presumed to be primary (of specified site) and certain specified histologies
C49.A-	Gastrointestinal Stromal Tumors (GIST)
C80.0-C80.2 C81._-C96._	Malignant neoplasm without specification of site Malignant neoplasms of lymphoid, hematopoietic and related tissue
D00._ - D09._	In-situ neoplasms (*Note: Carcinoma in situ of the cervix (CIN III-8077/2) and Prostatic Intraepithelial Carcinoma (PIN III-8148/2) are not reportable*).
D18.02	Hemangioma of intracranial structures and any site
D18.1	Lymphangioma, any site (*Note: Includes Lymphangiomas of Brain, Other parts of nervus system and endocrine glands, which are reportable*)
D32._	Benign neoplasm of meninges (cerebral, spinal and unspecified)
D33._	Benign neoplasm of brain and other parts of central nervous system
D35.2 - D35.4	Benign neoplasm of pituitary gland, craniopharyngeal duct and pineal gland
D42._, D43._	Neoplasm of uncertain or unknown behavior of meninges, brain, CNS
D44.3 - D44.5	Neoplasm of uncertain or unknown behavior of pituitary gland, craniopharyngeal duct and pineal gland
D45	Polycythemia vera (9950/3)
D46._	Myelodysplastic syndromes (9980, 9982, 9983, 9985, 9986, 9989, 9991, 9992)
D47.1	Chronic myeloproliferative disease (9963/3)
D47.3	Essential (hemorrhagic) thrombocythemia (9962/3)
D47.4	Osteomyelofibrosis (9961/3)
D47.Z_	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9960/3, 9970/1, 9931/3)
D47.9	Neoplasm of uncertain behavior of lymphoid, hematopoietic and related tissue, unspecified (9970/1, 9931/3)
D49.6, D49.7	Neoplasm of unspecified behavior of brain, endocrine glands and other CNS
R85.614	Cytologic evidence of malignancy on smear of anus
R87.614	Cytologic evidence of malignancy on smear of cervix
R87.624	Cytologic evidence of malignancy on smear of vagina

^ *International Classification of Diseases, ICD-10-CM Tabular List of Diseases and Injuries, FY 2017*
Source: https://seer.cancer.gov/tools/casefinding/case2016-icd10cm.html

SUPPLEMENTARY ICD-10-CM CODES

Table H.30 Supplementary ICD-10-CM Code (List Effective 10/01/2015 Forward)

ICD-10-CM CODE (5% Review Required)	DESCRIPTION
B20	Human immunodeficiency virus [HIV] disease with other diseases
B97.33, B97.34, B97.35	Human T-cell lymphotrophic virus,(type I [HTLV-1], type II [HTLV-II], type 2 [HIV 2]) as the cause of diseases classified elsewhere
B97.7	Papillomarvirus as the cause of diseases classified elsewhere
D10._ - D31._, D34, D35.0, D35.1, D35.5_ D35.9, D36._	Benign neoplasms (see "must collect" list for reportable benign neoplasms) ***Note**: Screen for incorrectly coded malignancies or reportable by agreement tumors* ***Note**: Borderline cystadenomas M-8442, 8451, 8462, 8472, 8473, of the ovaries moved from behavior /3 (malignant) to /1 (borderline malignancy) in ICD-O-3. SEER registries are not required to collect these cases for diagnoses made 1/1/2001 and after. However, cases diagnosed prior to 1/1/2001 should still be abstracted and reported to SEER.*
D3A._	Benign carcinoid tumors
D37._ - D41._	Neoplasms of uncertain or unknown behavior (see "must collect" list for reportable neoplasms of uncertain or unknown behavior) *Note: Screen for incorrectly coded malignancies or reportable by agreement tumors*
D44.0 - D44.2, D44.6-D44.9	Neoplasm of uncertain or unknown behavior of other endocrine glands (see "must collect" list for D44.3-D44.5) *Note: Screen for incorrectly coded malignancies or reportable by agreement tumors*
D47.0	Histiocytic and mast cell tumors of uncertain behavior
D47.2	Monoclonalgammopathy *Note: Screen for incorrectly coded Waldenstrom's macroglobulinemia*
D47.Z2	Castleman disease
D48._	Neoplasm of uncertain behavior of other and unspecified sites
D49.0 - D49.9	Neoplasm of unspecified behavior (except for D49.6 and D49.7)
D61.810	Antineoplastic chemotherapy induced pancytopenia
D63.0	Anemia in neoplastic disease
D64.81	Anemia due to antineoplastic chemotherapy
D69.49, D69.59, D69.6	Other thrombocytopenia *Note: Screen for incorrectly coded thrombocythemia*
D70.1	Agranulocytosis secondary to cancer chemotherapy
D72.1	Eosinophilia (*Note: Code for eosinophilia (9964/3). Not every case of eosinophilia is a malignancy. Reportable Diagnosis is "Hypereosonophilic syndrome."*)
D76._	Other specified diseases with participation of lymphoreticular and reticulohistiocytic tissue
D89.0, D89.1	Other disorders involving the immune mechanism, not elsewhere classified *Note: Review for miscodes*

