

Cancer Identification

CLASS OF CASE

Item Length: 1
 Allowable Values: 0–9
 NAACCR Item #610

Description

Classifies cases recorded in the database.

Rationale

This data item divides case records into analytic and nonanalytic categories. This allows cancer programs to select cases for use within their facility or to be reported to a central registry and the National Cancer Data Base (NCDB).

Instructions for Coding

- Class of Case has ten categories 0–9. Analytic cases are coded 0–2. Nonanalytic cases are coded 3–9.
- Abstracting for Class of Case 0 and 1 is to be completed within six months of diagnosis.
- Abstracting for Class of Case 2 is to be completed within six months of first contact with the facility.
- The CoC Approvals Program does NOT require hospitals to abstract nonanalytic cases (3–9).
- The CoC does not require that Class 0 cases diagnosed on or after January 1, 2006 be followed or AJCC staged.

Code	Definition
0	Diagnosis at the reporting facility and all of the first course of treatment was performed elsewhere or the decision not to treat was made at another facility.
1	Diagnosis at the reporting facility, and all or part of the first course of treatment was performed at the reporting facility.
2	Diagnosis elsewhere, and all or part of the first course of treatment was performed at the reporting facility.
3	Diagnosis and all of the first course of treatment was performed elsewhere. Presents at your facility with recurrence or persistent disease.
4	Diagnosis and/or first course of treatment was performed at the reporting facility prior to the reference date of the registry.
5	Diagnosed at autopsy.
6	Diagnosis and all of the first course of treatment was completed by the same staff physician in an office setting. "Staff physician" is any medical staff with admitting privileges at the reporting facility.
7	Pathology report only. Patient does not enter the reporting facility at any time for diagnosis or treatment. This category excludes cases diagnosed at autopsy.
8	Diagnosis was established by death certificate only. <i>Used by central registries only.</i>
9	Unknown. Sufficient detail for determining Class of Case is not stated in patient record. <i>Used by central registries only.</i>

Examples:

Code	Reason
0	Patient enters the reporting facility with dizziness and falling, and receives a clinical workup including CT and MRI of the brain. Results are positive for multiple metastatic deposits in both lobes of the brain. CT of the lung shows 4 cm mass in the right upper lung with mediastinal and hilar adenopathy. The patient is discharged to hospital B for treatment with a diagnosis of lung cancer with metastasis to the brain.
1	Patient is admitted with hemoptysis. Workup reveals right upper lobe mass. A biopsy is positive for adenocarcinoma. The patient undergoes surgery followed by radiation therapy at same facility.
2	Patient was diagnosed and had surgery at another facility for primary breast cancer. The patient then comes to your facility for XRT.
3	Patient was diagnosed and treated for primary bladder cancer four years prior to admission. Patient is then admitted to your facility for cystectomy for recurrent bladder cancer.
5	Patient dies at home, but autopsy performed at reporting facility. No previous knowledge or suspicion of cancer.
7	Hospital pathology department received a tissue sample for evaluation which was positive for malignant melanoma. The patient never visited the hospital.

FACILITY REFERRED FROM

Item Length: 10
 Right Justified, Zero-filled
 NAACCR Item #2410

Description

Identifies the facility that referred the patient to the reporting facility.

Rationale

Each facility's identification number (FIN) is unique. This number is used to document and monitor referral patterns.

Instructions for Coding

- For facilities with seven-digit FINs in the range of 6020009–6953290 that were assigned by the CoC before January 1, 2001, the coded FIN will consist of three leading zeros followed by the full seven-digit number.
- For facilities with eight-digit FINs greater than or equal to 10000000 that were assigned by the CoC after January 1, 2001, the coded FIN will consist of two leading zeros followed by the full eight-digit number.

Code	Definition
(fill spaces)	Seven or eight-digit FIN.
0000000000	If the patient was not referred to the reporting facility from another facility.
0099999999	If the patient was referred, but the referring facility's ID number is unknown.

Examples:

Code	Reason
0006439999	6439999, General Hospital, Anytown, Illinois
0010000099	10000099, Anytown Medical Center, Anytown, Illinois

Note: A complete list of FINs is available on the American College of Surgeons Web site at <http://www.facs.org/>.

NPI–INSTITUTION REFERRED FROM

Item Length: 10
 Allowable Value: Ten digits
 NAACCR Item #2415

Description

Identifies the facility that referred the patient to the reporting facility.

Rationale

Each facility's NPI is unique. This number is used to document and monitor referral patterns.

NPI–Institution Referred From is the NPI equivalent of *Facility Referred From* (NAACCR Item #2410). Both are required during a period of transition.

Instructions for Coding

- Record the 10-digit NPI for the referring facility.
- NPI should be recorded as available for cases diagnosed during 2007, and is required to be recorded for all cases diagnosed January 1, 2008, and later.
- NPI may be blank for cases diagnosed on or before December 31, 2006.
- Check with the registry, billing, or health information departments of the facility to determine its NPI.

Code	Definition
(fill spaces)	10-digit NPI number for the facility.
(leave blank)	NPI for the referring facility is unknown or not available.

FACILITY REFERRED TO

Item Length: 10
 Right Justified, Zero-filled
 NAACCR Item #2420

Description

Identifies the facility to which the patient was referred for further care after discharge from the reporting facility.

Rationale

Each facility's identification number (FIN) is unique. This number is used to document and monitor referral patterns.

Instructions for Coding

- For facilities with seven-digit FINs in the range of 6020009–6953290 that were assigned by the CoC before January 1, 2001, the coded FIN will consist of three leading zeros followed by the full seven-digit number.
- For facilities with eight-digit FINs greater than or equal to 10000000 that were assigned by the CoC after January 1, 2001, the coded FIN will consist of two leading zeros followed by the full eight-digit number.

Code	Definition
(fill spaces)	Eight-digit facility ID number.
0000000000	If the patient was not referred to another facility.
0099999999	If the patient was referred, but the facility's ID number is unknown.

