

**APPENDIX C:  
FORDS Page Revisions**



## ***FORDS: An Evolving Data Manual***

Following the initial release of *FORDS* in July 2002, the manual has undergone a series of modifications and revisions. All revisions have been made to the online edition of the manual and have been available to registries effective the date of revision.

This edition contains all the necessary additional documentation to support changes in case reporting to accommodate non-malignant brain/CNS tumors, Collaborative Staging, National Provider Identifier codes, and the 2007 Multiple Primary and Histology Rules.

Appendix C provides specific descriptions of all the revisions made to *FORDS* since its original publication in July 2002. This Appendix has been reorganized to reflect changes according to the year in which they occurred. Subsequent to this, revisions are listed in the order in which the material appears in the manual. They begin with the Section followed by the data item name, page number, NAACCR item number, date of the revision, and an explicit description of the revision. (Data item name and page number are not applicable to the changes in Section One. These are listed by year only.)

Specific questions regarding these revisions may be directed to either of the editors of *FORDS: Revised for 2007*, Jerri Linn Phillips, CTR ([jphillips@facs.org](mailto:jphillips@facs.org)) or Andrew K. Stewart, MA ([astewart@facs.org](mailto:astewart@facs.org)). All other *FORDS*-related questions should be directed to the CoC's Inquiry and Response System (I&R) at <http://web.facs.org/coc/default.htm>.

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### CHANGES TO *FORDS* SECTION ONE

#### **2006**

9/1/06

TUMORS REQUIRED BY THE CoC TO BE ACCESSIONED, ABSTRACTED, AND FOLLOWED was revised as follows (p.4):

#### *Examples of Diagnostic Terms:*

- The inpatient discharge summary documents a chest x-ray *consistent with carcinoma* of the right upper lobe. The patient refused further work-up or treatment. *Consistent with carcinoma* is indicative of cancer.
- The mammogram report states *suspicious for malignancy*. *Suspicious for malignancy* is indicative of cancer.

#### *Examples of Nondiagnostic Terms:*

- The inpatient discharge summary documents a chest x-ray *consistent with neoplasm* of the right upper lobe. The patient refused further work-up or treatment. *Consistent with neoplasm* is not indicative of cancer. While “consistent with” can indicate involvement, “neoplasm” without specification of malignancy is not considered diagnostic except for non-malignant primary intracranial and central nervous system tumors.
- Final diagnosis is reported as *possible carcinoma* of the breast. *Possible* is not a diagnostic term for cancer.

Genetic findings in the absence of pathologic or clinical evidence of reportable disease are indicative of risk only and do not constitute a diagnosis.

**NATIONAL PROVIDER IDENTIFIER:** A section by this name was added and lists the new data items added to *FORDS* to reflect this change. (p.9)

<i>NPI–Archive FIN</i>	(NAACCR Item # 3105)
<i>NPI–Following Physician</i>	(NAACCR Item #2475)
<i>NPI–Following Registry</i>	(NAACCR Item # 2445)
<i>NPI–Institution Referred From</i>	(NAACCR Item # 2415)
<i>NPI–Institution Referred To</i>	(NAACCR Item # 2425)
<i>NPI–Managing Physician</i>	(NAACCR Item #2465)
<i>NPI–Physician #3</i>	(NAACCR Item # 2495)
<i>NPI–Physician #4</i>	(NAACCR Item #2505)
<i>NPI–Primary Surgeon</i>	(NAACCR Item #2485)
<i>NPI–Reporting Facility</i>	(NAACCR Item #545)

**Morphology: Histology Code:** The entire text under this heading was changed to reflect the SEER 2007 Multiple Primary and Histology Coding Rules. (p.13)

**Multiple Primaries:** The entire text under this heading was changed to reflect the SEER 2007 Multiple Primary and Histology Coding Rules. (p.16)

**Non-Malignant Primary Intracranial and CNS Tumors:** The introduction to the instructions for using the table was revised. (p.17)

**COMORBIDITIES AND COMPLICATIONS:** *Comorbidities and Complications #7–10* were added to the list correcting a previous omission. (p.19)

**AJCC TNM STAGING:** The following text was added to this section.

“Please refer to the current *Cancer Program Standards* to determine category-specific requirements for the appropriate person or persons designated to assign the AJCC Staging. The CoC requires that clinical and pathologic T, N, and M components and stage group must be recorded by the appropriate person or persons for all analytic cases that have an AJCC coding scheme. Class of Case 0 patients are not required to be AJCC staged by these rules. However, the appropriate codes must still be entered into the registry—leave blank where no T, N, or M is provided; code 99 or 88 for Stage Group. If all components are available, and no stage group has been recorded, the registrar may enter a stage group based on the component information. The following AJCC staging information should be included in each case record:

- Code the T, N, M elements (clinical and pathologic) as recorded in the medical record by the appropriate person or persons.
- Code the AJCC Stage Group (clinical and pathologic); if no stage group was recorded by the appropriate person or persons, the registrar may enter stage group based on the components recorded.” (p.21)

**The AJCC items that must be coded:** The NAACCR item numbers were corrected and the TNM Clinical and Pathologic Descriptor items were added to the list. (p.21)

**Coding CS Items:** The fourth sentence was changed to read: “The *CS Manual*, related information, and updates are available electronically on the AJCC Web site at <http://www.cancerstaging.org>.” (p.24)

**Site-Specific Factors:** ICD-O-3 codes were added to each site description. (p.25)

**OUTCOMES: Second sentence in introductory paragraph was revised to read:** “Follow-up information is obtained at least annually for all living Class of Case 1 or 2 patients included in a cancer registry’s database. (p.28G)

Revisions were made to the bullets under the text, “**Follow-up items that are required to be in the**

**facility's database:"** (p.28G)

**Added new text to third bullet:** "Use radiation or systemic treatment dates of 88888888 and treatment or "reason for no" treatment codes of 88 or 8 as ticklers to identify incomplete treatment information.

**Added new bullet (fifth):** "The CoC does not require Class 0 cases diagnosed on or after January 1, 2006 to be followed."

**Rephrased lead-in statement:** "While the patient is alive, be sure that contact information is kept current. In addition to the treatment and recurrence items, these include:" (p.28H)

**Added:** *Following Registry* (NAACCR Item #2440) to the list of contact information that should be kept current.

**Revised statement:** "Follow-up for *Vital Status* (NAACCR Item #1760) and *Cancer Status* (NAACCR Item # 1770) should be conducted annually for all analytic cases in the cancer program's registry. Class of Case 0 patients that are not followed will have current information as of the *Date of Last Contact*." (p.28H)

2005

06/1/05

**The entire text under the heading "Analytic Cases" was changed.** (p.5)

**Added bullet:** "The CoC does not require Class 0 cases diagnosed on or after January 1, 2006 to be AJCC staged by the physician, but Collaborative Staging must be completed by the registrar." (p.23)

**Text revised to read:** (Class of Case codes 1 or 2) (p.23)

**Added section of text:** "OUTCOMES" added prior to existing "CASE ADMINISTRATION" section. (p.28I); text moved (re-flowed) on pages 28I through 28L.

2004

09/01/04

**Added statement:** "Genetic findings in the absence of pathologic or clinical evidence of reportable disease are indicative of risk only, and do not constitute diagnosis." (p.4)

**Tumor grade for prostate cancers:** Reference to the following table was added; pattern 2-4 was changed to 2+4; and nuclear grade was noted as being obsolete for reporting tumor grade for these cancers. (p.14)

04/01/04

**Definition of case eligibility modified to read:** "...follow-up activities for required **tumors** diagnosed and/or initially treated at the abstracting facility. The **tumors** must meet..." (p.3)

**Heading modified to read:** "TUMORS REQUIRED BY THE CoC..." (p.3)

**Under the heading *Histology Differences*:** Exception 4 was replaced with revised instructions. (p.18)

**Under the heading *Examples of single or multiple primary coding*:** Example #10 was revised to read: "A patient had a **ganglioma, NOS (9505/1)** in the right.... Last week, a **desmoplastic infantile astrocytoma (9412/1)** of the right .... They represent a single tumor with the morphology, **9412/1, the more specific histology.**" (p.21)

**Description of boost treatment and dose changed to read:** "A boost treatment is provided to a smaller volume within the same volume as regional radiation, in order to enhance the effect of the regional treatment." (p.28E)

01/01/04

**Section One of FORDS: Revised for 2004 has been extensively revised, largely to accommodate the changing rules for case reporting and the introduction of the Collaborative Staging System. These revisions include, but are not limited to:**

- Guidelines for coding the data item *Date of First Contact*
- Inclusion of specific brain site codes in the list of paired organ sites
- Guidelines for coding specific tissues with ill-defined sites

- Guidelines for coding tumor grade, with specific instructions for handling two grade (eg, colon, rectosigmoid, rectum) and three grade (eg, breast, prostate, kidney) coding systems
- Changes in the multiple primary rules to support the reporting of non-malignant brain and CNS tumors
- Description of the allowable code values for the comorbidity and complications data items
- Instruction for coding pediatric stage
- An overview of the Collaborative Staging System
- Clarification of the relationships between the surgical treatment items, including coding multiple first course primary site surgical procedures and using the dates to describe definitive surgical resection and surgical discharge
- Instruction for coding the radiation treatment items when it is unknown or not stated whether the patient received regional or boost therapy
- Clarification of what may constitute therapy for hematopoietic disease in the item *Other Treatment*
- Modification of the rules for coding palliative care

2003

01/22/03

**The first exception under the heading MALIGNANCIES REQUIRED BY THE COC TO BE ACCESSIONED, ABSTRACTED, AND FOLLOWED, the histology code for juvenile astrocytoma was corrected to read:** 9421/1 and 9421/3, respectively. (p.3)

01/22/03

**Under the heading *Examples of single or multiple primary coding*:** Example #9 was replaced with a new example. (p.19)

2002

12/04/02

**The second bullet under the heading CASES NOT REQUIRED BY THE COC TO BE ACCESSIONED was changed to read:** “Patients seen only in consultation to confirm a diagnosis or treatment plan.” (p.5)

09/19/02

**The following ICD-O-3 site code and site definition was added to the table titled “List of Paired Organ Sites:”** C09.8–Overlapping lesion of tonsil (p.11)

## CHANGES TO *FORDS* SECTION TWO

2006

### Patient Identification

**SEQUENCE NUMBER** (p.34; NAACCR Item #560)

09/01/06

**Added new codes:** 36–59 (“Fifty-nine or more independent malignant or in situ primaries.”)

**PATIENT ADDRESS AT DIAGNOSIS–SUPPLEMENTAL**(p.43; NAACCR Item #2335)

09/01/06

**Removed text:** (NUMBER AND STREET) was removed from data item name.

**New coding instruction was added:** “Do not use this data item to record the number and street address of the patient.”

**STATE AT DIAGNOSIS** (p.45; NAACCR Item #80)09/01/06

**Definition for code XX was changed to read:** “Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country *is known*.”