ICD-10-CM CODE (5% Review Required)	DESCRIPTION
D89.4-	Mast cell activation syndrome and related disorders *Note: Effective 10/1/2016*
E34.0	Carcinoid syndrome
E83.52	Hypercalcemia
E88.09	Other disorders of plasma-protein metabolism, not elsewhere classified
E88.3	Tumor lysis syndrome (following antineoplastic chemotherapy)
G89.3	Neoplasm related pain (acute)(chronic)
K22.711	Barrett's esophagus with high grade dysplasia
K62.82	Dysplasia of anus (AIN I and AIN II)
K92.81	Gastrointestinal mucositis (ulcerated) (due to antineoplastic therapy)
N42.3	Dysplasia of prostate (PIN I and PIN II)
N87._	Dysplasia of cervix uteri (CIN I and CIN II)
N89.0,N89.1, N89.3	Vaginal dysplasia (VIN I and VIN II)
O01.-	Hydatidiform mole *Note: Benign tumor that can become malignant. If malignant, report as Choriocarcinoma (9100/3,) malignancy code in the C00-C97 range*
Q85.0-	Neurofibromatosis (nonmalignant) (9540/1) *Note: Neurofibromatosis is not cancer. These tumors can be precursors to acoustic neuromas, which are reportable*
R18.0	Malignant ascites *ICD-10-CM Coding instruction: Code first malignancy, such as:* *Malignant neoplasm of ovary (C56._), secondary malignant neoplasm of retroperitoneum and peritoneum (C78.6)*
R53.0	Neoplastic (malignant) related fatigue *ICD-10-CM Coding instruction: Code first associated neoplasm*
R59.-	Enlarged lymph nodes
R85.6-	Abnormal findings on cytological and histological examination of digestive organs *Note: see "must collect" list for R85.614*
R87.61-, R87.62-	Abnormal findings on cytological/histological examination of female genital organs Note: see "must collect" list for R87.614 and R87.624
R92.-	Abnormal findings on diagnostic imaging of breast
R97.-	Abnormal tumor markers
T38.8-, T38.9-	Poisoning by hormones and their synthetic substitutes
T45.1-	Poisoning by, adverse effect of and under dosing of antineoplastic and immunosuppressive drugs
T45.8-, T45.9-	Poisoning by primary systemic and hematological agent, unspecified
T66	Unspecified effects of radiation

ICD-10-CM CODE (5% Review Required)	DESCRIPTION
T80.2-	Infections following infusion, transfusion and therapeutic injection
Y63.2	Overdose of radiation given during therapy
Y84.2	Radiological procedure and radiotherapy as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure
Z03.89	Encounter for observation for other suspected diseases and conditions ruled out
Z08	Encounter for follow-up examination after completed treatment for malignant neoplasm
Z12._	Encounter for screening for malignant neoplasms
Z17.0, Z17.1	Estrogen receptor positive and negative status
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
Z51.0	Encounter for antineoplastic chemotherapy and immunotherapy
Z51.5, Z51.89	Encounter for palliative care and other specified aftercare
Z85._	Personal history of malignant neoplasm
Z86.0_, Z86.01_, Z86.03	Personal history of in situ and benign neoplasms and neoplasms of uncertain behavior
Z92.21, Z92.23, Z92.25. Z92.3	Personal history of antineoplastic chemotherapy, estrogen therapy, immunosuppression therapy or irradiation (radiation)
Z94.81, Z94.84	Bone marrow and stem cell transplant status

^International Classification of Diseases, ICD-10-CM Tabular List of Diseases and Injuries, FY 2016

A DI with supplementary ICD-10-CM Codes should be reviewed based on the instructions on page 24 in the Casefinding Section of the TCR CRH.

Table H.31 The following are **exclusions** and **do not** need to be reported to the TCR:

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

Ambiguous Terminology

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

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

Exception: If cytology is reported as “suspicious” do not interpret this as a diagnosis of cancer. Report the case only if there is either a positive biopsy, a physician’s clinical diagnosis of cancer supporting the cytology findings, or cancer directed therapy is administered.

Note: This list should be used only for determining case reportability. Do not use this list to determine the appropriate histology or stage.

Cases To Report Only If Cancer-Directed Therapy Is Planned Or Given

- Cases diagnosed and/or treated for cancer prior to admission should be reported if there is evidence of active disease, whether or not diagnostic or therapeutic procedures were performed.
- Cases diagnosed at autopsy, with no suspicion prior to death that the cancer existed, should be reported.
- Abstract cases using the medical record from the first admission (inpatient or outpatient) to your facility with a reportable diagnosis. Use information from subsequent admissions to include all first course treatment information and to supplement documentation.
- Do not report cases diagnosed prior to 1995
- Do not complete a report for each admission; submit one report per primary tumor.

***Examples*:**

a. A patient is diagnosed with prostate cancer and has several admissions for treatment of the prostate cancer. Only one abstract should be completed.

b. A patient is diagnosed with two separate primary tumors, such as adenocarcinoma of the prostate and squamous cell carcinoma of the lung. Complete one abstract for the prostate primary and another for the lung.

Helpful Hints:

- Report all cases of *active* cancer regardless of state of residence.
- Report all inpatients and outpatients.
- Do not report basal or squamous cell carcinomas of the skin, except skin of genital sites.
- To ensure case ascertainment, review the disease indexes; pathology, cytology, hematology, and autopsy reports.
- Do not complete an abstract for each admission.
- Report all benign and borderline tumors of the central nervous system.
- Cases in which the disease is no longer active (such as leukemia in remission) should only be reported if the patient is still receiving cancer-directed therapy.
- Do not report carcinoma in situ of cervix (any histology).
- Do not report intraepithelial neoplasia of the prostate (PIN III).

TREATMENT STANDARD TABLES

Table H.32 Scope of Regional Lymph Node Surgery Codes

CODE	DESCRIPTION
0	None
1	Biopsy or aspiration of regional lymph nodes, NOS
2	Sentinel lymph node biopsy (only)
3	Number of regional lymph nodes removed unknown or not stated; regional lymph nodes removed, NOS
4	1–3 regional lymph nodes removed
5	4 or more regional lymph nodes removed
6	Sentinel lymph node biopsy and code 3, 4, or 5 at same time, or timing not stated
7	Sentinel node biopsy and code 3, 4, or 5 at different times
9	Unknown or not applicable

Note: For specific instructions on coding this data field see page 185 of this manual.