Examples:

Code	Reason
0006439999	6439999, General Hospital, Anytown, Illinois
0010000099	10000099, Anytown Medical Center, Anytown, Illinois

Note: A complete list of FINs is available on the American College of Surgeons Web site at <http://www.facs.org/>.

NPI-INSTITUTION REFERRED TO

Item Length: 10
 Allowable Value: Ten digits
 NAACCR Item #2425

Description

Identifies the facility to which the patient was referred for further care after discharge from the reporting facility.

Rationale

Each facility's NPI is unique. This number is used to document and monitor referral patterns.

NPI-Institution Referred To is the NPI equivalent of *Facility Referred To* (NAACCR Item #2420). Both are required during a period of transition.

Instructions for Coding

- Record the 10-digit NPI for the facility to which the patient was referred.
- NPI should be recorded as available for cases diagnosed during 2007, and is required to be recorded for all cases diagnosed January 1, 2008, and later.
- NPI may be blank for cases diagnosed on or before December 31, 2006.
- Check with the registry, billing, or health information departments of the facility to determine its NPI.

Code	Definition
(fill spaces)	10-digit NPI number for the facility.
(leave blank)	NPI for the facility referred to is unknown or not available.

DATE OF FIRST CONTACT

Item Length: 8
NAACCR Item #580

Description

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

Rationale

This data item allows the facility to document its first contact with the patient. It can be used to measure the time between first contact and the date that the case was abstracted. It can also be used to measure the length of time between the first contact and treatment for quality of care reports.

Instructions for Coding:

- Date the patient first had contact with the facility as either an inpatient or outpatient for diagnosis and/or treatment of a reportable tumor.
- This may be the date of an outpatient visit for a biopsy, x-ray, or laboratory test, or the date a pathology specimen was collected at the hospital.
- If this is an autopsy-only or death certificate-only case, then use the date of death.
- When a patient is diagnosed in a staff physician's office, the date of first contact is the date the patient was physically first seen at the reporting facility.

Code	Definition
MMDDCCYY	The date the patient first had contact with the reporting facility for a diagnostic procedure; review or administration of treatment; palliative care; or, for pathology-only Class of Case 7 cases, the date on which the specimen was taken. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year.
99999999	When it is unknown when the first patient contact occurred.

Month	Day	Year
01 January	01	Use four-digit year
02 February	02	9999 Year unknown
03 March	03	
04 April	...	
05 May	...	
06 June	30	
07 July	31	
08 August	99	Day unknown
09 September		
10 October		
11 November		
12 December		
99 Month unknown		

Examples:

Code	Reason
02122004	If a patient has an outpatient mammography that is suspicious for malignancy on February 12, 2004, and subsequently undergoes an excisional biopsy or radical surgical procedure on February 14, 2004, then record the date of the mammography (February 12, 2004) as the date of first contact/first admission to this facility.
09142003	Patient undergoes a biopsy in a physician's office on September 8, 2003. The pathology specimen was sent to the reporting facility and was read as malignant melanoma. The patient enters that same reporting facility on September 14, 2003 for wide reexcision.
12072004	Patient has an MRI of the brain on December 7, 2004 for symptoms including severe headache and disorientation. The MRI findings are suspicious for astrocytoma. Surgery on December 19 removes all gross tumor. The date of first contact is December 7, 2004.
09992005	If the exact date of admission to the reporting facility is not known, then record an approximate date. For example, September 2005.
04992003	If information is limited to the description "Spring," 2003.
07992003	If information is limited to the description "The middle of the year," 2003.
10992003	If information is limited to the description "Fall," 2003.
12992003 or 01992004	If information is limited to the description "Winter." Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

DATE OF INITIAL DIAGNOSISItem Length: 8
NAACCR Item #390**Description**

Records the date of initial diagnosis by a physician for the tumor being reported.

Rationale

The timing for staging and treatment of cancer begins with the date of initial diagnosis for cancer.

Instructions for Coding

- Use the first date of diagnosis whether clinically or histologically confirmed.
- If the physician states that in retrospect the patient had cancer at an earlier date, then use the earlier date as the date of diagnosis.
- Use the date therapy was started as the date of diagnosis if the patient receives a first course of treatment before a definitive diagnosis.
- Refer to the list of “Ambiguous Terms” in Section One for language that represents a diagnosis of cancer.
- The date of death is the date of diagnosis for a Class of Case 5.
- Use the *Date of Birth* as the *Date of Initial Diagnosis* for an in-utero diagnosis.

Code	Definition
MMDDCCYY	The date of initial diagnosis is the month, day, and year that this primary cancer was first diagnosed by a recognized medical practitioner. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year. <i>Note:</i> If the exact date on which the diagnosis was made is not available, then record an approximate date.
99999999	When the date of initial diagnosis is unknown. Approximation is preferable to recording the date as unknown.

Month	Day	Year
01 January	01	Use four-digit year
02 February	02	9999 Year unknown
03 March	03	
04 April	...	
05 May	...	
06 June	30	
07 July	31	
08 August	99	Day unknown
09 September		
10 October		
11 November		
12 December		
99 Month unknown		

Examples:

Code	Reason
06302005	June 30, 2005
03122005	A March 12, 2005 mammogram reveals a mass in the upper-outer quadrant of a patient's right breast compatible with carcinoma. On March 20, 2005, the patient has an excisional breast biopsy that confirms infiltrating ductal carcinoma.
05122003	A physician notes a prostate nodule that is suspicious for cancer during a May 12, 2003 physical examination. On June 15, 2003, an ultrasound guided needle biopsy of the prostate provides histologic confirmation of adenocarcinoma.
01992004	A patient has a total abdominal hysterectomy for endometriosis in January 2004. The patient is admitted to the hospital with abdominal pain and distention in November 2005. A laparoscopy with omental biopsy shows metastatic cystadenocarcinoma. Pathologists review the 2004 hysterectomy specimen. They identify an area of cystadenocarcinoma in the left ovary.
09992005	If the exact date of the beginning of treatment is not available, then record an approximate date. For example, September 2005.
04992003	If information is limited to the description "Spring," 2003.
07992003	If information is limited to the description "The middle of the year," 2003.
10992003	If information is limited to the description "Fall," 2003.
12992003 or 01992004	If information is limited to the description "Winter." Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

PRIMARY SITEItem Length: 4
NAACCR Item #400**Description**

Identifies the primary site.