**Definition for code YY was changed to:** “Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country *is unknown*.”

**Definition of code ZZ was changed to read:** “Residence unknown.”

**Added new code:** *United States, state unknown (US)* was added to the list of “Common abbreviations.”

**Added new code:** *Canada, province unknown (CD)* was added to the list of “Common abbreviations.”

**COUNTY AT DIAGNOSIS** (p.48; NAACCR Item #90)09/01/06

**References:** Updated references for country codes.

**PATIENT ADDRESS CURRENT–SUPPLEMENTAL** (p.50; NAACCR Item #2355)09/01/06

**Removed text:** (NUMBER AND STREET) was removed from data item name.

**New coding instruction was added:** “Do not use this data item to record the number and street address of the patient.”

**STATE–CURRENT** (p.52; NAACCR Item #1820)09/01/06

**Definition for XX changed to read:** “Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country *is known*.”

**Definition for YY changed to:** “Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country *is unknown*.”

**Definition of ZZ changed to read:** “Residence unknown.”

**Added new code:** *United States, state unknown (US)* was added to the list of “Common abbreviations.”

**Added new code:** *Canada, province unknown (CD)* was added to the list of “Common abbreviations.”

**PLACE OF BIRTH** (p.56; NAACCR Item #250)09/01/06

**References:** Updated references for SEER geocodes.

**NPI–MANAGING PHYSICIAN**(p.75E; NAACCR Item #2465)09/01/06

**This data item was added.**

**NPI–FOLLOWING PHYSICIAN** (p.76A; NAACCR Item #2475)09/01/06

**This data item was added.**

**NPI–PRIMARY SURGEON** (p.77A; NAACCR Item #2485)09/01/06

**This data item was added.**

**NPI–PHYSICIAN #3 (Radiation Oncologist–CoC PreferredUse)** (p.78A; NAACCR Item #2495)09/01/06

**This data item was added.**

**NPI–PHYSICIAN #4 (Medical Oncologist–CoC Preferred Use)** (p.79A; NAACCR Item #2505)09/01/06

**This data item was added.**

**Cancer Identification****NPI-INSTITUTION REFERRED FROM** (p. 85A; NAACCR Item # 2415)09/01/06**This data item was added.****NPI-INSTITUTION REFERRED TO** (p. 86A; NAACCR Item # 2425)09/01/06**This data item was added.****DATE OF FIRST CONTACT** (p.87; NAACCR Item #580)09/01/06**New coding instruction was added:** “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.”**HISTOLOGY** (p.93; NAACCR Item #522)09/01/06**New coding instruction was added:** “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.”**AMBIGUOUS TERMINOLOGY DIAGNOSIS** (p.99A; NAACCR Item #442)09/01/06**This data item was added.****DATE OF CONCLUSIVE DIAGNOSIS** (p.99C; NAACCR Item #443)09/01/06**This data item was added.****DATE OF MULTIPLE TUMORS** (p.99E; NAACCR Item #445)09/01/06**This data item was added.****MULTIPLE TUMORS REPORTED AS ONE PRIMARY** (p.99G; NAACCR Item #444)09/01/06**This data item was added.****MULTIPLICITY COUNTER** (p. 99H; NAACCR Item #446)09/01/06**This data item was added.****REGIONAL LYMPH NODES EXAMINED** (p.102; NAACCR Item #830)09/01/06**Definition for code 95 revised:** “No regional nodes were removed, but aspiration or core biopsy of regional nodes was performed.”**REGIONAL LYMPH NODES POSITIVE** (p.103; NAACCR Item #820)09/01/06**Definition for code 95 revised:** “Positive aspiration or core biopsy of regional node(s) was performed.”

**Stage of Disease at Diagnosis****SURGICAL DIAGNOSTIC AND STAGING PROCEDURE** (p.109; NAACCR Item #1350)09/01/06

The following example was deleted: “01: A thoracentesis is performed on a patient to stage a lung...”

**CLINICAL T**(p.112; NAACCR Item #940)09/01/06

**New coding instruction was added:** “Code clinical T as recorded in the medical record.”

**Definition for code “leave blank” revised:** “Not recorded.”

**Revised “Note” to read:** “*Please refer to the current CoC Cancer Program Standards to determine category-specific requirements for the appropriate person or persons designated to assign the AJCC Staging.*”

**CLINICAL N** (p.113; NAACCR Item #950)09/01/06

**New coding instruction was added:** “Code clinical N as recorded in the medical record.”

**Definition for code “leave blank” revised:** “Not recorded.”

**Revised “Note” to read:** “*Please refer to the current CoC Cancer Program Standards to determine category-specific requirements for the appropriate person or persons designated to assign the AJCC Staging.*”

**CLINICAL M** (p.114; NAACCR Item #960)09/01/06

**New coding instructions were added:**

- Record clinical M as recorded in the medical record.
- The AJCC has determined that staging of metastatic disease is *clinical* unless there is pathologic information confirming the presence of metastatic disease.
- Cases should be assumed to be cM0 unless there is documented clinical or pathologic evidence of metastasis of disease.

**Definition for code “leave blank” revised:** “Not recorded.”

**Revised “Note” to read:** “*Please refer to the current CoC Cancer Program Standards to determine category-specific requirements for the appropriate person or persons designated to assign the AJCC Staging.*”

**CLINICAL STAGE GROUP** (p.115; NAACCR Item #970)09/01/06

**New coding instructions were added:**

- Record the clinical stage group as recorded in the medical record.
- If the clinical T, N, and M have been recorded in the medical record, the cancer registrar may complete the clinical stage group in the cancer registry database.
- When the T, N, and M components are not completed, the registrar is to record Stage Group 99 (unknown) in the cancer registry database.
- To assign Stage Group when some, but not all, T, N and/or M components were provided by the appropriate person or person, interpret missing components as “X.”

**Revised “Note” to read:** “*Please refer to the current CoC Cancer Program Standards to determine category-specific requirements for the appropriate person or persons designated to assign the AJCC Staging.*”

**CLINICAL STAGE (PREFIX/SUFFIX) DESCRIPTOR** (p.116; NAACCR Item #980)09/01/06

**New coding instruction was added:** “Record the clinical stage (prefix/suffix) descriptor as documented in the medical record.”

**Revised “Note” to read:** “*Please refer to the current CoC Cancer Program Standards to determine*

*category-specific requirements for the appropriate person or persons designated to assign the AJCC Staging.”*

**STAGED BY (CLINICAL STAGE)** (p.117; NAACCR Item #990)

09/01/06

**New coding instructions were added:**

- Record the person or persons who documented the AJCC clinical staging elements and the Stage Group in the medical record.
- If code 1, 2, 4, or 5 is used, then all of the staging elements (T, N, M, and Stage Group) must have been assigned by the same person.

**Removed coding instruction:** “The CoC Approvals Program requires that all analytic cases must be staged in the medical record by the physician(s) managing the patient’s care...”

**Revised “Note” to read:** “*Please refer to the current CoC Cancer Program Standards to determine category-specific requirements for the appropriate person or persons designated to assign the AJCC Staging.”*

**PATHOLOGIC T** (p.118; NAACCR Item #880)

09/01/06

**New coding instruction was added:** “Record pathologic T as recorded in the medical record.”

**Definition for code “leave blank” revised:** “Not recorded.”

**Revised “Note” to read:** “*Please refer to the current CoC Cancer Program Standards to determine category-specific requirements for the appropriate person or persons designated to assign the AJCC Staging.”*

**PATHOLOGIC N** (p.119; NAACCR Item #890)

09/01/06

**New coding instruction was added:** “Code pathologic N as recorded in the medical record.”

**Definition for code “leave blank” revised:** “Not recorded.”

**Revised “Note” to read:** “*Please refer to the current CoC Cancer Program Standards to determine category-specific requirements for the appropriate person or persons designated to assign the AJCC Staging.”*

**PATHOLOGIC M** (p.120; NAACCR Item #900)

09/01/06

**New coding instructions were added:**

- Record pathologic M as recorded in the medical record.
- The AJCC has determined that staging of metastatic disease is *clinical* unless there is pathologic information confirming the presence of metastatic disease.
- Cases should be assumed to be pMX unless there is documented clinical or pathologic evidence of metastasis of disease.

**Definition for code “leave blank” revised:** “Not recorded.”

**Revised “Note” to read:** “*Please refer to the current CoC Cancer Program Standards to determine category-specific requirements for the appropriate person or persons designated to assign the AJCC Staging.”*

**PATHOLOGIC STAGE GROUP** (p.121; NAACCR Item #910)

09/01/06

**New coding instructions were added:**

- Record the pathologic Stage Group as recorded in the medical record.
- If the pathologic T and N and either the clinical or pathologic M have been recorded by the appropriate person or persons, the cancer registrar may complete the pathologic Stage Group in the cancer registry database.
- When the appropriate person or persons do not complete any of the T, N, and M components, the

registrar is to record Stage Group 99 (unknown) in the cancer registry database.

- To assign Stage Group when some, but not all, of the T, N and/or M components were provided by the appropriate person, interpret the missing components as “X.”
- If *Pathologic M* (NAACCR Item #900) is coded as either X or blank and *Clinical M* (NAACCR Item #960) is coded as 0, 1, 1A, 1B, or 1C, then the combination of staging elements *pT*, *pN*, and *cM* (NAACCR Item #s 880, 890, 960) may be used to complete the pathologic stage group.

**Two coding instructions were modified:**

- Truncate the least significant subdivision of the category from the right as needed, if a specific code is not shown on the table below.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.

**Revised “Note” to read:** “Please refer to the current CoC Cancer Program Standards to determine category-specific requirements for the appropriate person or persons designated to assign the AJCC Staging.”

**PATHOLOGIC STAGE (PREFIX/SUFFIX) DESCRIPTOR** (p.122; NAACCR Item #920)

09/01/06

**New coding instruction was added:** “Record the pathologic stage (prefix/suffix) descriptor as documented in the medical record.”

**Revised “Note” to read:** “Please refer to the current CoC Cancer Program Standards to determine category-specific requirements for the appropriate person or persons designated to assign the AJCC Staging.”

**STAGED BY (PATHOLOGIC STAGE)** (p.123; NAACCR Item #930)

09/01/06

**New coding instructions were added:**

- The CoC Approvals Program requires that all eligible analytic cases are staged in the medical record.
- Record the person or persons who documented the AJCC clinical staging elements and the Stage Group in the medical record.
- If code 1, 2, 4, or 5 is used, then all of the staging elements (T, N, M, and Stage Group) must have been assigned by the same person.

**Removed coding instruction:** “The CoC Approvals Program requires that all analytic cases must be staged in the medical record by the physician(s) managing the patient’s care...”

**Revised “Note” to read:** “Please refer to the current CoC Cancer Program Standards to determine category-specific requirements for the appropriate person or persons designated to assign the AJCC Staging.”

**CS TUMOR SIZE** (p.125; NAACCR Item #2800)

09/01/06

**Updated reference:** *Collaborative Staging Manual and Coding Instructions, Version 01.03.00*

**Definitions for codes 992–995 revised to include optional range descriptions:**

“992–Described as less than 2 cm; greater than 1 cm; or, between 1 cm and 2 cm.”

“993–Described as less than 3 cm; greater than 2 cm; or, between 2 cm and 3 cm.”

“994–Described as less than 4 cm; greater than 3 cm; or, between 3 cm and 4 cm.”

“995–Described as less than 5 cm; greater than 4 cm; or, between 4 cm and 4 cm.”