Table H.33 Scope of Regional Lymph Node Surgery for Breast

CODE	DESCRIPTION
0	None
1	Biopsy or aspiration of regional lymph nodes, NOS
2	Sentinel lymph node biopsy (only)
3	Number of regional lymph nodes removed unknown or not stated; regional lymph nodes removed, NOS
4	1–3 regional lymph nodes removed
5	4 or more regional lymph nodes removed
6	Sentinel lymph node biopsy and code 3, 4, or 5 at same time, or timing not stated
7	Sentinel node biopsy and code 3, 4, or 5 at different times
9	Unknown or not applicable

Note: For specific instructions on coding this data field go to: http://www.facs.org/cancer/ncdb/scope-regional-lymph-node-surgery.pdf

Table H.34 Surgery Codes

CODE	DESCRIPTION
00	None
10-19	Site-specific codes; tumor destruction
20-80	Site-specific codes; resection
90	Surgery, NOS
98	Site-specific surgery codes; special
99	Unknown

Table H.35 RX Summ—Radiation Codes

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

Note: For specific instructions on coding this data field see page 203 of this manual.

Table H.36 Radiation-Regional Treatment Modality Codes

CODE	DESCRIPTION
00	No radiation treatment
20	External beam, NOS
21	Orthovoltage
22	Cobalt-60, Cesium-137
23	Photons (2-5 MV)
24	Photons (6-10 MV)
25	Photons (11-19 MV)
26	Photons (>19 MV)
27	Photons (mixed energies)
28	Electrons
29	Photons and electrons mixed
30	Neutrons with or without photons/electrons
31	IMRT
32	Conformal or 3-D therapy
40	Protons
41	Stereotactic radiosurgery, NOS
42	Linac radiosurgery
43	Gamma knife
50	Brachytherapy, NOS
51	Brachytherapy, intracavitary, low dose rate (LDR)
52	Brachytherapy, intracavitary, high dose rate (HDR)
53	Brachytherapy, Interstitial, LDR
54	Brachytherapy, Interstitial, HDR
55	Radium
60	Radioisotopes, NOS
61	Strontium-89
62	Strontium-90
80*	Combination modality, specified
85*	Combination modality, NOS
98	Other, NOS
99	Unknown

Note: For specific instructions on coding this data field see page 201 of this manual.

Table H.37 Chemotherapy Codes

CODE	DESCRIPTION
00	None; chemotherapy was not part of the first course of therapy
01	Chemotherapy administered as first course of therapy, but the type and number of agents is not documented in the patient record.
02	Single-agent chemotherapy administered as first course of therapy.
03	Multi-agent chemotherapy was delivered as first course of therapy.
82	Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors i.e., comorbid conditions, advanced age.
85	Chemotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Chemotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in the patient record.
87	Chemotherapy was not delivered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Chemotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a chemotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Note: For specific instructions on coding this data field see page 212 of this manual

Table H.38 Hormone Therapy Codes

CODE	DESCRIPTION
00	None; hormone therapy was no not part of the planned first course of therapy.
01	Hormone therapy was delivered as first course of therapy.
82	Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age).
85	Hormone therapy was not administered because the patient died prior to planned or recommended therapy.
86	Hormone therapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of treatment. No reason was stated in patient record
87	Hormone therapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Chemotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a chemotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Note: For specific instructions on coding this data field see page 220 of this manual.

Table H.39 Immunotherapy Codes

CODE	DESCRIPTION
00	None, immunotherapy was not part of the first course of therapy.
01	Immunotherapy administered as first course of therapy
82	Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age).
85	Immunotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Immunotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of treatment. No reason was stated in patient record.
87	Immunotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record
88	Immunotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether immunotherapy agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Note: For specific instructions on coding this data field see page 226 of this manual.

Table H.40 RX Summ-Transplant/Endocrine Codes

CODE	DESCRIPTION
00	No transplant procedure or endocrine therapy was administered as part of the first course of therapy.
10	A bone marrow transplant procedure was administered, but the type was not specified.
11	Bone marrow transplant-autologous.
12	Bone marrow transplant-allogeneic.
20	Stem cell harvest and infusion
30	Endocrine surgery and/or endocrine radiation therapy
40	Combination of endocrine surgery and/or radiation with a transplant procedure. (Combination of codes 30 and 10, 11, 12, or 20).
82	Hematologic transplant and/or endocrine surgery/radiation were not recommended/administered because it was contraindicated due to patient risk factors (i.e., comorbid conditions, advanced age).
85	Hematologic transplant and/or endocrine surgery/radiation were not administered because the patient died prior to planned or recommended therapy.
86	Hematologic transplant and/or endocrine surgery/radiation was not administered. It was recommended by the patient's physician, but was not administered as part of the first course therapy. No reason was stated in patient's record.
87	Hematologic transplant and/or endocrine surgery/radiation were not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Hematologic transplant and/or endocrine surgery/radiation were recommended, but it is unknown if it was administered.
99	It is unknown whether hematologic transplant and/or endocrine surgery/radiation were recommended or administered because it is not documented in the medical record. Death certificate only.

Note: For specific instructions on coding this data field see page 229 of this manual.

Table H.41 Other Treatment Codes

CODES	DESCRIPTION
0	None
1	Other
2	Other-Experimental
3	Other-Double Blind
6	Other-Unproven
7	Refusal
8	Recommended; unknown if administered
9	Unknown

Note: For specific instructions on coding this data field see page 236 of this manual.

COLLABORATIVE STAGE STANDARD TABLES

Data Field 820 REGIONAL NODES POSITIVE (page 152): Information from **Regional lymph nodes only, and based on pathologic information only.**

Table H.42 Regional Nodes Positive Standard Table

CODE	DESCRIPTION
00	All nodes examined are negative
01-89	1 to 89 nodes are positive (Code exact number of nodes positive)
90	90 or more nodes are positive
95	Positive aspiration or core biopsy of lymph node(s) was performed
97	Positive nodes are documented, but the number is unspecified.
98	No nodes were examined.
99	It is unknown whether nodes are positive, not applicable; not stated in patient record.

