

Outcomes

DATE OF FIRST RECURRENCE

Item Length: 8
 NAACCR Item #1860
 Revised 06/05

Description

Records the date of the first recurrence only.

Rationale

This data item is used to measure the efficacy of the first course of treatment.

Instructions for Coding

Record the date the physician diagnoses the first progression, metastasis, or recurrence of disease after a disease-free period.

Code	Definition
MMDDCCYY	The date of first recurrence is the month, day, and year that the first recurrence was diagnosed. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year. If the exact date on which the diagnosis was made is not available, then record an approximate date.
00000000	If the patient became disease-free after treatment, never had a recurrence, or if the patient was never disease-free. Diagnosed at autopsy.
99999999	When it is unknown if the patient had a first recurrence or the case was identified by death certificate only.

Month	Day	Year
00	00	0000
01 January	01	Use four-digit year
02 February	02	9999 Year unknown
03 March	03	
04 April	...	
05 May	...	
06 June	30	
07 July	31	
08 August	99 Day unknown	
09 September		
10 October		
11 November		
12 December		
99 Month unknown		

Examples:

Code	Reason
12152003	December 15, 2003.
09992005	If the exact date of the recurrence is not available, then record an approximate date. For example, September 2005.
04992003	If information is limited to the description "Spring," 2003.
07992003	If information is limited to the description "The middle of the year," 2003.
10992003	If information is limited to the description "Fall," 2003.
12992003 or 01992004	If information is limited to the description "Winter." Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

TYPE OF FIRST RECURRENCE

Item Length: 2

Allowable Values: 00, 04, 06, 10,
13–17, 20–22, 25–27, 30, 36, 40,
46, 51–59, 60, 62, 70, 88, 99

NAACCR Item #1880

Revised 06/05

Description

Identifies the type of first recurrence after a period of documented disease-free intermission or remission.

Rationale

This item is used to evaluate treatment efficacy and as a long-term prognostic factor.

Instructions for Coding

- Code the type of first recurrence. First recurrence may occur well after completion of the first course of treatment.
- If the patient has never been disease-free (code 70), continue to track for disease-free status. This may occur after first course or subsequent treatment has been completed.
- If the patient is disease-free (code 00), continue to track until a recurrence occurs. First recurrence may occur well after completion of the first course of treatment.
- Once a recurrence has been recorded (code 04-62 or 88), subsequent recurrences are NOT to be recorded.
- Codes 00 through 70 are hierarchical. Record the highest-numbered applicable response.
- If the tumor was originally diagnosed as in situ, code recurrence to 06, 16, 17, 26, 27, 36, or 46 only. Do not use those codes for any other tumors. Codes 00, 88, or 99 may apply to any tumor.
- Codes 51–59 (organ or organ system of distant recurrence) apply only if all occurrences were in a single category. There may be multiple metastases (or “seeding”) within the distant location.
- Code leukemias that are in remission 00. If the patient relapses, then code recurrence status as 59.
- If there is more than one primary tumor and the physician is unable to decide which has recurred, code the recurrent disease for each tumor. If, at a later date, the recurrent primary is identified, revise the codes as appropriate.

Code	Definition
00	Patient became disease-free after treatment and has not had a recurrence.
04	In situ recurrence of an invasive tumor.
06	In situ recurrence of an in situ tumor.
10	Local recurrence, and there is insufficient information available to code to 13–17. Local recurrence includes recurrence confined to the remnant of the organ of origin, to the organ of origin, to the anastomosis, or to scar tissue where the organ previously existed.
13	Local recurrence of an invasive tumor.
14	Trocar recurrence of an invasive tumor. Includes recurrence in the trocar path or entrance site following prior surgery.
15	Both local and trocar recurrence of an invasive tumor (both 13 and 14).
16	Local recurrence of an in situ tumor, NOS
17	Both local and trocar recurrence of an in situ tumor.
20	Regional recurrence, and there is insufficient information available to code to 21–27.
21	Recurrence of an invasive tumor in adjacent tissue or organ(s) only.
22	Recurrence of an invasive tumor in regional lymph nodes only.
25	Recurrence of an invasive tumor in adjacent tissue or organ(s) and in regional lymph nodes (both 21 and 22) at the same time.