**Revised text description for codes 996–998 to read:** “SITE/HISTOLOGY-SPECIFIC CODES”

**CS EXTENSION** (p.125C; NAACCR Item #2810)

09/01/06

**Updated reference:** *Collaborative Staging Manual and Coding Instructions, Version 01.03.00*

**CS LYMPH NODES** (p.125H; NAACCR Item #2830)09/01/06**Updated reference:** *Collaborative Staging Manual and Coding Instructions, Version 01.03.00***Removed code 80 and its description from the table.****CS REG NODES EVAL** (p.125J; NAACCR Item #2840)09/01/06**Updated reference:** *Collaborative Staging Manual and Coding Instructions, Version 01.03.00***CS METS AT DX** (p.125L; NAACCR Item #2850)09/01/06**Updated reference:** *Collaborative Staging Manual and Coding Instructions, Version 01.03.00***Revised text description for codes 41–49 to read:** “SITE/HISTOLOGY-SPECIFIC CODES”**CS METS EVAL** (p.125M; NAACCR Item #2860)09/01/06**Updated reference:** *Collaborative Staging Manual and Coding Instructions, Version 01.03.00***CS SITE-SPECIFIC FACTOR 1** (p.125O; NAACCR Item #2880)09/01/06**Updated reference:** *Collaborative Staging Manual and Coding Instructions, Version 01.03.00***Added four sites with SSF1 defined:** Pleura, Other CNS, Other Endocrine, Lymphoma**CS SITE-SPECIFIC FACTOR 2** (p.125Q; NAACCR Item #2890)09/01/06**Updated reference:** *Collaborative Staging Manual and Coding Instructions, Version 01.03.00***Revised Site/Histology list:** “Malignant Melanoma of Iris and Ciliary Body” and its corresponding **Factor**, “CS Extension of Ciliary Body,” was removed from the list of sites with SSF2 defined.**CS SITE-SPECIFIC FACTOR 3** (p.125R; NAACCR Item #2900)09/01/06**Updated reference:** *Collaborative Staging Manual and Coding Instructions, Version 01.03.00***Defined LDH:** Lactate Dehydrogenase**CS SITE-SPECIFIC FACTOR 4** (p.125S; NAACCR Item #2910)09/01/06**Updated reference:** *Collaborative Staging Manual and Coding Instructions, Version 01.03.00***Revised Site/Histology list:** The **Factor** corresponding to “Prostate” was changed from “Prostatic Acid Phosphatase ( PAP)” to “Prostate Apex Involvement” and a note was added for clarification.**CS SITE-SPECIFIC FACTOR 5** (p.125T; NAACCR Item #2920)09/01/06**Updated reference:** *Collaborative Staging Manual and Coding Instructions, Version 01.03.00***CS SITE-SPECIFIC FACTOR 6** (p.125U; NAACCR Item #2930)09/01/06**Updated reference:** *Collaborative Staging Manual and Coding Instructions, Version 01.03.00***First Course of Treatment****REGIONAL TREATMENT MODALITY** (p.155; NAACCR Item #1570)09/01/06**New coding instruction was added:** “Code IMRT or conformal 3D whenever either is explicitly mentioned.”

**Clarified code 98 (Other, NOS) definition to read:** “Other radiation, NOS; Radiation therapy administered, but the treatment modality is not specified or is unknown.”

**Clarified code 99 (Unknown) definition to read:** “It is unknown whether radiation therapy was administered.”

### Outcomes

**NPI-FOLLOWING REGISTRY** (p.202A; NAACCR Item #2445)  
09/01/06

**This data item was added.**

### Case Administration

**NPI-REPORTING FACILITY** (p.208A; NAACCR Item #545)  
09/01/06

**This data item was added.**

**NPI-ARCHIVE FIN** (p.209A; NAACCR Item #3105)  
09/01/06

**This data item was added.**

**OVERRIDE ACSN/CLASS/SEQ** (p.210; NAACCR Item #1985)  
09/01/06

**Italicized “CoC” when used in an edit name.**

**OVERRIDE HOSPSEQ/DXCONF** (p.211; NAACCR Item #1986)  
09/01/06

**Italicized “CoC” when used in an edit name.**

**OVERRIDE COC—SITE/TYPE** (p.212; NAACCR Item #1987)  
09/01/06

**Italicized “CoC” when used in an edit name.**

**Updated edit name:** *Morphology-Type Check* was changed to *Morphology-Type ICDO2*.

**Revised coding instruction to read:** “Leave blank if the EDITS program does not generate an error message for edits of the type *Primary Site, Morphology-Type*.”

**OVERRIDE HOSPSEQ/SITE** (p.213; NAACCR Item #1988)  
09/01/06

**Italicized “CoC” when used in an edit name.**

**Updated edit name:** *Seq Num–Hosp, Primary Site, Morph ICDO2 (CoC)*

**OVERRIDE AGE/SITE/MORPH** (p.215; NAACCR Item #1990)  
09/01/06

**Updated edit names:** *Age, Primary Site, Morphology ICDO2 (SEER IF15); Age, Primary Site, Morphology ICDO3 (SEER IF15); Age, Primary Site, Morph ICDO3–Adult (SEER), and/or Age, Primary Site, Morph ICDO3–Pediatric (NPCR)*

**Removed obsolete Age/Morphology/Site table.**

**Revised coding instruction to read:** “Leave blank if the EDITS program does not generate an error message for the edit *Age, Primary Site, Morphology* edits.”

**OVERRIDE SURG/DXCONF** (p.216; NAACCR Item #2020)  
09/01/06

**Updated edit names:** *RX Summ–Surg Prim Site, Diag Conf (SEER IF76); RX Summ–Surgery Type, Diag Conf (SEER IF46); and/or RX Summ–Surg Site 98-02, Diag Conf (SEER 106)*

**OVERRIDE SITE/TYPE** (p.217; NAACCR Item #2030)09/01/06

**Updated edit names:** *Primary Site, Morphology-Type ICDO2 (SEER IF25); Primary Site, Morphology-Type ICDO3 (SEER IF25); Primary Site, Morphology-Type ICDO2 (CoC); and/or Primary Site, Morphology-Type ICDO3 (CoC)*

**Revised coding instruction to read:** “Leave blank and correct any errors for the case if any item is discovered to be incorrect.”

**OVERRIDE HISTOLOGY** (p.218; NAACCR Item #2040)09/01/06

**Updated edit names:** *Diagnostic Confirmation, Behavior ICDO2 (SEER IF31); Diagnostic Confirmation, Behavior ICDO3 (SEER IF31); Morphology–Type/Behavior ICDO2 (SEER MORPH); Morphology–Type/Behavior ICDO3 (SEER MORPH); and/or Morph (1973-91) ICD-O-1 (SEER MORPH)*

**Revised coding instruction to read:** “Leave blank if the EDITS program does not generate an error message for the edits of the types, *Diagnostic Confirmation, Morph* or *Morphology–Type/Behavior.*”

**OVERRIDE LEUK, LYMPHOMA** (p.219; NAACCR Item #2070)09/01/06

**Updated edit names:** *Diagnostic Confirmation, Histology ICDO2 (SEER IF48); and/or Diagnostic Confirmation, Histology ICDO3 (SEER IF48)*

**Revised coding instruction to read:** “Leave blank if the EDITS program does not generate an error message for the edits of the type *Diagnostic Confirmation, Histology.*”

**OVERRIDE SITE/BEHAVIOR** (p.220; NAACCR Item #2071)09/01/06

**Updated edit names:** *Primary Site, Behavior Code ICDO2 (SEER IF39); and/or Primary Site, Behavior Code ICDO3 (SEER IF39)*

**Revised coding instruction to read:** “Leave blank if the EDITS program does not generate an error message for *Primary Site, Behavior* edits.”

**OVERRIDE SITE/LAT/MORPH** (p.221; NAACCR Item #2071)09/01/06

**Updated edit names:** *Laterality, Primary Site, Morph ICDO2 (SEER IF42); and/or Laterality, Primary Site, Morph ICDO3 (SEER IF42)*

**Revised coding instruction to read:** “Leave blank if the EDITS program does not generate an error message for the *Laterality, Primary Site, Morphology* edits.”

**Appendix C**09/01/06

**Appendix C was completely revised and reorganized.**

**2005****Patient Identification****SEQUENCE NUMBER** (p.34; NAACCR Item #560)06/01/05

**Last coding example was corrected to read:** “myeloproliferative disease is resequenced to 62”

**MILITARY MEDICAL RECORD NUMBER SUFFIX** ( p.38; NAACCR Item #2310)06/01/05

**New coding instruction was added:** “Leave blank for non-military facilities.”

**PRIMARY PAYOR AT DIAGNOSIS** (p.67; NAACCR Item#630)

06/01/05

**Allowable Values revised:** 01, 02, 10, 20, 21, 31, 35, 60–68, 99**New coding instruction added; table revised to reflect code changes.****COMORBIDITIES AND COMPLICATIONS #1–#10**

(pp.69–75D; NAACCR Item #s 3110, 3120, 3130, 3140, 3150, 3160, 3161, 3162, 3163, 3164)

06/01/05

**Code V0740 deleted from allowable values.** Example removed. (p.70)**Added four new data items:** Comorbidities and Complications #7–#10. (p.75A–75D); all Comorbidities and Complications data items revised to reflect “up to 10” comorbid conditions and complications.**Stage of Disease at Diagnosis****CLINICAL STAGE GROUP** (p.115; NAACCR Item #970)

06/01/05

**New coding instructions were added:**

- If the clinical T, N, and M have been recorded by the physician the cancer registrar may complete the clinical stage group in the cancer registry database.
- If the managing physician does not complete the T,N,M, components or stage group, the registrar is to leave the appropriate fields blank.
- When the physician does not complete any of the T, N, and M components, the registrar is to record stage group 99 (unknown) in the cancer registry database.
- To assign stage group when some, but not all, T, N and/or M components were provided by the physician, interpret missing components as “X.”
- As of January 1, 2006, the CoC does not require Class 0 cases to be AJCC Staged.

**New allowable code value and definition was added:** 1C and Stage IC, respectively.**PATHOLOGIC STAGE GROUP** (p.121; NAACCR Item #910)

06/01/05

**New coding instructions were added:**

- If the clinical T, N, and M have been recorded by the physician the cancer registrar may complete the clinical stage group in the cancer registry database.
- If the managing physician does not complete the T,N,M, components or stage group, the registrar is to leave the appropriate fields blank.
- When the physician does not complete any of the T, N, and M components, the registrar is to record stage group 99 (unknown) in the cancer registry database.
- To assign stage group when some, but not all, T, N and/or M components were provided by the physician, interpret missing components as “X.”
- As of January 1, 2006, the CoC does not require Class 0 cases to be AJCC Staged.

**New allowable code value and definition was added:** 1C and Stage IC, respectively.**First Course of Treatment****SURGICAL PROCEDURE OF PRIMARY SITE** (p.135; NAACCR Item #1290)

06/01/05

**New coding instruction was added:** “There may be times when the first course of treatment information is incomplete. Therefore, it is important to continue follow-up efforts to be certain the complete treatment information is collected.”**READMISSION TO THE SAME HOSPITAL WITHIN 30 DAYS OF SURGICAL DISCHARGE** (p.146; NAACCR Item #3190)

06/01/05

**New coding instruction was added:** “There may be times when the first course of treatment information is incomplete. Therefore, it is important to continue follow-up efforts to be certain the complete treatment information is collected.”