Note: For specific instructions on coding this data field see page 156 of this manual.

Data Field 830 REGIONAL NODES EXAMINED (page 156): Information from **Regional lymph nodes only, and based on pathologic information only**

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.

Table H.43 Regional Nodes Examined Standard Table

CODE	DESCRIPTION
00	No nodes were examined
01-89	1 to 89 nodes were examined. (Code the exact number of regional lymph nodes examined.)
90	90 or more nodes were examined
95	No regional nodes were removed, but aspiration or core biopsy of regional nodes was performed.
96	Regional lymph node removal was documented as a sampling, and the number of nodes is unknown/not stated.
97	Regional lymph node removal was documented as a dissection, and the number of nodes is unknown/not stated.
98	Regional lymph nodes were surgically removed, but the number of lymph nodes is unknown/not stated and not documented as a sampling or dissection; nodes were examined, but the number is unknown.
99	It is unknown whether nodes were examined; not applicable or negative, not stated in record

Note: For specific instructions on coding this data field see page 160 of this manual.

Table H.44 Purpose: **This table contains the data items currently or previously collected.** The Texas Cancer Registry adheres to reporting requirements mandated by the National Program of Cancer Registries. Additional data items are required to meet requests from our data users.

DATA ITEM	NAACCR ITEM NUMBER	COLLECTION DATES
Date of Admission/First Contact	580	1995 - present
Date of Admission/First Contact Flag *	581	2010 – present
Registry Number	550	1995 - present
Reporting Facility	540	1995 - present
NPI Reporting Facility (Derived)	545	2009 - present
Reporting Source	500	1995 - present
Medical Record #	2300	1995 - present
Class of Case	610	1998 - present
Last Name	2230	1995 - present
First Name	2240	1995 - present
Middle Name	2250	1995 - present
Maiden Name	2390	1995 - present
Alias	2280	1995 - 2002 2006 - present
Street Address	2330	1995 - present
Address at Dx Supplemental	2335	2006 - present
City	70	1995 - present
State	80	1995 - present
Zip Code	100	1995 - present
FIPS County Code at DX	90	1995 - present
Address at Dx-Country	102	2013 - present

DATA ITEM	NAACCR ITEM NUMBER	COLLECTION DATES
Social Security Number	2320	1995 - present
Date of Birth	240	1995 - present
Date of Birth Flag *	241	2010 - present
Place of Birth	250	1998 - 2013
Birthplace-State	252	2013 - present
Birthplace-Country	254	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
Text Usual Occupation	310	2010 - present
Text Usual Industry	320	2010 - present
Other Pertinent Information	2680	1995 - present
Physician Managing	2460	2006 - 2010
Physician Follow Up	2470	2006 - present
Facility Referred From	2410	2001 - 2010
Facility Referred To	2420	2001 - 2010
Sequence Number Hospital	560	1995 - present
Sequence Number Central	380	2011 - present

DATA ITEM	NAACCR ITEM NUMBER	COLLECTION DATES
Other Primary Tumors	2200	1995 - present
Primary Payer at DX	630	2007 - present
Comorbidity/Secondary Diagnosis #1	3110	2011 - present
Comorbidity/Secondary Diagnosis #2	3120	2011 - present
Comorbidity/Secondary Diagnosis #3	3130	2011 - present
Comorbidity/Secondary Diagnosis #4	3140	2011 - present
Comorbidity/Secondary Diagnosis #5	3150	2011 - present
Comorbidity/Secondary Diagnosis #6	3160	2011 - present
Comorbidity/Secondary Diagnosis #7	3161	2011 - present
Comorbidity/Secondary Diagnosis #8	3162	2011 - present
Comorbidity/Secondary Diagnosis #9	3163	2011 - present
Comorbidity/Secondary Diagnosis #10	3164	2011 - present
Source Comorbidity/Secondary Diagnosis	Non-NAACCR 9970	2011 - present
Date of Initial Diagnosis	390	1995 - present
Date of Diagnosis Flag	391	2010 - present
ICD-O-2 Morph Prior to 2001	420	1995 - 2001
Behavior prior to 2001	430	1995 - 2001
ICD-O-3 2001 and forward	522	2001 - present
Behavior 2001 and forward	523	2001 - present
Primary Site	400	1995 - present
Grade of Tumor	440	1995 - present
Grade Path Value	441	2011 - 2013

DATA ITEM	NAACCR ITEM NUMBER	COLLECTION DATES
Grade Path System	449	2011 - 2013
Laterality	410	1995 - present
Final DX Morph/Beh/Grade	2590	1995 - present
Final DX Primary Site and Laterality	2580	1995 - present
Lymph - Vascular Invasion	1182	2011 - present
Diagnostic Confirmation	490	1995 - present
Tumor Size Summary	756	2016
Tumor Size Prior to 2004	780	1998 – 2003
Summary Stage 1977 for appropriate years	760	1995 - 2000
Summary Stage 2000 for appropriate years	759	2001 – 2004, 2014-present
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
Regional Nodes Positive	820	1998 - present
Regional Nodes Examined	830	1998 - present
CS Mets at DX	2850	2004 - 2015
CS Mets Eval	2860	2011 - 2015
CS Site Specific Factor 1 NPCR required only	2880	2004 - present
CS Site Specific Factor 2 NPCR required only	2890	2010 - present
CS Site Specific Factor 3 NPCR required only	2900	2004 - 2015