Rationale

Primary site is a basis for staging and the determination of treatment options. It also affects the prognosis and course of the disease.

Instructions for Coding

- Record the ICD-O-3* topography code for the site of origin.
- Consult the physician advisor to identify the primary site or the most definitive site code if the medical record does not contain that information.
- Primary site codes may be found in the ICD-O-3 Topography, Numerical List section (ICD-O-3, p. 43) and in the Alphabetic Index (ICD-O-3, p. 105).
- Topography codes are indicated by a “C” preceding the three-digit code number (do not record the decimal point).
- Follow the coding rules outlined in ICD-O-3, pp. 20–40.
- Use subcategory 8 for single tumors that overlap the boundaries of two or more sub-sites and the point of origin is not known.
- Use subcategory 9 for multiple tumors that originate in one organ.
- Code adenocarcinoma in multiple polyps as a single primary even if they involve more than one segment of the colon.
- Code leukemias to bone marrow (C42.1).

EXCEPTION: Code myeloid sarcoma to the site of origin (see ICD-O-3 for coding rules).**Examples:**

Code	Reason
C108	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.
C678	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.
C679	Bladder, NOS. Use subcategory 9 when multiple lesions arise in both the bladder trigone (C67.0) and lateral wall (C67.2).
C189	Colon, NOS. Familial polyposis with carcinoma and carcinoma in situ throughout the transverse (C18.4) and descending colon (C18.6) would be one primary and coded to colon, NOS (C18.9). For a full explanation see the <i>SEER 2007 Multiple Primary and Histology Rules</i> .
C16–	Stomach (sub-site as identified). An extranodal lymphoma of the stomach would be coded to C16.– (sub-site as identified).

*International Classification of Diseases for Oncology, Third Edition (ICD-O-3)

LATERALITY

Item Length: 1
 Allowable Values: 0–4, 9
 NAACCR Item #410

Description

Identifies the side of a paired organ or the side of the body on which the reportable tumor originated. This applies to the primary site only.

Rationale

Laterality supplements staging and extent of disease information and defines the number of primaries involved.

Instructions for Coding

- Code laterality for all paired sites. (See Section One for additional information.)
- Code all nonpaired sites 0. (See Section One for additional information.)
- Record laterality for unknown primary site (C80.9) as 0 (not a paired site).
- Do not code metastatic sites as bilateral involvement.
- Code midline lesions 9.

Code	Definition
0	Organ is not considered to be a paired site.
1	Origin of primary is right.
2	Origin of primary is left.
3	Only one side involved, right or left origin not specified.
4	Bilateral involvement, side of origin unknown, stated to be a single primary. This includes: <ul style="list-style-type: none"> • Both ovaries simultaneously involved with a single histology • Bilateral retinoblastomas • Bilateral Wilms' tumors
9	Paired site, but lateral origin unknown; midline tumor.

HISTOLOGYItem Length: 4
NAACCR Item #522**Description**

Identifies the microscopic anatomy of cells.

Rationale

Histology is a basis for staging and the determination of treatment options. It also affects the prognosis and course of the disease.

Instructions for Coding

- Record histology using the ICD-O-3 codes in the Numeric Lists/Morphology section (ICD-O-3, pp. 69–104) and in the Alphabetic Index (ICD-O-3, pp. 105–218).
- ICD-O-3 identifies the morphology codes with an “M” preceding the code number. Do not record the “M.”
- Follow the coding rules outlined on pages 20 through 40 of ICD-O-3.
- Use the SEER 2007 Multiple Primary and Histology Coding Rules when coding the histology for all reportable solid malignant tumors. These rules are effective for cases diagnosed January 1, 2007, or later. Do not use these rules to abstract cases diagnosed prior to January 1, 2007.
- Review all pathology reports.
- Code the **final** pathologic diagnosis.

EXCEPTION: If the final diagnosis is “Not Otherwise Specified” (carcinoma, NOS; melanoma, NOS; sarcoma, NOS; lymphoma, NOS; or malignant tumor, NOS), then code the histology from the microscopic description or comment if it identifies a more specific histologic type (higher ICD-O-3 code) such as adenocarcinoma, amelanotic melanoma, spindle cell sarcoma.

- The codes for cancer, NOS (8000) and carcinoma, NOS (8010) are **not** interchangeable. If the physician says that the patient has carcinoma, then code carcinoma, NOS (8010).
- Lymphomas may be classified by the Rappaport classification or the Working Formulation. If both systems are used to classify the disease, then the term used to describe the lymphoma may differ. The Working Formulation term should take precedence (ICD-O-3, pp. 13–18).

Examples:

Code	Label	Definition
8140	Adenocarcinoma	Final pathologic diagnosis is carcinoma, NOS (8010) of the prostate. Microscopic diagnosis specifies adenocarcinoma (8140) of the prostate.
9680	Diffuse large B-cell lymphoma	Diffuse large B-cell lymphoma, per the WHO Classification of Hematopoietic and Lymphoid Neoplasms.

BEHAVIOR CODE

Item Length: 1
 Allowable Values: 0–3
 NAACCR Item #523

Description

Records the behavior of the tumor being reported. The fifth digit of the morphology code is the behavior code.

Rationale

The behavior code is used by pathologists to describe whether tissue samples are benign (0), borderline (1), in situ (2), or malignant (3).