**DATE RADIATION STARTED** (p.148; NAACCR Item #1210)06/01/05

**New coding instruction was added:** “There may be times when the first course of treatment information is incomplete. Therefore, it is important to continue follow-up efforts to be certain the complete treatment information is collected.”

**BOOST DOSE: cGy** (p.162; NAACCR Item #3210)06/01/05

**New coding instruction was added:** “There may be times when the first course of treatment information is incomplete. Therefore, it is important to continue follow-up efforts to be certain the complete treatment information is collected.”

**DATE RADIATION ENDED** (p. 166; NAACCR Item #3220)06/01/05

**New coding instruction was added:** “There may be times when the first course of treatment information is incomplete. Therefore, it is important to continue follow-up efforts to be certain the complete treatment information is collected.”

**CHEMOTHERAPY** (p.171; NAACCR Item #1390)06/01/05

**New coding instruction was added:** “Code 88 if chemotherapy was planned, but not started at the time of the most recent follow-up. The date should be revised at the next follow-up.”

**CHEMOTHERAPY AT THIS FACILITY** (p.173; NAACCR Item #700)06/01/05

**New coding instruction was added:** “Code 88 if chemotherapy was planned, but not started at the time of the most recent follow-up. The date should be revised at the next follow-up.”

**HORMONE THERAPY** (p.175; NAACCR Item #1400)06/01/05

**New coding instruction was added:** “Code 88 if hormone therapy was planned, but not started at the time of the most recent follow-up. The date should be revised at the next follow-up.”

**HORMONE THERAPY AT THIS FACILITY** (p.177; NAACCR Item #710)06/01/05

**New coding instruction was added:** “Code 88 if hormone therapy was planned, but not started at the time of the most recent follow-up. The date should be revised at the next follow-up.”

**IMMUNOTHERAPY** (p.179; NAACCR Item #1410)06/01/05

**New coding instruction was added:** “Code 88 if immunotherapy was planned, but not started at the time of the most recent follow-up. The date should be revised at the next follow-up.”

**IMMUNOTHERAPY AT THIS FACILITY** (p.181; NAACCR Item #720)06/01/05

**New coding instruction was added:** “Code 88 if immunotherapy was planned, but not started at the time of the most recent follow-up. The date should be revised at the next follow-up.”

**HEMATOLOGIC TRANSPLANT AND ENDOCRINE PROCEDURES**

(p.182; NAACCR Item #3250)

06/01/05

**New coding instruction was added:** “Code 88 if hematologic transplant or endocrine procedure was planned, but not started at the time of the most recent follow-up. The date should be revised at the next follow-up.”

**SYSTEMIC/SURGERY SEQUENCE** (p.183A-183B; NAACCR Item #1639)06/01/05**New data item added to manual: SYSTEMIC/SURGERY SEQUENCE.****OTHER TREATMENT** (p.186; NAACCR Item #1420)06/01/05**New coding instruction was added:** “Code 8 if other treatment was planned, but not started at the time of the most recent follow-up. The date should be revised at the next follow-up.”**Outcomes****DATE OF FIRST RECURRENCE** (p.195; NAACCR Item #1860)06/01/05**Item Description was modified to read:** “Records the date of first recurrence only.”**Coding instruction was modified to read:** “Record the date the physician diagnoses the first progression, metastasis, or recurrence of disease after a disease-free period.”**TYPE OF FIRST RECURRENCE** (p.197; NAACCR Item #1880)06/01/05**Instructions for Coding were revised:** Original first instruction was removed; four new instructions added.**DATE OF LAST CONTACT OR DEATH** (p. 199; NAACCR Item #1750)06/01/05**New coding instruction was added:** “As of January 1, 2006, the CoC does not require class 0 cases to be followed.”**FOLLOWING REGISTRY** (p. 202; NAACCR Item #2440)06/01/05**New coding instruction was added:** “As of January 1, 2006, the CoC does not require class 0 cases to be followed.”**NEXT FOLLOW-UP SOURCE** (p.204; NAACCR Item #1800)06/01/05**New coding instruction was added:** “As of January 1, 2006, the CoC does not require class 0 cases to be followed.”**Case Administration****ICD REVISION COMORBIDITIES AND COMPLICATIONS** (p.234A; NAACCR Item #3165)06/01/05**New data item added to manual: ICD REVISION COMORBIDITIES AND COMPLICATIONS****2004****Patient Identification****ACCESSION NUMBER** (p.33; NAACCR Item #550)01/01/04**New coding instruction was added:** A patient's accession number is never reassigned.**New coding instruction was added:** If a patient is first accessioned into the registry, then the registry later changes its reference date and the patient is subsequently accessioned into the registry with a new primary, use the original accession number associated with the patient and code the data item *Sequence Number* (NAACCR Item #560) appropriately.**New example was added:** Code: 199100067; Reason: Patient enters the hospital in 1991, and is diagnosed

with prostate cancer. The registry later sets a new reference date of January 1, 1997. The same patient presents with a diagnosis of lymphoma in 2005.

**SEQUENCE NUMBER** (p.34; NAACCR Item #560)

09/01/04

**Last coding example was changed to read: “Myeloproliferative disease (9975/1) is diagnosed...”**

01/01/04

**Item description was modified to read: “Indicates the sequence of **malignant and non-malignant** neoplasms over the lifetime of the patient.”**

**Item rationale was modified to read: “...select patients with only one **malignant** primary tumor...”**

**All coding instructions for this item have been modified to accommodate the inclusion of non-malignant tumors.**

**The table name “CoC-Required” has been changed to: “Malignant or in situ”**

**The table name “Reportable-By-Agreement” has been changed to: “Non-Malignant”**

**LAST NAME** (p.39; NAACCR Item #2230)

01/01/04

**Coding instruction was modified to read: “...apostrophes are allowed. Do not use other punctuation.”**

**STATE AT DIAGNOSIS** (p.45; NAACCR Item #80)

01/01/04

**Abbreviation for Canadian province of Newfoundland and Labrador was changed:**

From NF to NL

**COUNTY AT DIAGNOSIS** (p.48; NAACCR Item #90)

01/01/04

**Rationale was modified to read: “...to measure the cancer **incidence** in a particular geographic area.”**

**Publications mentioned in the coding instructions were updated to read:**

*The SEER Program Coding and Staging Manual, First Edition*

*Standards for Cancer Registries Volume II: Data Standards and Data Dictionary Version 10.1, Eighth Edition*

**References were updated to read:**

Johnson C, ed. *SEER Program Coding and Staging Manual, First Edition*. Bethesda MD, NIH, NCI, 2003.

Hulstrom D, Havener L, eds. *Standards for Cancer Registries Volume II: Data Standards and Data*

*Dictionary Version 10.1, Eighth Edition*. Springfield IL: North American Association for Central Cancer Registries, March 2003.

**PATIENT ADDRESS (NUMBER AND STREET) - CURRENT** (p. 49; NAACCR Item #2350)

09/01/04

**New coding instruction was added: “Do not change this item when the patient dies.”**

**New code definition added: UNKNOWN - Patient’s street address is unknown.**

**PATIENT ADDRESS (NUMBER AND STREET) CURRENT - SUPPLEMENTAL** (p. 50; NAACCR Item #2355)

09/01/04

**New coding instruction was added: “Do not change this item when the patient dies.”**

**CITY/TOWN - CURRENT** (p. 51; NAACCR Item #1810)

09/01/04

**New coding instruction was added: “Do not change this item when the patient dies.”**

**STATE-CURRENT** (p.53; NAACCR Item #1820)

09/01/04

**New coding instruction was added: “Do not change this item when the patient dies.”**

01/01/04

**Abbreviation for Canadian province of Newfoundland and Labrador was changed:**  
From NF to NL

**PLACE OF BIRTH** (p.56; NAACCR Item #250)

01/01/04

**Publications mentioned in the coding instructions were updated to read:**

*The SEER Program Coding and Staging Manual*, First Edition  
*Standards for Cancer Registries Volume II: Data Standards and Data Dictionary Version 10.1*, Eighth Edition.

**References were updated to read:**

Johnson C, ed. *SEER Program Coding and Staging Manual*, First Edition. Bethesda MD, NIH, NCI, 2003.

Hulstrom D, Havener L, eds. *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary Version 10.1*, Eighth Edition. Springfield IL: North American Association for Central Cancer Registries, March 2003.

**RACE 1** (p.59; NAACCR Item #160)

01/01/04

**Coding instruction was modified to read:** “If the patient is multiracial, then code all races using *Race 2* (NAACCR Item #161) through *Race 5* (NAACCR Item #164), and code all remaining Race items 88.”

**New coding instruction was added:** “If *Race 1* is coded 99, then *Race 2* through *Race 5* must all be coded 99.”

**New coding instruction was added:** “If *Race Coding System–Current* (NAACCR Item #170) is less than six (6) for cases diagnosed prior to January 1, 2000, then *Race 2* through *Race 5* must be blank.”

**New coding instruction was added:** “If a patient is diagnosed prior to January 1, 2000, develops a subsequent primary after that date, then *Race Coding System–Current* (NAACCR Item #170) must be six (6), and data items *Race 2* through *Race 5* that do not have specific race recorded must be coded 88.”

**RACE 2** (p.61; NAACCR Item #161)

01/01/04

**New coding instruction was added:** “If *Race 1* (NAACCR Item #160) is coded 99, then *Race 2* must be coded 99.”

**RACE 3** (p.62; NAACCR Item #162)

01/01/04

**New coding instruction was added:** “If *Race 2* (NAACCR Item #161) is coded 88 or 99, then *Race 3* must be coded with the same value.”

**RACE 4** (p. 63; NAACCR Item #163)

01/01/04

**New coding instruction was added:** “If *Race 3* (NAACCR Item #162) is coded 88 or 99, then *Race 4* must be coded with the same value.”

**RACE 5** (p.64; NAACCR Item #164)

01/01/04

**New coding instruction was added:** “If *Race 4* (NAACCR Item #163) is coded 88 or 99, then *Race 5* must be coded with the same value.”

**SPANISH ORIGIN—ALL SOURCES** (p.65; NAACCR Item #190)

09/01/04

**New coding value was added:** 8 - Dominican Republic (for use for patients whose cancer was diagnosed 01/01/2005 or later).

01/01/04

**Rationale was modified to read:** "...other populations that may be included in the 01 (White category) of *Race 1* through *Race 5* (NAACCR Item #s 160-164)."

**Coding instruction was modified to read:** "Code 0 (Non-Spanish; non-Hispanic) for Portuguese and Brazilian persons."

### **COMORBIDITIES AND COMPLICATIONS #1–#10**

(pp.69-75D; NAACCR Item #s 3110, 3120, 3130, 3140, 3150, 3160, 3161, 3162, 3163, 3164)

01/01/04

**List of allowable values was modified to include:** V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049.

**Item Descriptions were modified to read:** "Records the patient's preexisting medical conditions, factors influencing health status, and/or complications during...."

**Item Rationales were modified to read:** "...preexisting medical conditions, factors influencing health status, and/or complications may..."