DATA ITEM	NAACCR ITEM NUMBER	COLLECTION DATES
CS Site Specific Factor 4 NPCR required only	2910	2011 - 2015
CS Site Specific Factor 5 NPCR required only	2920	2011 - present
CS Site Specific Factor 6 NPCR required only	2930	2011 - present
CS Site Specific Factor 7 NPCR required only	2861	2011 - 2015
CS Site Specific Factor 8 NPCR required only	2862	2010 - present
CS Site Specific Factor 9 NPCR required only	2863	2010 - present
CS Site Specific Factor 10 NPCR required only	2864	2010 - present
CS Site Specific Factor 11 NPCR required only	2865	2010 - present
CS Site Specific Factor 12 NPCR required only	2866	2010 - 2015
CS Site Specific Factor 13 NPCR required only	2867	2010 - present
CS Site Specific Factor 14 NPCR required only	2868	2010 - present
CS Site Specific Factor 15 NPCR required only	2869	2011 - present
CS Site Specific Factor 16 NPCR required only	2870	2011 - present
CS Site Specific Factor 17 NPCR required only	2871	2011 - 2015
CS Site Specific Factor 25 NPCR required only	2879	2010 - present
Summary Stage Documentation	2600	1995 - present
TNM Clinical T	940	2015 - present
TNM Clinical N	950	2015 - present
TNM Clinical M	960	2015 - present
TNM Clinical Stage (Prefix/Suffix) Descriptor	980	2015 - present
TNM Clinical Stage Group	970	2015 - present
TNM Pathologic T	880	2015 - present

DATA ITEM	NAACCR ITEM NUMBER	COLLECTION DATES
TNM Pathologic N	890	2015 - present
TNM Pathologic M	900	2015 - present
TNM Pathologic Stage (Prefix/Suffix) Descriptor	920	2015 - present
TNM Pathologic Stage Group	910	2015 - present
RX Summary - Reg LN Examined	1296	2001 - 2005
RX Summary - Scope of Reg LN Surgery	1292	2001 - present
Date of Initial Treatment	1260	2010 - present
Date of Initial Treatment Flag	1261	2010 - present
RX Date Surgery	1200	1995 - present
RX Date Surgery Flag	1201	2010 - present
Surgery RX Code	1290	1995 - present
RX Date Mst Defn Srg	3170	2015 - present
RX Date Mst Defn Srg Flag	3171	2015 - present
Reason for No Surgery	1340	1998 - 2002 2006 - present
RX Summary - Surgery Other/Dist RX Code	1294	1998 - present
RX Text Surgery	2610	2004 - present
Date Radiation Started	1210	1995 - present
RX Date Radiation Flag	1211	2010 - present
RX Summary - Radiation	1360	1998 - 2002 2012 - present
Radiation Regional RX Modality Code	1570	2003 - present
Reason for no Radiation	1430	1998 - 2002 2011 - present
RX Text - Radiation	2620, 2630	2004 - present

DATA ITEM	NAACCR ITEM NUMBER	COLLECTION DATES
RX Summary - Surgery/Radiation Sequence	1380	2004 - present
RX Date - Systemic	3230	2004 - 2010
Date Chemotherapy Started	1220	2010 - present
RX Date Chemotherapy Flag	1221	2010 - present
Chemotherapy Code	1390	1995 - present
Reason for no Chemotherapy	1440	1998 - 2002
RX Text - Chemotherapy	2640	2004 - present
Date Hormone Therapy Started	1230	2010 - present
RX Date Hormone Flag	1231	2010 - present
Hormone Code	1400	1995 - present
Reason for no Hormone	1450	1998 - 2002
RX Text - Hormone	2650	2004 - present
Date Immunotherapy Started	1240	2010 - present
RX Date Immunotherapy Flag	1241	2010 - present
Immunotherapy Code	1410	1995 - present
RX Summary Transplant/Endocrine	3250	2003 - present
RX Text - Immunotherapy	2660	2004 - present
RX Summary - Systemic/Surgery Sequence	1639	2006 - present
Date other Treatment Started	1250	1995 - present
RX Date Other Flag	1251	2010 - present
Other Treatment Code	1420	1995 - present
RX Text - Other	2670	2004 - present

DATA ITEM	NAACCR ITEM NUMBER	COLLECTION DATES
RX - Summary Treatment Status	1285	2010 - present
Date of Last Contact or Death	1750	1995 - present
Date of Last Contact Flag	1751	2010 - present
Vital Status	1760	1998 - present
Place of Death-State	1942	2013 - present
Place of Death-Country	1944	2013 - present
Follow Up Source (Derived)	1790	2009 - present
Date Abstracted	2090	1995 - present
Abstractor Initials	570	1995 - present
NAACCR Record Version	50	2003 - present
AJCC Edition Number	1060	2015 - present
Height	Non - NAACCR 9960	2011 - present
Weight	Non - NAACCR 9961	2011 - present
Tobacco Use	Non - NAACCR 9965 - 9968	- present

***Please note that the TCR does not allow blanks for the following items:**

- **Date of Admission/First Contact, NAACCR #580**
- **Date of Date of Birth, NAACCR #240**

I

APPENDIX I:
HEALTH SERVICES REGIONS

Available on the web:
https://www.dshs.texas.gov/tcr/training/handbook/Appendix-Health-Service-Regions.pdf

J

APPENDIX J: SPANISH/HISPANIC SURNAMES

Available on the web:
https://www.dshs.texas.gov/tcr/training/handbook/Appendix-Spanish-Hispanic-Surnames.pdf

K

APPENDIX K: GUIDELINES FOR ICD-O-3 UPDATE IMPLEMENTATION

Acknowledgment
We wish to acknowledge that the information presented here was taken verbatim from: https://20tqtx36s1la18rvn82wcmpn-wpengine.netdna-ssl.com/wp-content/uploads/2016/11/ICD-O-3-Implementation-Guide-FINAL.pdf

North American Association of Central Cancer Registries, Inc.