Instructions for Coding

- Code 3 if any invasion is present, no matter how limited.
- If the specimen is from a metastatic site, code the histology of the metastatic site and code 3 for behavior.

Note: The ICD-O-3 behavior code for juvenile astrocytoma (9421/1) is coded as 3. Refer to “Case Eligibility” in Section One for information.

Code	Label	Definition
0	Benign	Benign
1	Borderline	Uncertain whether benign or malignant.
		Borderline malignancy.
		Low malignant potential.
		Uncertain malignant potential.
2	In situ and/or carcinoma in situ	Adenocarcinoma in an adenomatous polyp with no invasion of stalk.
		Clark level 1 for melanoma (limited to epithelium).
		Comedocarcinoma, noninfiltrating (C50.-).
2	Synonymous with in situ	Confined to epithelium.
		Hutchinson melanotic freckle, NOS (C44.-).
		Intracystic, noninfiltrating.
		Intraductal.
		Intraepidermal, NOS.
		Intraepithelial, NOS.
		Involvement up to, but not including the basement membrane.
		Lentigo maligna (C44.-).
		Lobular neoplasia (C50.-).
		Lobular, noninfiltrating (C50.-).
		Noninfiltrating.
		Noninvasive.
No stromal involvement.		

Code	Label	Definition
2		Papillary, noninfiltrating or intraductal.
		Precancerous melanosis (C44.-).
		Queyrat erythroplasia (C60.-).
3	Invasive	Invasive or microinvasive.

Example:

Code	Reason
3	Intraductal carcinoma (8500/2) with focal areas of invasion.

GRADE/DIFFERENTIATION

Item Length: 1
Allowable Values: 1–9
NAACCR Item #440

Description

Describes the tumor's resemblance to normal tissue. Well differentiated (Grade I) is the most like normal tissue, and undifferentiated (Grade IV) is the least like normal tissue.

Rationale

This data item is useful for prognosis.

Instructions for Coding

- Code grade according to ICD-O-3 (pp. 30–31 and 67).
- Code the grade or differentiation as stated in the **final** pathologic diagnosis. If the differentiation is not stated in the final pathologic diagnosis, use the information from the microscopic description or comments.
- When the pathology report(s) lists more than one grade of tumor, code to the highest grade, even if the highest grade is only a focus (Rule G, ICD-O-3, p. 21).
- Code the grade or differentiation from the pathologic examination of the primary tumor, not from metastatic sites.
- When there is no tissue diagnosis, it may be possible to establish grade through magnetic resonance imaging (MRI) or positron emission tomography (PET). When available, code grade based on the recorded findings from these imaging reports.
- If the primary site is unknown, code the grade/differentiation as 9 (Unknown).
- Code the grade for in situ lesions if the information is available. If the lesion is both invasive and in situ, code only the invasive portion. If the invasive component grade is unknown, then code 9.
- **Do not** use “high grade,” “low grade,” or “intermediate grade” descriptions for lymphomas as a basis for differentiation. These terms are categories in the Working Formulation of Lymphoma Diagnoses and do not relate to the grade.
- Codes 5–8 define T-cell or B-cell origin for leukemias and lymphomas. T-cell, B-cell, or null cell classifications have precedence over grading or differentiation.
- Do not use the WHO grade to code this data item.
- If no grade is given for astrocytomas, then code 9 (Unknown).
- If no grade is given for glioblastoma multiforme, then code 9 (Unknown).

Code	Grade/Cell	Label
1	Grade I,1,i	Well differentiated; differentiated, NOS
2	Grade II,2,ii I/III or 1/3	Moderately differentiated; moderately well differentiated; intermediate differentiation
3	Grade III,3,iii II/III or 2/3	Poorly differentiated
4	Grade IV,4,iv III/III or 3/3	Undifferentiated; anaplastic
For Lymphomas and Leukemias		
5		T cell; T-precursor
6		B cell; pre-B; B-precursor
7		Null cell; non T-non B
8		NK (natural killer) cell (effective with diagnosis 1/1/95 and after)
For Use in All Histologies		
9		Cell type not determined, not stated or not applicable; unknown primaries; high grade dysplasia (adenocarcinoma in situ)

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DIAGNOSTIC CONFIRMATION

Item Length: 1
 Allowable Values: 1, 2, 4–9
 NAACCR Item #490

Description

Records the best method of diagnostic confirmation of the cancer being reported at any time in the patient's history.

Rationale

It is often useful to calculate the percent of microscopically confirmed cancers. The percentage of cases that are clinically diagnosed only is an indication of whether casefinding is including sources outside of pathology reports. Full incidence calculations must include both clinically and pathologically confirmed cases.

Instructions for Coding

- This is a hierarchical schema to identify how the malignancy was determined—from histologic confirmation (1) being most precise to unknown (9) being the least. Code 1 is the highest determination and takes precedence.
- This data item must be changed to the lower code if a more definitive method confirms the diagnosis at any time during the course of the disease.
- Code 1 for positive hematologic findings and bone marrow specimens for leukemia, including peripheral blood smears and aspiration biopsies.
- Code 2 for positive brushings, washings, cell aspiration, and hematologic findings (except for leukemia).

Code	Label	Definition
1	Positive histology	Histologic confirmation (tissue microscopically examined).
2	Positive cytology	Cytologic confirmation (no tissue microscopically examined; fluid cells microscopically examined).
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.
5	Positive laboratory test/marker study	A clinical diagnosis of cancer is based on laboratory tests/marker studies which are clinically diagnostic for cancer. This includes alpha-fetoprotein for liver cancer and abnormal electrophoretic spike for multiple myeloma. Elevated PSA is nondiagnostic of cancer. If the physician uses the PSA as a basis for diagnosing prostate cancer with no other workup, record as code 5. (Adapted from SEER.)
6	Direct visualization without microscopic confirmation	The tumor was visualized during a surgical/endoscopic procedure only with no tissue resected for microscopic examination.
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 malignancy was reported by the physician in the medical record. Refer to Section One—Ambiguous Terminology.
9	Unknown whether or not microscopically confirmed	A statement of malignancy was reported in the medical record, but there is no statement of how the cancer was diagnosed (usually Class of Case 3).