**Instructions for coding these items have been extensively clarified.**

**Definitions for codes were changed to read:** "Note: For complications (ICD-9-CM "E" codes) and factors influencing health status (ICD-9-CM "V" codes) there is an assumed decimal point between the 4<sup>th</sup> and 5<sup>th</sup> characters."

### **PHYSICIAN #3** (p.78; NAACCR Item #2490)

01/01/04

**Definition for code 00000000 was changed to read:** "None; no additional physician."

**Definition for code 99999999 was modified to read:** "Physician is unknown or an identification number is not assigned."

### **PHYSICIAN #4** (p.79; NAACCR Item #2500)

01/01/04

**Definition for code 00000000 was changed to read:** "None; no additional physician."

**Definition for code 99999999 was modified to read:** "Physician is unknown or an identification number is not assigned."

### **Cancer Identification**

#### **DATE OF FIRST CONTACT** (p.87; NAACCR Item #580)

01/01/04

**In Examples table:** The "Reason" for coding the second example was revised.

#### **DATE OF INITIAL DIAGNOSIS** (p. 89; NAACCR Item #390)

09/01/04

**New coding instruction was added:** "Use the date of birth as the date of diagnosis for an in-utero diagnosis".

#### **PRIMARY SITE** (p.91; NAACCR Item #400)

01/01/04

**Exception to coding instruction was modified to read:** "Code myeloid sarcoma to the site of origin (see ICD-0-3 for coding rules)."

#### **HISTOLOGY** (p.93; NAACCR Item #522)

01/01/04

**NAACCR Item Number was corrected to read:** #522

**BEHAVIOR CODE** (p.94; NAACCR Item #523)04/01/04**Rational, Instructions for Coding, and Code/Definition table all revised:**

Rationale changed to read: **“The behavior code is used by pathologists to describe whether tissue samples are benign (0), borderline (1), in situ (2), or malignant (3).”**

Instruction for Coding removed: The instruction “Record only tumors with behavior codes 2 or 3.” was removed.

The Exception following the instructions for coding changed to a Note, and reads: **“The ICD-O-3 behavior code for juvenile astrocytoma (9421/1) should be coded as 3. Refer to “Case Eligibility” in Section One for information.”**

Table of code definitions expanded: The table listing allowable codes and their definitions was expanded to include behavior codes 0 and 1.

01/01/04**Definitions for code 2 were revised to include only three categories [Bowen disease was removed]:**

Adenocarcinoma in an adenomatous polyp with no invasion of stalk

Clark level 1 for melanoma (limited to epithelium)

Comedocarcinoma, noninfiltrating (C50.\_)

**GRADE/DIFFERENTIATION** (p.96; NAACCR Item #440)01/01/04

**Coding instruction was modified to read:** “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.”

**Coding instruction was modified to read:** “Codes 5–8 define T-cell or B-cell origin...”

**Coding instruction was modified to read:** “Do not use the WHO grade to code this data item.”

**New coding instruction was added:** “If no grade is given for astrocytomas, then code 9 (Unknown).”

**New coding instruction was added:** “If no grade is given for glioblastoma multiforme, then code 9 (Unknown).”

**Grade/Cell values in the table were modified:**

Grade I, 1, i

Grade II, 2, ii, I/III, or 1/3

Grade III, 3, iii, II/III, or 2/3

Grade IV, 4, iv, III/III, or 3/3

**Labels for codes 5, 8 and 9 in the table were modified:**

5 - T cell; T-precursor

8 - NK (natural killer) cell (effective with diagnosis year 1/1/95 and after)

9 - Cell type not determined, not stated or not applicable; unknown primaries; high grade dysplasia (adenocarcinoma in situ)

**The ‘Notes’ and conversion tables for 2-grade and 3-grade systems were moved to Section One of the manual.** These materials have been substantially modified for use beginning with cases diagnosed January 1, 2004.

**DIAGNOSTIC CONFIRMATION** (p.99; NAACCR Item #490)01/01/04

**New coding instruction was added:** “Code 1 for positive hematologic findings and bone marrow specimens for leukemia, including peripheral blood smears and aspiration biopsies.”

**New coding instruction was added:** “Code 2 for positive brushings, washings, cell aspirations and hematologic findings (except for leukemia).”

**TUMOR SIZE** (p.100; NAACCR Item #780)09/01/04

**Exception to first coding instruction was changed from “... scrotum (C63.3)” to read: “... scrotum (C63.2)”**

01/01/04

**New coding instruction was added:** “Code this data item for cases diagnosed on or before December 31, 2003.”

**New coding instruction was added:** “Code tumor size using CS Tumor Size (NAACCR Item #2800) for cases diagnosed on or after January 1, 2004.”

**REGIONAL LYMPH NODES EXAMINED** (p.102; NAACCR Item #830)

01/01/04

**The Description, Rationale, and Instructions for Coding have all been modified to be consistent with the Collaborative Staging System.**

**REGIONAL LYMPH NODES POSITIVE** (p.103; NAACCR Item #820)

01/01/04

**The Description, Rationale and Instructions for Coding have all been modified to be consistent with the Collaborative Staging System.**

**Stage of Disease at Diagnosis**

**SURGICAL DIAGNOSTIC AND STAGING PROCEDURE** (p.109; NAACCR Item #1350)

01/01/04

**New coding instruction was added:** “Code brushings, washings, cell aspiration, and hematologic findings (peripheral blood smears) as positive cytologic diagnostic confirmation in the data item *Diagnostic Confirmation* (NAACCR Item #490). These are not considered surgical procedures and should not be coded in this item.”

**Examples provided for codes 00 and 01 have been revised.**

**SURGICAL DIAGNOSTIC AND STAGING PROCEDURE AT THIS FACILITY**

(p.111 NAACCR Item #740)

01/01/04

**New coding instruction was added:** “Code brushings, washings, cell aspiration, and hematologic findings (peripheral blood smears) as positive cytologic diagnostic confirmation in the data item *Diagnostic Confirmation* (NAACCR Item #490). These are not considered surgical procedures and should not be coded in this item.”

**CLINICAL T** (p.112; NAACCR Item #940)

09/01/04

**Modified note:** “Staging assigned by residents or fellows and co-signed by a faculty or attending physician meets the requirement for physician staging. Staging assigned by medical students, cancer registrars, or other nonphysician professionals does not meet the requirement for physician staging.”

**CLINICAL N** (p.113; NAACCR Item #950)

9/01/04

**Modified note:** “Staging assigned by residents or fellows and co-signed by a faculty or attending physician meets the requirement for physician staging. Staging assigned by medical students, cancer registrars, or other nonphysician professionals does not meet the requirement for physician staging.”

**CLINICAL M** (p.114; NAACCR Item #960)

9/01/04

**Modified note:** “Staging assigned by residents or fellows and co-signed by a faculty or attending physician meets the requirement for physician staging. Staging assigned by medical students, cancer registrars, or other nonphysician professionals does not meet the requirement for physician staging.”

**CLINICAL STAGE GROUP** (p.115; NAACCR Item #970)9/01/04**Added sentence to second bullet:** “Interpret missing components as ‘X’“**Modified note:** “Staging assigned by residents or fellows and co-signed by a faculty or attending physician meets the requirement for physician staging. Staging assigned by medical students, cancer registrars, or other nonphysician professionals does not meet the requirement for physician staging.”01/01/04**New allowable code value and definition was added:** OC and Occult, respectively.**CLINICAL STAGE (PREFIX/SUFFIX) DESCRIPTOR** (p.116; NAACCR Item #980)9/01/04**Modified note:** “Staging assigned by residents or fellows and co-signed by a faculty or attending physician meets the requirement for physician staging. Staging assigned by medical students, cancer registrars, or other nonphysician professionals does not meet the requirement for physician staging.”**STAGED BY (CLINICAL STAGE)** (p.117; NAACCR Item #990)9/01/04**Modified note:** “Staging assigned by residents or fellows and co-signed by a faculty or attending physician meets the requirement for physician staging. Staging assigned by medical students, cancer registrars, or other nonphysician professionals does not meet the requirement for physician staging.”**PATHOLOGIC T** (p.118; NAACCR Item #880)9/01/04**Modified note:** “Staging assigned by residents or fellows and co-signed by a faculty or attending physician meets the requirement for physician staging. Staging assigned by medical students, cancer registrars, or other nonphysician professionals does not meet the requirement for physician staging.”**PATHOLOGIC N** (p. 119; NAACCR Item #890).09/01/04**New allowable code values were added:** I-, N0(i-); I+, N0(I+); M-, N0(mol-); M+, N0(mol+).**Modified note:** “Staging assigned by residents or fellows and co-signed by a faculty or attending physician meets the requirement for physician staging. Staging assigned by medical students, cancer registrars, or other nonphysician professionals does not meet the requirement for physician staging.”**PATHOLOGIC M** (p.120; NAACCR Item #900)9/01/04**Modified note:** “Staging assigned by residents or fellows and co-signed by a faculty or attending physician meets the requirement for physician staging. Staging assigned by medical students, cancer registrars, or other nonphysician professionals does not meet the requirement for physician staging.”**PATHOLOGIC STAGE GROUP** (p.121; NAACCR Item #910)9/01/04**Added sentence to second bullet:** “Interpret missing components as ‘X’“**Modified note:** “Staging assigned by residents or fellows and co-signed by a faculty or attending physician meets the requirement for physician staging. Staging assigned by medical students, cancer registrars, or other nonphysician professionals does not meet the requirement for physician staging.”**PATHOLOGIC STAGE (PREFIX/SUFFIX) DESCRIPTOR** (p. 122; NAACCR Item #920)9/01/04**Modified note:** “Staging assigned by residents or fellows and co-signed by a faculty or attending physician meets the requirement for physician staging. Staging assigned by medical students, cancer registrars, or other nonphysician professionals does not meet the requirement for physician staging.”

**STAGED BY (PATHOLOGIC STAGE)** (p.123; NAACCR Item #930)9/01/04

**Modified note:** “Staging assigned by residents or fellows and co-signed by a faculty or attending physician meets the requirement for physician staging. Staging assigned by medical students, cancer registrars, or other nonphysician professionals does not meet the requirement for physician staging.”