GUIDELINES FOR ICD-O-3 UPDATE IMPLEMENTATION

Effective January 1, 2014

Prepared by the

NAACCR ICD-O-3 Update Implementation Work Group

December 1, 2013

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1 INTRODUCTION

These implementation guidelines, developed by the North American Association of Central Cancer Registries, Inc. (NAACCR) ICD-O-3 Implementation Work Group and approved by the Cancer Registration Steering Committee (CRSC) Change Management Board (CMB), address implementation of ICD-O-3 Update terms and codes for cases diagnosed on or after January 1, 2014. Members of the work group represent standard setting organizations, central registries, and cancer registry software vendors.

On an international level, the need was recognized in 2010 for updating the morphology section to accurately code contemporary diagnoses described in the terms of the fourth editions of the World Health Organization's Classifications of Hematopoietic and Lymphoid Neoplasms, Tumors of the Central Nervous System, and Tumors of the Digestive System. In September 2011, the International Agency for Research on Cancer (IARC) and the World Health Organization (WHO) released the document *Updates to the International Classification of Diseases for Oncology, third edition (ICDO-3)* (http://www.who.int/classifications/icd/updates/ICDO3Updates2011.pdf) According to that document, the changes were valid for implementation with cases diagnosed January 1, 2012, and later. Many countries adopted the new terms and codes immediately; others, along with the United States, have taken a more stepwise approach to implementation.

The CRSC in North America recommended that NAACCR member registries not incorporate the updates until the impact of these changes could be evaluated. CRSC requested that NAACCR create a work group to determine how and when NAACCR member registries should implement the ICD-O-3 changes. The ICD-O-3 Update Implementation Work Group, with April Fritz as chair, began meeting in July 2012. The Work Group forwarded their implementation recommendations to the CMB in June 2013. The CMB reviewed the recommendations and accepted them with implementation dates as shown below. The CMB instructed the ICD-O-3 Update Implementation Work Group to prepare a communication plan to disseminate the information to NAACCR members. This implementation document is one step in disseminating the information. The changes and effective dates follow.

The ICD-O-3 Implementation Work Group was charged with developing the implementation document and they will also act as the clearinghouse for review and resolution of ICD-O-3 implementation questions. If there are any questions, email them to April Fritz (april@afritz.org) as chair of this Work Group. Updates will be posted on NAACCR's web site (www.naaccr.org). The Work Group will also be communicating updates via email using the NAACCR listserv and mailing lists of all organizations involved.

2 BACKGROUND AND IMPLEMENTATION ISSUES

Implementation of new standards is never 100 percent problem-free. In anticipation of questions that may arise in this update, the Work Group has developed the following explanations.

2.1 Why is there an update to ICD-O-3 at this time?

WHO has been publishing updates to the WHO Classification of Tumors (Blue Book) series for several years. As part of each new edition, subject matter experts review current literature pertaining to the organ or body system covered in the WHO Classification and make recommendations regarding revised histologic terminology. These revisions are reviewed pre-publication by the WHO/IARC Committee on ICD-O-3 to make sure that recommended code changes and additions are appropriate. When each new Blue Book edition is published, the terminology and codes are introduced into contemporary pathology terminology to be used in pathology reports. Malignant diagnoses from these books that find their way into cancer registries may not be listed in ICD-O-3, the standard reference for reportable conditions. This becomes an issue if there is no histology code available to register a case.

The IARC and WHO responded to this by creating a list of terms and codes that were added or modified in the new edition of the Blue Books in print as of 2010. In September 2011, WHO published the first update to the ICD-O-3 since its publication in 2000. The 2011 Update list incorporated terms from the Blue Books published at the time:
WHO Classification of Tumors of the Central Nervous System (2007)
WHO Classification of Tumors of the Hematopoietic and Lymphoid Tissues (2008)
WHO Classification of Tumors of the Digestive System (2010)

It should be noted that the terms and codes pertaining to the *WHO Classification of Tumors of the Hematopoietic and Lymphoid Tissues* (fourth edition, 2008) had already been reviewed and accepted by NAACCR and were implemented for use in North America effective with cases diagnosed on or after January 1, 2010. These hematopoietic and lymphoid terms comprised almost half of the terms on the 2011 WHO ICD-O-3 Update List.

2.2 How sweeping are the changes?

The CMB has approved 36 new terms to be added to existing codes in ICD-O-3 for use in the United States and Canada beginning with cases diagnosed on or after January 1, 2014. Of these terms, 21 are malignant (/3) terms, and one is a new borderline (/1) tumor of the central nervous system. All of these are reportable. The remaining 14 are benign (/0) or uncertain malignancy (/1) and are not reportable conditions. Table 1 displays the terms approved for use with 2014 diagnoses and forward.

It is important to understand that cancer registry reportability rules based on behavior code still apply. With the exception of primary intracranial and central nervous system benign and borderline tumors, the addition of a /0 or /1 coded term to ICD-O-3 does not imply that it is now reportable.

For 2015, 16 new codes and terms were proposed for addition to ICD-O-3. Of these, 7 are reportable malignant (/3) tumors and 4 are reportable borderline (/1) tumors of the central nervous system (see Table 2). The implementation of these updates was postponed until 2015 because these are new codes, and the terms cannot be used until the codes have been added to registry manuals, software, edits, and documentation. Most of these new codes and terms are rare or very site-specific. The newly reportable malignant codes were not incorporated into CS version 02.05 and thus cannot be used at this time because no CS Stage Group will be derived. Until the new codes can be used, the Work Group has prepared a coding guideline (Table 2) for the terms with new codes on the WHO Update List, (which may appear in pathology reports) showing which existing codes to use.