AMBIGUOUS TERMINOLOGY DIAGNOSIS

Item Length: 1

Allowable Values: 0, 1, 2, and 9

NAACCR Item #442

Description

Identifies cases for which an ambiguous term is the most definitive word or phrase used to establish a cancer diagnosis.

Rationale

This data item allows cases to be identified within an analysis file. It also allows these cases to be identified and excluded from patient contact studies.

Instructions for Coding

- Refer to Section One for a list of ambiguous terms that constitute a diagnosis of cancer.
- Code 2 cases are those that were originally diagnosed based only on ambiguous terminology; then, more than two months after the initial diagnosis, a conclusive diagnosis was made by any diagnostic method including, but not limited to, clinical diagnosis, cytology, pathology, or autopsy.
- Leave blank for cases diagnosed on or before December 31, 2006.

Code	Definition
0	Conclusive term(s): Diagnosis based on a definitive statement of malignancy within two months of the original diagnosis.
1	Ambiguous term(s) only: Diagnosis based on ambiguous terminology within two months of initial diagnosis (diagnosis from a pathology report, cytology report, or radiology report or in the medical record). Update to 2 if a definitive diagnosis is made more than 2 months later.
2	Conclusive cancer diagnosis, by any method, more than two months following an initial diagnosis based on ambiguous terminology.
9	Unknown if diagnosis was based on ambiguous terminology.
(leave blank)	Case diagnosed on or before December 31, 2006.

Examples:

Code	Reason
0	Pathology report stated adenocarcinoma in TURP chips. No prior diagnosis based on ambiguous terminology.
0	Mammogram suspicious for ductal carcinoma in situ. Pathology from lumpectomy two weeks later confirmed ductal carcinoma in situ.
1	MRI of chest shows a malignant appearing lesion in the right upper lobe of lung. Patient refused further work-up or treatment.
1	Patient with elevated PSA is admitted for TRUS. Pathology from biopsy states, "prostatic chips consistent with carcinoma." No further information is available.
2	Biopsy of thyroid reads, "most likely thyroid cancer." Three months later, a biopsy is positive for papillary follicular cancer. Initially the case would have been coded 1 (ambiguous terminology only). Because of the conclusive term in the biopsy, the code is changed to 2.
9	Discharge summary states patient has adenocarcinoma of the prostate. No other information available.
(leave blank)	Patient diagnosed 11/25/06 at another facility and treated at reporting facility 1/27/07.

Note: Programs are not required by CoC to collect cases that contain ambiguous terms describing a cytology diagnosis.

DATE OF CONCLUSIVE DIAGNOSISItem Length: 8
NAACCR Item #443**Description**

Records the date when a conclusive cancer diagnosis (based on definitive statement of malignancy) is made following an initial diagnosis that was based only on ambiguous terminology. The date of the conclusive diagnosis must be more than two months following the initial (ambiguous terminology only) diagnosis.

If the date of conclusive diagnosis is within two months following the initial (ambiguous terminology only) diagnosis, the case does not meet the criteria for ambiguous terminology only.

Rationale

This date item allows for analysis of the time interval between cancer diagnosis based on ambiguous terminology and confirmation of the cancer diagnosis by conclusive means.

Instructions for Coding

- The date must be greater than two months from the date of initial diagnosis.
- Record the date a conclusive diagnosis was made based on a definitive statement of malignancy.
- Leave blank for cases diagnosed on or before December 31, 2006.

Code	Definition
00000000	No conclusive diagnosis made; the only diagnosis was by ambiguous terminology.
MMDDCCYY	The date the conclusive cancer diagnosis is made at least 2 months after an initial diagnosis based on ambiguous terminology.
88888888	Not applicable; initial diagnosis made by definitive terminology.
99999999	Unknown date, unknown if diagnosis based on ambiguous terminology.
(leave blank)	Patient was diagnosed on or before December 31, 2006.

Month

01 January
02 February
03 March
04 April
05 May
06 June
07 July
08 August
09 September
10 October
11 November
12 December
99 Month unknown

Day

01
02
03
...
...
30
31
99 Day unknown

Year

Use four-digit year
9999 Year unknown

Examples:

Code	Reason
00000000	CT of chest 09/12/2007 states suspicious for lung cancer. No further work-up or treatment.
12302007	Pathology report for the case above dated 12/30/2007, states "small cell carcinoma of the left lower lobe, lung." Changed from 00000000 based on pathology report 2 or more months after initial diagnosis based on ambiguous terminology.
88888888	Patient diagnosed with Non-Hodgkin's lymphoma.
99992007	Consult report states, "patient had TURP for adenocarcinoma of the prostate in 2007."
99999999	Discharge summary states patient has prostate cancer; no other diagnostic or treatment information available.
(leave blank)	Patient had mastectomy at another facility 11/29/2006. Seen at reporting facility in 2007 for radiation therapy.

DATE OF MULTIPLE TUMORS

Item length: 8

NAACCR Item #445

Description

Identifies the date the patient is diagnosed with multiple or subsequent reportable tumor(s) reported as a single primary. Multiple tumors must have the same histologic group as the original tumor and must be located in the same organ or primary site as the original tumor, using the primary site and histology coding rules.

Rationale

This data item allows for the separation of cases with multiple reportable tumors present at the time of initial diagnosis from cases with subsequent reportable tumors. The date allows for tracking the time interval between the date of original diagnosis and the first date of subsequent tumor(s) for specific primary sites and tumor histologies.