**SEER SUMMARY STAGE 2000** (p. 124; NAACCR Item #759)09/01/04

**New coding instruction was added:** “Code this data item for cases diagnosed prior to January 1, 2004.”

**CS CODED AND DERIVED ITEMS** (pp.125–125EE)01/01/04

**Thirteen new data items introduced by the Collaborative Staging System have been incorporated into this portion of FORDS and are to be coded by registry staff.**

- CS Tumor Size* (NAACCR Item #2800)
- CS Extension* (NAACCR Item #2810)
- CS Tumor Size Ext/Eval* (NAACCR Item # 820)
- CS Lymph Nodes* (NAACCR Item #2230)
- CS Reg Nodes Eval* (NAACCR Item #2840)
- CS Mets At Dx* (NAACCR Item #2850)
- CS Mets Eval* (NAACCR Item #2860)
- CS Site Specific Factor 1* (NAACCR Item #2880)
- CS Site Specific Factor 2* (NAACCR Item #2890)
- CS Site Specific Factor 3* (NAACCR Item #2900)
- CS Site Specific Factor 4* (NAACCR Item #2910)
- CS Site Specific Factor 5* (NAACCR Item #2920)
- CS Site Specific Factor 6* (NAACCR Item #2930)

**Nine new data items introduced by the Collaborative Staging System have been incorporated into this portion of FORDS and are to be autocoded by the software provider.**

- Derived AJCC T* (NAACCR Item #2940)
- Derived AJCC T Descriptor* (NAACCR Item #2950)
- Derived AJCC N* (NAACCR Item #2960)
- Derived AJCC N Descriptor* (NAACCR Item #2970)
- Derived AJCC M* (NAACCR Item #2980)
- Derived AJCC M Descriptor* (NAACCR Item #2990)
- Derived AJCC Stage Group* (NAACCR Item #3000)
- Derived SS1977* (NAACCR Item #3010)
- Derived SS2000* (NAACCR Item #3020)

**DERIVED AJCC T DESCRIPTOR** (p. 125W; NAACCR Item #2950)09/01/04

**New allowable code values were added:** N, Not applicable; 0 (zero), Not derived.

**DERIVED AJCC N DESCRIPTOR** (p. 125Y; NAACCR Item #2970)09/01/04

**New allowable code values were added:** N, Not applicable; 0 (zero), Not derived.

**DERIVED AJCC M DESCRIPTOR** (p. 125AA; NAACCR Item #2990)09/01/04

**New allowable code values were added:** N, Not applicable; 0 (zero), Not derived.

**First Course of Treatment****SURGICAL PROCEDURE OF PRIMARY SITE** (p.135; NAACCR Item #1290)01/01/04

**New coding instruction was added:** “If the procedure coded in this item was provided to prolong a patient’s life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item *Palliative Care* (NAACCR Item #3270).”

**SURGICAL PROCEDURE OF PRIMARY SITE AT THIS FACILITY** (p.136; NAACCR Item #670)01/01/04

**New coding instruction was added:** “If the procedure coded in this item was provided to prolong a patient’s life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item *Palliative Care* (NAACCR Item #3280).”

**SCOPE OF REGIONAL LYMPH NODE SURGERY** (p.138; NAACCR Item #1292)01/01/04

**New coding instruction was added:** “If the procedure coded in this item was provided to prolong a patient’s life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item *Palliative Care* (NAACCR Item #3270).”

**SCOPE OF REGIONAL LYMPH NODE SURGERY AT THIS FACILITY**

(p.140; NAACCR Item #672)

01/01/04

**New coding instruction was added:** “If the procedure coded in this item was provided to prolong a patient’s life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item *Palliative Care at This Facility* (NAACCR Item #3280).”

**SURGICAL PROCEDURE/OTHER SITE** (p.142; NAACCR Item #1294)01/01/04

**New coding instruction was added:** “Code 1 if any surgery is performed to treat tumors of unknown or ill-defined primary sites (C76.0–C76.8, C80.9) or for hematopoietic reticuloendothelial immunoproliferative or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4 or 9750, 9760–9764, 9800–9820, 9826, 9831–9964, 9980–9989).”

**New coding instruction was added:** “If the procedure coded in this item was provided to prolong a patient’s life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item *Palliative Care* (NAACCR Item #3270).”

**SURGICAL PROCEDURE/OTHER SITE AT THIS FACILITY** (p.143; NAACCR Item #674)01/01/04

**New coding instruction was added:** “Code 1 if any surgery is performed to treat tumors of unknown or ill-defined primary sites (C76.0–76.8, C80.9) or for hematopoietic reticuloendothelial immunoproliferative or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4 or 9750, 9760–9764, 9800–9820, 9826, 9831–9964, 9980–9989).”

**New coding instruction was added:** “If the procedure coded in this item was provided to prolong a patient’s life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item *Palliative Care at This Facility* (NAACCR Item #3280).”

**READMISSION TO THE SAME HOSPITAL WITHIN 30 DAYS OF SURGICAL DISCHARGE** (p.146; NAACCR Item #3190)01/01/04

**Description was modified to read:** “...to the same hospital, for the same illness, within 30 days...”

**New coding instruction was added:** “If there was an unplanned admission following surgical discharge, check for an ICD-9-CM “E” code and record it, space allowing, as an additional *Cormorbidities and Complications* (NAACCR Item # 3110, 3120, 3130, 3140, 3150, 3160).”

**REASON FOR NO SURGERY OF PRIMARY SITE** (p.147; NAACCR Item #1340)01/01/04

**Rationale was changed to read:** “This data item provides information related to the quality of care and describes why primary site surgery was not performed.”

**Coding instruction was modified to read:** “If Surgical Procedure of Primary Site (NAACCR Item #1290) is coded 00, then record...”

**New coding instruction was added:** “Code 1 if *Surgical Procedure of Primary Site* (NAACCR Item #1290) is coded 98.”

**LOCATION OF RADIATION TREATMENT** (p.150; NAACCR Item #1550)01/01/04

**New coding instruction was added:** “If radiation therapy was provided to prolong a patient’s life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the radiation administered in the item *Palliative Care* (NAACCR Item #3270) or *Palliative Care at This Facility* (NAACCR Item #3280), as appropriate.”

**RADIATION TREATMENT VOLUME** (p.151; NAACCR Item #1540)01/01/04

**Definition for code 00 was modified to include cases:** “Diagnosed at autopsy.”

**Definition for code 18 was modified to read:** “The primary target is the intact breast and no attempt has been made to irradiate the regional lymph nodes. Intact breast includes tissue that either was not surgically treated or received a lumpectomy or partial mastectomy (C50.0–C50.9, *Surgical Procedure of Primary Site* (NAACCR Item #1290] codes 0–24).”

**Definition for code 19 was modified to read:** “A deliberate attempt has been made to include lymph nodes in the treatment of an intact breast. See definition of intact breast above.”

**Definition for code 99 was modified to include cases diagnosed by:** “Death certificate only.”

**REGIONAL TREATMENT MODALITY** (p.155; NAACCR Item #1570)01/01/04

**Definition for code 00 was modified to include cases:** “Diagnosed at autopsy.”

**Definition for code 99 was modified to include cases diagnosed by:** “Death certificate only.”

**REGIONAL DOSE: cGy** (p. 158; NAACCR Item #1510)01/01/04

**Definition for code 00000 was modified to include cases:** “Diagnosed at autopsy.”

**Definition for code 99999 was modified to include cases diagnosed by:** “Death certificate only.”

**BOOST TREATMENT MODALITY** (p.159; NAACCR Item #3200)01/01/04

**Definition for code 00 was modified to include cases:** “Diagnosed at autopsy.”

**Definition for code 99 was modified to include cases diagnosed by:** “Death certificate only.”

**BOOST DOSE: cGy** (p.162; NAACCR Item #3210)01/01/04

**Definition for code 00000 was modified to include cases:** “Diagnosed at autopsy.”

**Definition for code 99999 was modified to include cases diagnosed by:** “Death certificate only.”

**Code value changed:** Stage II breast carcinoma example, code changed from 02500 to 88888.

**NUMBER OF TREATMENTS TO THIS VOLUME** (p.163; NAACCR Item #1520)01/01/04

**Definition for code 0 was modified to include cases:** “Diagnosed at autopsy.”

**Definition for code 9 was modified to include cases diagnosed by:** “Death certificate only.”

**RADIATION/SURGERY SEQUENCE** (p.164; NAACCR Item #1380)01/01/04

**New coding instruction was added:** “If the patient received both radiation therapy and any one of the following surgical procedures: *Surgical Procedure of Primary Site, Regional Lymph Node Surgery, or Surgical Procedure/Other Site*, then code this item 2–9, as appropriate.”

**Definition for code 0 was modified to include cases:** “Diagnosed at autopsy.”

**Definition for code 9 was modified to include cases diagnosed by:** “Death certificate only.”

**REASON FOR NO RADIATION** (p. 168; NAACCR Item #1430)09/01/04

**Description changed to read:** “... radiation therapy was administered to the **patient**.”

**CHEMOTHERAPY** (p.171; NAACCR Item #1390)01/01/04

**New coding instruction was added:** “If chemotherapy was provided to prolong a patient’s life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the chemotherapy provided in the item *Palliative Care* (NAACCR Item #3270).”

**Definition for code 00 was modified to include cases:** “Diagnosed at autopsy.”

**CHEMOTHERAPY AT THIS FACILITY** (p.173; NAACCR Item #700)01/01/04

**New coding instruction was added:** “If chemotherapy was provided to prolong a patient’s life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the chemotherapy provided in the item *Palliative Care at This Facility* (NAACCR Item #3280).”

**Definition for code 00 was modified to include cases:** “Diagnosed at autopsy.”

**HORMONE THERAPY** (p.175; NAACCR Item #1400)01/01/04

**New coding instruction was added:** “If hormone therapy was provided to prolong a patient’s life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the hormone therapy provided in the item *Palliative Care* (NAACCR Item #3270).”

**Definition for code 00 was modified to include cases:** “Diagnosed at autopsy.”

**HORMONE THERAPY AT THIS FACILITY** (p.177; NAACCR Item #710)01/01/04

**New coding instruction was added:** “If hormone therapy was provided to prolong a patient’s life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the hormone therapy provided in the item *Palliative Care at This Facility* (NAACCR Item #3280).”

**Definition for code 00 was modified to include cases:** “Diagnosed at autopsy.”

**IMMUNOTHERAPY** (p.179; NAACCR Item #1410)01/01/04

**New coding instruction was added:** “If immunotherapy was provided to prolong a patient’s life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the immunotherapy provided in the item *Palliative Care* (NAACCR Item #3270).”

**Definition for code 00 was modified to include cases:** “Diagnosed at autopsy.”

**IMMUNOTHERAPY AT THIS FACILITY** (p.181; NAACCR Item #720)01/01/04

**New coding instruction was added:** “If immunotherapy was provided to prolong a patient’s life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the immunotherapy provided in the item *Palliative Care at This Facility* (NAACCR Item #3280).”

**Definition for code 00 was modified to include cases:** “Diagnosed at autopsy.”

**HEMATOLOGIC TRANSPLANT AND ENDOCRINE PROCEDURES**

(p.182; NAACCR Item #3250)

01/01/04

**New coding instruction was added:** “If the hematologic transplant or endocrine procedure coded in this item was provided to prolong a patient’s life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the hematologic transplant or endocrine procedure provided in the item *Palliative Care* (NAACCR Item #3270) or *Palliative Care at This Facility* (NAACCR Item #3280), as appropriate.”

**Definition for code 00 was modified to include cases:** “Diagnosed at autopsy.”

**Definition for code 20 was modified to read:** “Stem cell harvest and infusion.”

**OTHER TREATMENT** (p.186; NAACCR Item #1420)01/01/04

**New coding instruction was added:** “If other treatment was provided to prolong a patient’s life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the other treatment administered in the item *Palliative Care* (NAACCR Item #3270).”

**Definition for code 0 was modified to include cases:** “Diagnosed at autopsy.”

**Definition for code 9 was modified to include cases diagnosed by:** “Death certificate only.”

**The ‘Note’ following the table of codes and definitions was moved to Section One of the manual.**

**OTHER TREATMENT AT THIS FACILITY** (p.187; NAACCR Item #730)01/01/04

**New coding instruction was added:** “If other treatment was provided to prolong a patient’s life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the other treatment administered in the item *Palliative Care at This Facility* (NAACCR Item #3280).”