Also proposed for 2015 is a behavior and reportability change for carcinoid of the appendix (See section 4). This change was made in the *WHO Classification of Digestive System Tumors* published in 2010. The Work Group supports this reportability change, since current terminology for "carcinoid" – well- differentiated neuroendocrine tumor – is coded to 8240/3 and most 'former' carcinoids of the appendix are already being accessioned under the new terminology. Based on an analysis of data from a large university hospital pathology department and cancer registry, the Work Group believes there will be only a minimal effect on casefinding and abstracting if all carcinoids of the appendix are made reportable. Canada adopted this behavior and reportability change for carcinoid of the appendix as of 2012 diagnoses.

2.3 Why is the 2014 list of approved terms so limited compared to the WHO ICD-O-3 Update List?

As mentioned above, the CRSC wanted to proceed deliberately and study the implications of adding new codes and terms. The first terms approved by the CMB (for 2014) are additions (synonymous terms) to existing codes so there should be no problems with invalid codes or edit conflicts. The next set of terms to be implemented in 2015 includes new codes and terms. The delay in implementing terms with new codes is to allow software vendors and others who work with ICD-O-3 codes in their databases to have more time to add new codes, check code ranges and test any software revisions. The discontinuation of Collaborative Staging has further delayed the use of the new malignant codes until 2016. The remaining terms may or may not be implemented for cancer registries in the United States because of the terminology used and potential reportability issues. Please refer to the remaining ICD-O-3 issues in section 5 of this guide.

2.4 What about training for data collectors?

Short articles/announcements have been issued in blast emails from standard setting organizations and in the *Journal of Registry Management* to highlight some of the changes, and more are planned. Educational materials/presentations are also planned.

2.5 What are the conversion issues?

To the Work Group's knowledge, there are no conversion issues with the list of terms in Table 1, as they are terminology additions to existing codes. There is one recode required in 2015, which will have minimal impact on cancer registries and could be done manually (see section 4).

2.6 Will a new version of the ICD-O-3 manual be available?

WHO has announced a "first revision" of ICD-O-3. It is important to note that this new printing includes all of the terms added to ICD-O-3 in the 2011 WHO Update. Consequently, purchasers of the "ICD-O-3 First Revision" may be confused by terms added internationally but not yet implemented in the United States and/or Canada. At this time, the Work Group recommends using the original publication of the ICD-O-3 book (Copyright 2000) since only the terms in Table 1 have been approved in the United States and Canada for 2014 and forward.

Until all update terms are approved for use in the United States and Canada, print Tables 1 and 2 and include those terms in the original ICD-O-3 book.

3 TABLE 1. ICD-O-3 CHANGES EFFECTIVE JANUARY 1, 2014

Use the following new terms, synonyms, and related terms for existing ICD-O-3 codes.
Bold indicates a preferred term. Sans-serif font indicates a new reportable term.

New preferred term	**8150/0**	**Pancreatic endocrine tumor, benign (C25._)**
Move former preferred term to synonym	8150/0	Islet cell adenoma (C25._)
New related term	8150/0	Pancreatic microadenoma (C25._)
New preferred term	**8150/1**	**Pancreatic endocrine tumor, NOS (C25._)**
Move former preferred term to synonym	8150/1	Islet cell tumor, NOS (C25._)
New preferred term	**8150/3**	**Pancreatic endocrine tumor, malignant(C25._)**
Move former preferred term to synonym	8150/3	Islet cell carcinoma (C25._)
New related term	8150/3	Pancreatic endocrine tumor, nonfunctioning (C25._)
New related term	8152/1	L-cell tumor
New related term	8152/1	Glucagon-like peptide-producing tumor (C25._)
New related term	8152/1	Pancreatic peptide and pancreatic peptide-like peptide within terminal tyrosine amide producing tumor
New synonym for related term	8152/1	PP/PYY producing tumor
New preferred term	**8154/3**	**Mixed pancreatic endocrine and exocrine tumor, malignant (C25._)**
New related term	8154/3	Mixed endocrine and exocrine adenocarcinoma(C25._)
New synonym for related term	8154/3	Mixed islet cell and exocrine adenocarcinoma(C25._)
New related term	8154/3	Mixed acinar-endocrine-ductal carcinoma
New related term	8201/3	Cribriform comedo-type carcinoma (C18._, C19.9, C20.9)
New synonym	8201/3	Adenocarcinoma, cribriform comedo-type (C18._, C19.9, C20.9)
New synonym to primary term	8213/0	Traditional serrated adenoma
New related term	8213/0	Sessile serrated adenoma
New related term	8213/0	Sessile serrated polyp
New related term	8213/0	Traditional sessile serrated adenoma
New related term	8240/3	Neuroendocrine tumor, grade 1
New related term	8240/3	Neuroendocrine carcinoma, low grade
New related term	8240/3	Neuroendocrine carcinoma, well-differentiated
New preferred term	**8244/3**	**Mixed adenoneuroendocrine carcinoma**
Move former preferred term to synonym	8244/3	Composite carcinoid
New synonym	8244/3	Combined/mixed carcinoid and adenocarcinoma
New synonym	8244/3	MANEC

New synonym	8249/3	Neuroendocrine tumor, grade 2
New related term	8249/3	Neuroendocrine carcinoma, moderately differentiated
New synonym	8263/0	Tubulo-papillary adenoma
New related term	8290/0	Spindle cell oncocytoma (C75.1)
New related term	8490/3	Poorly cohesive carcinoma
New related term	8811/0	Plexiform fibromyxoma
New related term	8970/3	Hepatoblastoma, epithelioid (C22.0)
New related term	8970/3	Hepatoblastoma, mixed epithelial-mesenchymal (C22.0)
New related term	9471/3	Medulloblastoma with extensive nodularity
New related term	9474/3	Anaplastic medulloblastoma
New related term	9506/1	Extraventricular neurocytoma

NOTE: It is important to understand that cancer registry reportability rules based on behavior code still apply. With the exception of primary intracranial and central nervous system benign and borderline tumors, the addition of a /0 or /1 coded term to ICD-O-3 does not imply that it is now reportable.