Instructions for Coding

- Record the date the patient is diagnosed with synchronous multiple tumors abstracted as a single primary.
- Record the *Date of Initial Diagnosis* as the *Date of Multiple Tumors* when reportable tumors are abstracted and reported as a single primary at the time of initial diagnosis.
- The *Date of Multiple Tumors* must occur within the time specified by the SEER 2007 Multiple Primary and Histology Coding Rules following the site-specific rules, when available.
- Use 88888888 for leukemia (M9800–M9949), lymphoma (M9590–M9729), immunoproliferative disease (M9760–M9769), and unknown primaries (C80.9).
- Leave blank for cases diagnosed on or before December 31, 2006.

Code	Definition
00000000	Single tumor.
MMDDCCYY	The date that multiple tumors from the same primary are identified.
88888888	Information on multiple tumors is not applicable for this site.
9999CCYY	Day and month are unknown, year is known.
99999999	Unknown date.
(leave blank)	Case diagnosed on or before December 31, 2006.

Month

01 January
 02 February
 03 March
 04 April
 05 May
 06 June
 07 July
 08 August
 09 September
 10 October
 11 November
 12 December
 99 Month unknown

Day

01
 02
 03
 ...
 ...
 30
 31
 99 Day unknown

Year

Use four-digit year
 9999 Year unknown

Examples:

Code	Reason
00000000	Pathology from colon resection: 2 cm adenocarcinoma of the ascending colon. No other tumor is mentioned.
05212007	5/21/07: Mastectomy, patient has multiple tumors: a 2 cm infiltrating ductal carcinoma in the lower inner quadrant and a 1 cm infiltrating ductal carcinoma of the upper inner quadrant of the left breast.
04132007	Results from 4/13/07 TURB pathology report shows papillary transitional cell carcinoma present in tissue from bladder neck, dome and posterior wall. Using the bladder, renal pelvis, and ureter multiple primary rules, these tumors are accessioned as a single primary.
88888888	Biopsy of multiple lymph nodes shows B cell lymphoma.
99999999	Patient seen at reporting facility for palliative care following treatment for multiple colon tumors. No other information is available.
(leave blank)	Patient diagnosed at other facility 12/27/2006 and seen at reporting facility for surgery 1/10/2007.

MULTIPLE TUMORS REPORTED AS ONE PRIMARY

Item Length: 2
Allowable Values: 00, 10–12, 20,
30–32, 40, 80, 88, 99
NAACCR Item #444

Description

Identifies cases with multiple tumors that are abstracted as a single primary using the multiple primary rules. Multiple tumors may individually exhibit in situ, invasive, or any combination of in situ and invasive behaviors. Multiple intracranial and central nervous system tumors may individually exhibit benign, borderline, malignant, or any combination of these behaviors. Multiple tumors found in the same organ or in a single primary site may occur at the same time of initial diagnosis or within the time specified by the SEER 2007 Multiple Primary and Histology Coding Rules.

Rationale

Patients with multiple tumors that are reported as a single primary for surveillance purposes may have a worse prognosis or more extensive treatment than patients with a single tumor. This data item makes it possible to identify important information about these cases for data analysis. Data collected for this item are used to assess the number, type, and anatomic location of multiple tumors currently abstracted as a single primary using the rules for determining multiple primary cancers and the impact these cases have on cancer case counts and incidence rates.

Instructions for Coding

- The data item does not apply to metastatic tumors.
- This data item is used when a physician states that there are two or more primaries, but for surveillance purposes, the case is reported as a single primary.
- Use 88 for leukemia (M9800–M9949), lymphoma (M9590–M9729), immunoproliferative disease (M9760–M9769), and unknown primaries (C80.9).
- Leave blank for cases diagnosed on or before December 31, 2006.

Code	Definition
00	Single tumor. Includes single tumor with both in situ and invasive components.
10	At least two benign tumors in the same organ or primary site (Behavior = 0).
11	At least two borderline tumors in the same organ/primary site (Behavior = 1).
12	At least one benign AND at least one borderline tumors in the same organ/primary site.
20	At least two in situ tumors in the same organ/primary site (Behavior = 2).
30	One or more in situ tumor(s) AND one or more invasive tumor(s) in the same organ/primary site.
31	One or more polyps with either in situ carcinoma or invasive carcinoma AND one or more frank adenocarcinoma(s) in the same segment of colon, rectosigmoid, and/or rectum.
32	Diagnosis of Familial Polyposis (FAP) AND carcinoma (in situ or invasive) is present in at least one of the polyps.
40	At least two invasive tumors in the same organ (Behavior = 3).
80	Multiple tumors present in the same organ/primary site, unknown if in situ or invasive.
88	Information on multiple tumors is not applicable for this site.
99	Unknown if multiple tumors, death certificate only cases.
(leave blank)	Patient was diagnosed on or before December 31, 2006.

MULTIPLICITY COUNTER

Item length: 2

Allowable Values: 01–88, 99

NAACCR Item #446

Description

Records the number of tumors (multiplicity) reported as a single primary.

Rationale

Patients with multiple tumors reported as a single primary for surveillance purposes may have a worse prognosis and more extensive treatment than patients with a single tumor. This data item will make it possible to identify important information about these cases for data analysis.

Data collected for this item will be used to assess the number, type, and anatomic location of multiple reportable tumors currently abstracted as a single primary and the impact of these cases on cancer case counts and incidence rates.

Instructions for Coding

- Use the multiple primary rules for the specific site to determine whether the tumors are a single primary or multiple primaries.
- Code the number of tumors being abstracted as a single primary.
- Do not count metastasis.
- Use code 01 when:
 - There is a single tumor in the primary site being abstracted
 - There is a single tumor with separate foci of tumor
 - It is unknown if there is a single tumor or multiple tumors and the multiple primary rules instructed you to default to a single tumor
- Use code 88 for:
 - Leukemia (M9800–M9949)
 - Lymphoma (M9590–M9729)
 - Immunoproliferative disease (M9760–M9769)
 - Unknown primary (C80.9)
- Use code 99 when:
 - The original pathology report is not available and the documentation does not specify whether there was a single tumor or multiple tumors in the primary site
 - The tumor is described as multifocal or multicentric
 - The tumor is described as diffuse
 - The operative or pathology report describes multiple tumors, but does not give an exact number
- Leave blank for cases diagnosed on or before December 31, 2006.