**Definition for code 0 was modified to include cases:** “Diagnosed at autopsy.”

**Definition for code 9 was modified to include cases diagnosed by:** “Death certificate only.”

**The ‘Note’ following the table of codes and definitions was moved to Section One of the manual.**

**PALLIATIVE PROCEDURE** (p. 189; NAACCR Item #3270)01/01/04

**The name of this data item has been changed to PALLIATIVE CARE.**

**Item Description was modified to read:** “...alleviate symptoms. Palliative care is performed to...”

**Item Rationale was modified to read:** “...to track care that is considered palliative rather than diagnostic or curative in intent.”

**All coding instructions for this item have been changed.**

**Definition for code 1 was modified to include cases:** “Diagnosed at autopsy.”

**Definition for code 7 was expanded to read:** “...Palliative care was provided that does not fit the descriptions for codes 1–6.”

**Coding examples have been changed to reflect changes made to the coding instructions for this item.**

**PALLIATIVE PROCEDURE AT THIS FACILITY** (p.191; NAACCR Item #3280)01/01/04

**The name of this data item has been changed to PALLIATIVE CARE AT THIS FACILITY.**

**Item Description was modified to read:** “...alleviate symptoms. Palliative care is performed to...”

**Item Rationale was modified to read:** “...to track care that is considered palliative rather than diagnostic or curative in intent.”

**All coding instructions for this item have been changed.**

**Definition for code 1 was modified to include cases:** “Diagnosed at autopsy.”

**Definition for code 7 was expanded to read:** “...Palliative care was provided that does not fit the descriptions for codes 1–6.”

## Outcomes

### **CANCER STATUS** (p.201; NAACCR Item #1770)

01/01/04

**Item Description was changed to accommodate follow-up of non-malignant brain/CNS tumors and reads:** "...clinical evidence of the patient's malignant or non-malignant tumor as of the..."

**Labels were changed for codes 1 and 2:** The word 'cancer' was replaced with 'tumor.'

**Second example was changed to replace the word 'cancer' with 'tumor' in the first sentence:** "...February 2, 2004 with no evidence of this tumor..."

## Case Administration

### **OVERRIDE ITEMS** (pp. 210–221; NAACCR Item #s 1985–1990, 2020, 2030, 2040, 2070, 2071, 2074)

01/01/04

**Descriptions and Rationales have been clarified for ALL of the override items. In addition, each item includes documentation describing the specific edit check with which the override flag is to be used.**

### **OVERRIDE SITE/TNM-STAGE GROUP** (p. 214; NAACCR Item #1989)

09/01/04

**Description of EDITS Use was modified to read:** "...according to a pediatric scheme instead, use **Override Site/TNM-Stage Group** to indicate the case was coded according to a pediatric staging system if it was not coded according to the AJCC manual.... When any AJCC component of either is used..."

### **OVERRIDE AGE/SITE/MORPH** (p. 215; NAACCR Item #1990)

04/01/04

**List of age, morphology and site combinations expanded to include the following combination:**  
Age: >age 45, Morphology: 9100, and Site: C58.9

### **RACE CODING SYSTEM–CURRENT** (p.226; NAACCR Item #170)

01/01/04

**Item Description was modified to read:** "Describes how race is currently coded..."

**Item Rationale was modified to read:** "Race codes (NAACCR Items #160–164) have changed over time..."

### **RACE CODING SYSTEM–ORIGINAL** (p.227; NAACCR Item #180)

01/01/04

**New coding instruction was added:** "For cases diagnosed on or after January 1, 2000, this data item must be coded 6."

### **MORPHOLOGY CODING SYSTEM–ORIGINAL** (p.231; NAACCR Item #480)

01/01/04

**New coding instruction was added:** "For cases diagnosed on or after January 1, 2000, this data item must be coded 7."

### **ICD-O-2 CONVERSION FLAG** (p.232; NAACCR Item #1980)

01/01/04

**Item Description was changed to read:** "Specifies whether or how site and morphology codes were converted to ICD-O-2."

**Second coding instruction was modified to read:** "...automated morphology conversion from ICD-O-1 or ICD-O-3 to ICD-O-2."

**TNM EDITION NUMBER** (p.234; NAACCR Item #1060)01/01/04**New coding instruction was added:** “This item is autocoded by the software provider.”**CS FLAGS and VERSION ITEMS** (pp.235A–235E)01/01/04**Five new data items introduced by the Collaborative Staging System have been incorporated into this portion of FORDS.***Derived AJCC–Flag* (NAACCR Item #3030)*Derived SS1977–Flag* (NAACCR Item #3040)*Derived SS2000–Flag* (NAACCR Item #3050)*CS Version First* (NAACCR Item #2935)*CS Version Latest* (NAACCR Item #2936)**2003****First Course Treatment****SCOPE OF REGIONAL LYMPH NODE SURGERY AT THIS FACILITY**

(p.140; NAACCR Item #672)

03/06/03**List of brain/CNS primary sites in fourth coding instruction was corrected to include:**  
(C70.0-C70.9, C71.0-C71.9, C72.0-C72.9)**RADIATION TREATMENT VOLUME** (p.151; NAACCR Item #1540)03/06/03**Definition for code 06 corrected to read:** “Limited volume treatment of a head and neck primary with the exception of glottis (code 7), sinus (code 8), or parotid (code 9).”**REGIONAL TREATMENT MODALITY** (p.155; NAACCR Item #1570)01/03/03**Definition for code 22 was corrected:** The code now indicates that intracavitary use of Cobalt-60 or Cesium-137 should be coded as 50 or 51.**BOOST TREATMENT MODALITY** (p.159; NAACCR Item #3200)01/03/03**Definition for code 22 was corrected:** The code now indicates that intracavitary use of Cobalt-60 or Cesium-137 should be coded as 50 or 51.**2002****Patient Identification****LAST NAME** (p.39; NAACCR Item #2230)12/04/02**Typographical error in item length was corrected:** Item length was changed to 25.**First coding instruction was modified to read:** “Truncate name if more than 25 letters long. Blanks, spaces, hyphens and apostrophes are allowed. Do not use other punctuation.”**STATE AT DIAGNOSIS** (p.45; NAACCR Item #80)12/04/02**New abbreviations and labels were added to the list of US addresses:** AA - APO/FPO Armed Services America; AE - APO/FPO Armed Services Europe; AP - APO/FPO Armed Services Pacific; FM - Micronesia; MH - Marshal Islands; PW - Palau; UM - Outlying Islands

09/19/02

**Abbreviation for Canadian province of Alberta was changed:** From AL to AB

**COUNTY AT DIAGNOSIS** (p.48; NAACCR Item #90)

12/04/02

**Typographical error in the citation for NAACCR vol II was corrected:** From Version 9.1, Sixth Edition to Version 10, Seventh Edition; and the year of publication was changed from 2001 to 2002.

**STATE–CURRENT** (p.53; NAACCR Item #1820)

12/04/02

**New abbreviations and labels were added to the list of US addresses:** AA - APO/FPO Armed Services America; AE - APO/FPO Armed Services Europe; AP - APO/FPO Armed Services Pacific; FM - Micronesia; MH - Marshal Islands; PW - Palau; UM - Outlying Islands

09/19/02

**Abbreviation for Canadian province of Alberta was changed:** From AL to AB

**PLACE OF BIRTH** (p.56; NAACCR Item #250)

12/04/02

**Typographical errors in the citation for NAACCR vol II was corrected:** From Version 9.1, Sixth Edition to Version 10, Seventh Edition; and the year of publication was changed from 2001 to 2002.

**COMORBIDITIES AND COMPLICATIONS #1–#10**

(pp.69-75D; NAACCR Item #s 3110, 3120, 3130, 3140, 3150, 3160, 3161, 3162, 3163, 3164)

09/19/02

**List of allowable values was corrected:** Code 00000 was added to the list of allowable values for the item *Comorbidities and Complications #1* (NAACCR Item #3110) per the eleventh coding instruction on page 69.

**List of allowable values was corrected:** The ‘E’ codes E8700– E8799 and E9300–E9499 were added to the list of allowable values for the data item *Comorbidities and Complications #4* (NAACCR Item #3140) per the eighth coding instruction on page 69.

### Cancer Identification

**DATE OF FIRST CONTACT** (p.87; NAACCR Item #580)

12/04/02

**Allowable codes for month, day, and year were revised to exclude 00, 00, and 0000 respectively from the displayed list.**

10/02/02

**Definitions for codes changed:** Per the third coding instruction, 00000000 cannot be used to record autopsy-only cases, and code 99999999 cannot be used to code death certificate-only cases.

**Code 00000000 was removed as a defined code.**

**Definition for code 99999999 was changed to read:** “When it is unknown when the first patient contact occurred.”

**TUMOR SIZE** (p.100; NAACCR Item #780)

12/04/02

**Exception to first coding instruction was changed from “Code 990 for melanomas of the skin ... which are 1cm (10mm) or greater in depth” to read:** “Code 989 for melanomas of the skin ... which are 9.89mm or greater in depth.”

**Corresponding code definitions were corrected:**

**The definition of code 990 was corrected to read:** “Microscopic focus or foci only, no size is given.”

**The definition of code 989 was corrected to read:** “989 millimeters or larger; melanomas greater than or equal to 9.89mm in depth.”

10/02/02

**Last coding instruction was corrected and rewritten to read:** “If the patient received neoadjuvant therapy (presurgical) radiation or systemic therapy (chemotherapy, hormone therapy, and/or immunotherapy), then code the size of the tumor documented prior to the start of first course therapy, do not code the size of tumor recorded in the pathology report.”

09/19/02

**List of allowable values corrected:** Code 998 was added to the list of allowable values per the ninth coding instruction. This code was also inserted into the Code and Definition Table appearing on page 101.

## **REGIONAL LYMPH NODES POSITIVE (p.103; NAACCR Item #820)**

12/04/02

**Definitions for codes were corrected:** The codes and definitions for this item were rewritten to be consistent with the item as it was described in *ROADS, Vol II, 1998*.

**Allowable values were changed to:** 00-99

**New coding instruction was added, directly following the second instruction:** “Code 96 when 96 or more nodes are positive.”

**The third coding instruction (now the fourth) was changed from “Code 95...” to read:** “Code 97...”

**The morphology code specification was changed in the seventh coding instruction (now the eighth) to:**  
From M-9720 to M-9750

**The table was updated accordingly to include codes 00, 01-95, 96, 97, 98, and 99 and their respective descriptions.**

## **Stage of Disease at Diagnosis**

### **CLINICAL T (p.112; NAACCR Item #940)**

12/04/02

**New allowable code value and definition was added:** 2C and T2c, respectively.

### **CLINICAL N (p.113; NAACCR Item #950)**

12/04/02

**New allowable code values and definitions were added:**

1A and N1a, respectively.

1B and N1b, respectively.