TABLE 2. ICD-O-3 CHANGES EFFECTIVE FOR JANUARY 1, 2015

ICD-O-3 change	New code in ICD-O-3	Description	Comment	Use this code in 2015
New term and code	8158/1	Endocrine tumor, functioning, NOS	Not reportable	
New related term	8158/1	ACTH-producing tumor	Not reportable	
New term and code	8163/3	Pancreatobiliary-type carcinoma (C24.1)	DO NOT use new code	8255/3
New synonym	8163/3	Adenocarcinoma, pancreatobiliary-type (C24.1)	DO NOT use new code	8255/3
New term	8213/3	Serrated adenocarcinoma		8213/3*
New code and term	8265/3	Micropapillary carcinoma, NOS (C18._, C19.9, C20.9)	DO NOT use new code	8507/3*
New code and term	8480/1	Low grade appendiceal mucinous neoplasm (C18.1)	Not reportable	
New term and code	8552/3	Mixed acinar ductal carcinoma	DO NOT use new code	8523/3
New term and code	8975/1	Calcifying nested epithelial stromal tumor (C22.0)	Not reportable	
New term and code	9395/3	Papillary tumor of the pineal region	DO NOT use new code	9361/3*
New term and code	9425/3	Pilomyxoid astrocytoma	DO NOT use new code	9421/3
New term and code	9431/1	Angiocentric glioma	DO NOT use new code	9380/1*
New term and code	9432/1	Pituicytoma	DO NOT use new code	9380/1*
New term and code	9509/1	Papillary glioneuronal tumor	DO NOT use new code	9505/1
New related term	9509/1	Rosette-forming glioneuronal tumor	DO NOT use new code	9505/1
New term and code	9741/1	Indolent systemic mastocytosis	Not reportable	

** ICD-O-3 rule F applies (code the behavior stated by the pathologist). If necessary, over-ride any advisory messages.*

4 REPORTABILITY AND RECODE CHANGES EFFECTIVE IN 2015

Make the following reportability change.
Behavior code change

- ☐ Delete code and term, 8240/1, Carcinoid tumor, NOS, of appendix (C18.1).
- ☐ Code carcinoid tumor, NOS, of appendix to 8240/3. (Change made in Canada in 2012).

Recode the following conditions as shown.

- ☐ Recode all cases of enteroglucagonoma, NOS, as 8152/1. *Enteroglucagonoma is now a related term for glucagonoma.*
- ☐ Then delete code 8157/1 Enteroglucagonoma, NOS.
- ☐ Recode all cases of enteroglucagonoma, malignant as 8152/3. *Enteroglucagonoma, malignant is now a related term for glucagonoma, malignant.*
- ☐ Then delete code 8157/3 Enteroglucagonoma, malignant.

NOTE: It is important to understand that cancer registry reportability rules based on behavior code still apply. With the exception of primary intracranial and central nervous system benign and borderline tumors, the addition of a /0 or /1 coded term to ICD-O-3 does not imply that it is now reportable.

5 REMAINING ISSUES

The publication of this implementation guideline document containing the list of approved new terms and its dissemination through the United States standards setters does not mean that the job of the ICD-O-3 Update Implementation Work Group is complete. A number of other issues remain.

The review of other terms that were included in the WHO Updates List has not been completed. While the WHO "Blue Books" reflect current thinking and current terminology among pathologists and specialists, reportability to population-based cancer registries is not clear in many instances. NAACCR is taking a close look at some of the terms and the potential challenges in implementing them as reportable neoplasms in the United States. Most of the problematic terms include the words "high grade neoplasia" or "high grade dysplasia" or "severe dysplasia" in digestive system sites and breast. These dysplasia terms are not included in most states' reporting legislation. The implications of accepting these terms as reportable are being carefully studied as they may affect not only reporting legislation, but also workload in case ascertainment (casefinding), abstracting, follow-up (as applicable) and incidence reporting. The ICD-O-3 Work Group is cooperating with CRSC and the College of American Pathologists (CAP) (among others) to make recommendations on the adoption of various dysplasia terminologies for future inclusion in cancer registries. (Note: Canada has recommended the adoption and collection of all reportable high grade dysplasia tumors in the digestive system beginning with cases diagnosed on or after January 1, 2012).

In addition, other issues regarding morphology coding have been identified. These are not within the original scope of the Work Group but should be addressed soon.

- The *WHO Classifications of Soft Tissue and Bone, Breast, and Female Genital Organs* have been published since 2011. These pathology references include more new terms and codes but they have not been organized into updated lists for future adoption. More updated volumes of WHO Classification are planned, and WHO is planning further update lists as new editions of the classifications are published.

  Suggested Next steps: North American standard setting organizations provide guidance on how to handle new codes, obsolete codes, other changes, and timing of implementation. In conjunction with the assessments of the impact of additions and changes on incidence, there should be assessments of the impact on the Multiple Primary and Histology coding rules.

- Although the new edition of the Lung WHO Classification is not expected until 2015, updated terms for bronchioloalveolar carcinoma – including changes in behavior codes – are already in use by pathologists around the United States and Canada.

  Suggested Next steps: Review new terminology and provide recommendations for interim codes to disseminate for consistent use in registries long before the WHO Lung Classification is published.

- Reportability guidelines for GIST tumors has been partially addressed in a sentence added to *FORDS* 2013 and the *SEER 2013 Coding Manual*, which indicate that GIST tumors and thymomas are reportable when there is evidence of multiple foci, lymph node involvement, or metastasis.

  Suggested Next steps: North American standard setters provide additional guidance for GIST tumors, such as formal interpretation of the "risk assessment" categories as benign, borderline, or malignant.

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