Code	Definition
01	One tumor only.
02	Two tumors present.
03	Three tumors present.
04–87	Four through eighty-seven or more tumors present.
88	Information on multiple tumors not applicable for this site.
99	Multiple tumors present, unknown how many.
(leave blank)	Patient was diagnosed on or before December 31, 2006.

Examples:

Code	Reason
01	Pathology from colon resection shows a 3 cm adenocarcinoma in the ascending colon.
01	Pathology from colon resection shows a 3 cm adenocarcinoma in the ascending colon. Biopsy of liver shows a solitary metastatic lesion compatible with the colon primary.
02	The patient has a 2 cm infiltrating ductal carcinoma in the lower inner quadrant of the left breast and a 1 cm infiltrating ductal carcinoma in the upper inner quadrant of the left breast.
03	CT of chest shows two lesions in the left lung and a single lesion in the right lung. Biopsy of the right lung lesions shows adenocarcinoma. No other work-up is done. Using the multiple primary rules for lung, the case is abstracted as a single primary and multiplicity counter is 3.
88	Patient is diagnosed with Non-Hodgkin lymphoma.
99	Pathology report for TURB mentions multiple bladder tumors. Pathology report states papillary transitional cell carcinoma present in tissue from bladder neck, dome, and posterior wall.
(leave blank)	Pathology report from a 12/30/2006 colonoscopy states patient has 2 lesions in the ascending colon.

TUMOR SIZE

Item Length: 3

Allowable Values: 000–990, 999

NAACCR Item #780

Description

Describes the largest dimension of the diameter of the primary tumor in millimeters (mm).

Rationale

Tumor size is an important prognostic factor for cancer.

Instructions for Coding

- **Code this data item for cases diagnosed on or before December 31, 2003.**

- Code tumor size using *CS Tumor Size* (NAACCR Item #2800) for cases diagnosed on or after January 1, 2004.

- Code the exact size of the primary tumor in millimeters (mm).

Converting units of measure:

- 1 mm is one-tenth of a centimeter (cm), thus, a 20-mm or 2-cm tumor is coded as 020.

EXCEPTION:

- For melanomas of the skin (C44.0–C44.9), vulva (C51.0–C51.9), penis (C60.0–C60.9), scrotum (C63.2), and conjunctiva (C69.0), code the depth of invasion in HUNDREDTHS of millimeters.
- Code 989 for melanomas of the skin (C44.0–C44.9), vulva (C51.0–C51.9), penis (C60.0–C60.0), scrotum (C63.3), and conjunctiva (C69.0) which are 9.89 mm or greater in depth.
- Code the largest dimension or diameter of the tumor, whether it is from a biopsy specimen or the complete resection of the primary tumor.
- Code the size of the primary tumor, not the size of polyps, ulcers, cysts, or metastases.
- Record the size of the tumor from the pathology report, if available.
- Information on tumor size from imaging/radiographic techniques can be used to code size, but should be taken as low priority, just above physical exam.
- Code 001 for tumors less than 1 mm in size.
- Code the size as stated for purely *in situ* tumors.
- If both an *in situ* and an invasive component are present, and each is measured, code the size of the invasive component even if it is smaller.
- Code 998 when following terms describe tumor involvement for these specified sites:
 - Esophagus (C15.0–C15.5, C15.8, C15.9): Entire circumference.
 - Stomach (C16.0–C16.6, C16.8, C16.9): Diffuse, widespread, $\frac{3}{4}$ or more, linitis plastica.
 - Colorectal (C18.0–C20.9 with M-8220/8221 and /2 or /3): Familial/multiple polyposis.
 - Lung and main stem bronchus (C34.0–C34.3, C34.8, C34.9): Diffuse, entire lobe or lung.
 - Breast (C50.0–C50.6, C50.8, C50.9): Inflammatory carcinoma; diffuse, widespread, $\frac{3}{4}$ or more of breast.
- Code 999, unknown, if only one size is given for a mixed *in situ* and invasive tumor.
- Code the size of the residual tumor if an excisional biopsy is performed and residual tumor at time of resection of the primary site is found to be larger than the excisional biopsy.
- **Do not** add pieces or chips together to create a whole; they may not be from the same location, or the may represent only a very small portion of a large tumor.
- Code 999 if the size of the tumor is unknown or the tumor size is not documented in the patient record.
- Code 999 for histologies or sites where size is not applicable:
 - Unknown or ill-defined primary (C76.0–C76.8, C80.9)
 - Hematopoietic, reticuloendothelial, immunoproliferative or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4 and/or M-9750, 9760–9764, 9800–9820, 9826, 9831–9920, 9931–9964, 9980–9989)
 - Multiple myeloma (9732)
 - Letterer-Siwe disease (9754)

- Code 999 for a needle biopsy specimen.
- If the patient received neoadjuvant (presurgical) radiation or systemic therapy (chemotherapy, hormone therapy, and/or immunotherapy), then code the size of tumor documented prior to the start of first course therapy, **do not** code the size of tumor recorded in the pathology report.

Code	Definition
000	No mass or tumor found, ie, a tumor of a stated primary site is not found, but the tumor has metastasized.
001–988	Exact size in millimeters.
989	989 millimeters or larger; melanomas greater than or equal to 9.89 mm in depth.
990	Microscopic focus or foci only, no size is given.
998	Tumor involvement of specified esophageal, stomach, colorectal, lung and main stem bronchus, and breast primaries. See coding instructions.
999	Unknown; size not stated; not stated in patient record; not applicable.