### **PATHOLOGIC T (p.118; NAACCR Item #880)**

12/04/02

**New allowable code value and definition was added:** 2C and T2c, respectively.

### **PATHOLOGIC STAGE GROUP (p.121; NAACCR Item #910)**

12/04/02

**New coding instruction was added:** “If *Pathologic M* (NAACCR Item #900) is coded as either X or blank, and clinical M (NAACCR Item #960) is coded as 0, 1, 1A, 1B, or 1C then the combination of staging elements pT, pN and cM (NAACCR Item #s 880, 890, 960) may be used to complete the pathologic stage group.”

## **First Course of Treatment**

### **SURGICAL PROCEDURE OF PRIMARY SITE (p.135; NAACCR Item #1290)**

12/04/02

**New sentence was added to the fourth coding instruction for clarification:** “Use codes 80 and 90 only if more precise information about the surgery is not available.”

**SURGICAL PROCEDURE OF PRIMARY SITE AT THIS FACILITY** (p.136; NAACCR Item #670)12/04/02

**New sentence was added to the fourth coding instruction for clarification:** “Use codes 80 and 90 only if more precise information about the surgery is not available.”

**SURGICAL MARGINS OF THE PRIMARY SITE** (p.137; NAACCR Item #1320)08/17/02

**Morphology code specification was corrected in fifth coding instruction:** From M-9720 to M-9750

**SCOPE OF REGIONAL LYMPH NODE SURGERY** (p.138; NAACCR Item #1292)09/19/02

**The code assignments in the third, fourth and fifth examples were corrected:** Where they originally read 3, 4, and 5, respectively, they now read 2, 3, and 6, respectively.

08/17/02

**Morphology code specification was corrected in sixth coding instruction:** From M-9720 to M-9750

**SCOPE OF REGIONAL LYMPH NODE SURGERY AT THIS FACILITY**

(p.140; NAACCR Item #672)

08/17/02

**Morphology code specification was corrected in sixth coding instruction:** From M-9720 to M-9750

**LOCATION OF RADIATION TREATMENT** (p.150; NAACCR Item #1550)09/19/02

**Definition for code 9 was expanded to read:** “Radiation therapy was administered, but the location of the treatment facility is unknown or not stated in the patient record; it is unknown whether radiation therapy was administered. Death certificate only.”

**REGIONAL TREATMENT MODALITY** (p.155; NAACCR Item #1570)09/19/02

**Definition for code 99 was expanded to read:** “Radiation therapy administered, treatment volume unknown or not stated in the patient record; it is unknown whether radiation therapy was administered.”

**REGIONAL DOSE: cGy** (p. 158; NAACCR Item #1510)12/04/02

**New coding instruction was added:** “Code 88888 when brachytherapy or radioisotopes, *Regional Treatment Modality* (NAACCR Item #1570) codes 50–62, was administered to the patient.”

**New code was added:** 88888 (Not applicable, brachytherapy or radioisotopes administered to the patient)

09/19/02

**Definition for code 99999 was expanded to read:** “Regional radiation therapy was administered, but the dose is unknown. Or it is unknown whether radiation therapy was administered.”

**BOOST DOSE: cGy** (p.162; NAACCR Item #3210)12/04/02

**New coding instruction was added:** “Code 88888 when brachytherapy or radioisotopes, *Boost Treatment Modality* (NAACCR Item #3200) codes 50 - 62, was administered to the patient.”

**New code was added:** 88888 (Not applicable, brachytherapy or radioisotopes administered to the patient)

**NUMBER OF TREATMENTS TO THIS VOLUME** (p.163; NAACCR Item #1520)09/19/02

**Definition for code 99 was expanded to read:** “Radiation therapy was administered, but the number of treatments is unknown. Or it is unknown whether radiation therapy was administered.”

**RADIATION/SURGERY SEQUENCE** (p.164; NAACCR Item #1380)09/19/02**Label for code 9 was changed to read:** “Sequence Unknown.”**Definition for code 9 was expanded to read:** “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. It is unknown whether radiation therapy was administered and/or it is unknown whether 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.”**PAIN ASSESSMENT** (p.188; NAACCR Item #3260)10/02/02**This item was removed from FORDS.****PALLIATIVE PROCEDURE** (p. 189; NAACCR Item #3270)09/18/02**First coding instruction was rewritten to read:** “Record the type of palliative procedure administered during the first course of treatment or in lieu of treatment.”**PALLIATIVE PROCEDURE AT THIS FACILITY** (p.191; NAACCR Item #3280)09/18/02**First coding instruction was rewritten to read:** “Record the type of palliative procedure administered during the first course of treatment or in lieu of treatment.”**Case Administration****ICD-O-2 CONVERSION FLAG** (p.232; NAACCR Item #1980)12/04/02**Allowable code list was corrected to include codes 5 and 6.****Definition for code 5 was added to read:** “Morphology converted from ICD-O-3 without review.”**Definition for code 6 was added to read:** “Morphology converted from ICD-O-3 with review.”**CHANGES TO APPENDIX B: SITE-SPECIFIC SURGERY CODES****2004**09/01/04**Lymph Nodes** (p. 283)**Coding reminder was modified following code 25: From** “Less than a full chain, includes a lymph node biopsy.” **to** “Less than a full chain, includes an excisional biopsy of a single lymph node.”01/01/04**Anus** (p.260)**Coding reminder was added following codes 60–63:** “The lymph node dissection should also be coded under *Scope Regional Lymph Node Surgery* (NAACCR Item #1292) or *Scope Regional Lymph Node Surgery at This Facility* (NAACCR Item #672).”**Lung** (p.264)**Coding reminder was added following codes 30 and 33:** “The lymph node dissection should also be coded under *Scope Regional Lymph Node Surgery* (NAACCR Item #1292) or *Scope Regional Lymph Node Surgery at This Facility* (NAACCR Item #672).”**Coding reminder was modified following codes 55 and 56, and 70 to read:** “The lymph node dissection should also be coded under *Scope Regional Lymph Node Surgery* (NAACCR Item #1292) or *Scope Regional Lymph Node Surgery at This Facility* (NAACCR Item #672).”

**Hematopoietic/Reticuloendothelial/Immunoproliferative/Myeloproliferative Disease (p.265)**

**Coding reminder was modified following code 98 to read:** “Surgical Procedures for hematopoietic/reticuloendothelial/immunoproliferative/myeloproliferative primaries are to be recorded using the data item *Surgical Procedure/Other Site* (NAACCR Item #1294) or *Surgical Procedure/Other Site at This Facility* (NAACCR Item #647).”

**Bones, Joints, etc. (p.266)**

**List of morphology exceptions was corrected and changed from:** (...998-9989) to (...9980-9989)

**Spleen (p.267)**

**Definition for code 19 modified to read:** “Local tumor destruction or excision, NOS.”

**Clarification for code 19 was modified to read:** “Unknown whether a specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).”

**Skin (p.268)**

**Definition for code 46 was modified to read:** “WITH margins more than 1 cm and less than or equal to 2 cm.”

**Coding clarification was added following codes 45–47:** “If the excision does not have microscopically negative margins greater than 1 cm, use the appropriate code 20–36.”

**Breast (p.269)**

**Coding reminder was modified following codes 47–49 and 75 to read:** “For single primaries only, code removal of involved contralateral breast under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294) or *Surgical Procedure/Other Site at This Facility* (NAACCR Item #647).”

**Coding reminder was modified following codes 52–49 and 63 to read:** “For single primaries only, code removal of involved contralateral breast under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294) or *Surgical Procedure/Other Site at This Facility* (NAACCR Item #647).”

**Cervix Uteri (p.272)**

**Coding reminder was modified following codes 70 and 71 to read:** “Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.”

**Coding reminder was modified following code 72 to read:** “Includes rectum and rectosigmoid WITH their ligamentous attachments and pelvic lymph nodes.”

**Coding reminder was modified following code 73 to read:** “Includes removal of all pelvic contents pelvic lymph nodes.”

**Corpus Uteri (p.274)**

**Coding reminder was modified following codes 75 and 76 to read:** “Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.”

**Coding reminder was modified following code 77 to read:** “Includes rectum and rectosigmoid WITH their ligamentous attachments and pelvic lymph nodes.”

**Coding reminder was modified following code 78 to read:** “Includes removal of all pelvic contents pelvic lymph nodes.”

**Ovary (p.275)**

**Coding reminder was modified following codes 70 and 71 to read:** “Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.”

**Coding reminder was modified following code 72 to read:** “Includes rectum and rectosigmoid WITH their ligamentous attachments and pelvic lymph nodes.”

**Coding reminder was modified following code 73 to read:** “Includes removal of all pelvic contents pelvic lymph nodes.”

**Definition for code 74 was modified to read:** “Extended exenteration.”

**Testis** (p.278)

**Definition for code 30 was modified to read:** “Excision of testical WITHOUT cord.”

**Definition for code 40 was modified to read:** “Excision of testical WITH cord or cord not mentioned (radical orchiectomy).”

**Bladder** (p.280)

**Coding reminder was added following code 73:** “The lymph node dissection should also be coded under *Scope Regional Lymph Node Surgery* (NAACCR Item #1292) or *Scope Regional Lymph Node Surgery at This Facility* (NAACCR Item #672).”

**Brain** (p. 281)

**Definition for code 20 was modified to read:** “Local excision (biopsy) of lesion or mass.”

**All Other Sites** (p. 280)

**Primary site code specification was corrected:** From C14.1–C14.8,... to C14.2–C14.8,...

**Unknown and Ill-Defined Primary Sites** (p. 285)

**Coding reminder was modified following code 98 to read:** “Surgical procedures for unknown and ill-defined primaries are to be recorded using the data item *Surgical Procedure/Other Site* (NAACCR Item #1294) or *Surgical Procedure/Other Site at This Facility* (NAACCR Item #647).”

**2003**03/06/03**Breast** (pp.269–270)

New codes to capture reconstructive surgery concomitant with a total (simple) mastectomy were added. Codes 43–46, 47–49 and 75 were added to page 269, forcing some previously existing text to move onto page 270.

**2002**12/04/02**Oral Cavity** (p.249)

**Code 10 and its definition were aligned with code 00.**

**Prostate** (p.277)

**Response codes 24–26 refer to 20–23 rather than 21–23.**

**Lymph Nodes** (p.283)

**Title was reformatted to be consistent with other Appendix B pages.**

08/17/02**Hematopoietic/Reticuloendothelial/Immunoproliferative/Myeloproliferative Disease** (p.265)

**Site definition was clarified to include:** C42.0, C42.1, C42,3, and C42.4 (with any histology) or M-9750, 9760-9764, 9800-9820, 9826, 9831-9964, 9980-9989 (with any site).

**Bones, Joints, etc.** (p.266 )

**Typographical error corrected:** “Connective, Subcutaneous, and Other Soft Tissues C49.0– C49.9.”

**Brain** (p.281)

**Site definition was clarified to read:** “Meninges C70.0–C70.9.”

**All Other Sites** (p. 284)

**Typographical error corrected:** All Other Sites include: C14.1–C14.8, C17.0–C17.9, C23.9, C24.0–C24.9, C26.0–C26.9, C30.0–C 30.1, C31.0–C31.9, C33.9, C37.9, C38.0–C38.8, C39.0–C39.9, C48.0–C48.8, C51.0–C51.9, C52.9, C57.0–C57.9, C58.9, C60.0–C60.9, C63.0–C63.9, C68.0–C68.9, C69.0–C69.9, C74.0–C74.9, C75.0–C75.9