Examples:

Code	Reason
013	A patient with lung cancer is described as having a 1-cm nodule in the right upper lobe and a 1.3-cm nodule in the right middle lobe of the lung. Code the size of the largest nodule as 13 mm.
044	A pathology report describes the tumor size as 3 x 4.4 x 2.5 cm. Code the largest diameter of the tumor as 44 mm.
001	A pathology report describes a specimen that measures 2 x 3 cm with a focus (microscopic) of infiltrating carcinoma. Code microscopic focus as 1 mm.
010	A pathology report describes a breast mass as 2- x 1.5-cm intraductal carcinoma and a 1-cm nodule of infiltrating ductal carcinoma. Code the invasive component as 10 mm.
045	A patient with melanoma of the skin has the primary tumor excised, and the thickness of the tumor was measured as 0.45 mm. Code the depth of invasion in HUNDREDTHS of mm or 45.

REGIONAL LYMPH NODES EXAMINED

Item Length: 2

Allowable Values: 00–90, 95–99

NAACCR Item #830

Description

Records the total number of regional lymph nodes that were removed and examined by the pathologist. Beginning with cases diagnosed on or after January 1, 2004, this item is a component of the Collaborative Staging System (CS).

Rationale

This data item serves as a quality measure of the pathologic and surgical evaluation and treatment of the patient.

Instructions for Coding

- Only record information about regional lymph nodes in this data item. Involved distant lymph nodes should be coded in *CS Mets at Dx* (NAACCR Item #2850).
- This data item is based on pathology information only. If no lymph nodes were removed for examination, or if a lymph node drainage area was removed, but no lymph nodes were found, code 00.
- Record the total number of regional lymph nodes removed and examined by the pathologist.
 - 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.
 - Code 98 if lymph nodes are aspirated and other lymph nodes are removed.
 - This data item is to be recorded regardless of whether the patient received preoperative treatment.
- If a lymph node biopsy was performed, code the number of nodes removed, if known. If the number of nodes removed by biopsy is not known, code 96.
- Code 99 for the following primary sites and histologies:
 - Placenta (C58.9)
 - Brain and Cerebral Meninges (C70.0, C71.0–C71.9)
 - Other Parts of Central Nervous System (C70.1, C70.9, C72.0–C72.5, C72.8–C72.9)
 - Hodgkin and non-Hodgkin Lymphoma (M-959–972) EXCEPT 9700/3 and 9701/3)
 - Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms (M-9731–9734, 9740–9742, 9750–9758, 9760–9762, 9764–9769, 9800–9801, 9805, 9820, 9823, 9826–827, 9831–9837, 9840, 9860–9861, 9863, 9866–9867, 9870–9876, 9891, 9895–9897, 9910, 9920, 9930–9931, 9940, 9945–9946, 9948, 9950, 9960–9964, 9970, 9975, 9980, 9982–9987, 9989)
 - Unknown and Ill-Defined Primary Sites (C42.0–C42.4, C76.0–C76.5, C76.7–C76.8, C77.0–C77.5, C77.8–C77.9, C80.9; Note: For C42._ and C77._, other than hematopoietic, reticuloendothelial, immunoproliferative and myeloproliferative neoplasms as listed above, Hodgkin and non-Hodgkin Lymphomas as listed above, and Kaposi sarcoma 9140/3)

Code	Description
00	No nodes were examined.
01–89	1–89 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.

Code	Description
98	Regional lymph nodes were surgically removed, but the number of lymph nodes is unknown/not stated and not documented as a sampling or dissection; nodes were examined, but the number is unknown.
99	It is unknown whether nodes were examined; not applicable or negative; not stated in patient record.

REGIONAL LYMPH NODES POSITIVE

Item Length: 2
 Allowable Values: 00–99
 Right Justified, Zero-filled
 NAACCR Item #820

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 is a component of the Collaborative Staging System (CS).

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.

Instructions for Coding

- Only record information about regional lymph nodes in this item. Involved distant lymph nodes should be coded in *CS Mets at Dx* (NAACCR Item #2850).
- This item is based on pathology information only. If no lymph nodes were removed for examination, or if a lymph node drainage area was removed, but no lymph nodes were found, code 98.
- Record the total number of regional lymph nodes removed and found to be positive by pathologic examination.
 - 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.
 - This item is to be recorded regardless of whether the patient received preoperative treatment.
- Any combination of positive aspirated, biopsied, sampled or dissected lymph nodes is coded 97 if the number of involved nodes cannot be determined on the basis of cytology or histology.
- Code 99 for the following primary sites and histologies:
 - Placenta (C58.9)
 - Brain and Cerebral Meninges (C70.0, C71.0–C71.9)
 - Other Parts of Central Nervous System (C70.1, C70.9, C72.0–C72.5, C72.8–C72.9)
 - Hodgkin and non-Hodgkin Lymphoma (M-959–972 EXCEPT 9700/3 and 9701/3)
 - Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative

Neoplasms

(M-9731–9734, 9740–9742, 9750–9758, 9760–9762, 9764–9769, 9800–9801, 9805, 9820, 9823, 9826–9827, 9831–9837, 9840, 9860–9861, 9863, 9866–9867, 9870–9876, 9891, 9895–9897, 9910, 9920, 9930–9931, 9940, 9945–9946, 9948, 9950, 9960–9964, 9970, 9975, 9980, 9982–9987, 9989)

Unknown and Ill-Defined Primary Sites

(C42.0–C42.4, C76.0–C76.5, C76.7–C76.8, C77.0–C77.5, C77.8–C77.9, C80.9; Note: For C42._ and C77._, other than hematopoietic, reticuloendothelial, immunoproliferative and myeloproliferative neoplasms as listed above, Hodgkin and non-Hodgkin Lymphomas as listed above, and Kaposi sarcoma 9140/3)

Code	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 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.