Code	Definition
26	Regional recurrence of an in situ tumor, NOS.
27	Recurrence of an in situ tumor in adjacent tissue or organ(s) and in regional lymph nodes at the same time.
30	Both regional recurrence of an invasive tumor in adjacent tissue or organs(s) and/or regional lymph nodes (20–25) and local and/or trocar recurrence (10, 13, 14, or 15).
36	Both regional recurrence of an in situ tumor in adjacent tissue or organ(s) and/or regional lymph nodes (26 or 27) and local and/or trocar recurrence (16 or 17).
40	Distant recurrence, and there is insufficient information available to code to 46–62.
46	Distant recurrence of an in situ tumor.
51	Distant recurrence of an invasive tumor in the peritoneum only. Peritoneum includes peritoneal surfaces of all structures within the abdominal cavity and/or positive ascitic fluid.
52	Distant recurrence of an invasive tumor in the lung only. Lung includes the visceral pleura.
53	Distant recurrence of an invasive tumor in the pleura only. Pleura includes the pleural surface of all structures within the thoracic cavity and/or positive pleural fluid.
54	Distant recurrence of an invasive tumor in the liver only.
55	Distant recurrence of an invasive tumor in bone only. This includes bones other than the primary site.
56	Distant recurrence of an invasive tumor in the CNS only. This includes the brain and spinal cord, but not the external eye.
57	Distant recurrence of an invasive tumor in the skin only. This includes skin other than the primary site.
58	Distant recurrence of an invasive tumor in lymph node only. Refer to the staging scheme for a description of lymph nodes that are distant for a particular site.
59	Distant systemic recurrence of an invasive tumor only. This includes leukemia, bone marrow metastasis, carcinomatosis, generalized disease.
60	Distant recurrence of an invasive tumor in a single distant site (51–58) and local, trocar and/or regional recurrence (10–15, 20–25, or 30).
62	Distant recurrence of an invasive tumor in multiple sites (recurrences that can be coded to more than one category 51–59).
70	Since diagnosis, patient has never been disease-free. This includes cases with distant metastasis at diagnosis, systemic disease, unknown primary, or minimal disease that is not treated.
88	Disease has recurred, but the type of recurrence is unknown.
99	It is unknown whether the disease has recurred or if the patient was ever disease-free.

Examples:

Code	Reason
52	Distant site of recurrence, lung.
62	Multiple distant sites of recurrence, ie, liver and lung.

DATE OF LAST CONTACT OR DEATH

Item Length: 8
 NAACCR #1750
 Revised 06/05

Description

Records the date of last contact with the patient or the date of death.

Rationale

This information is used for patient follow-up and outcomes studies.

Instructions for Coding

- Record the last date on which the patient was known to be alive or the date of death.
- If a patient has multiple primaries, all records should have the same date of last contact.
- As of January 1, 2006, the CoC does not require class 0 cases to be followed.

Code	Definition
MMDDCCYY	The date of last contact is the month, day, and year that last contact was made. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year. If the exact date on which last contact was made is not available, then record an approximate date.

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

Examples:

Code	Reason
06302004	The patient's date of death was June 30, 2004.
99992003	The medical record contains only the year of death (2003).
01142005	A patient returns his follow-up inquiry with no date information, the envelope is postmarked January 14, 2005.

VITAL STATUS

Item Length: 1
 Allowable Values: 0, 1
 NAACCR Item #1760

Description

Records the vital status of the patient as of the date entered in *Date of Last Contact or Death* (NAACCR Item #1750).

Rationale

This information is used for patient follow-up and outcomes studies.

Instructions for Coding

- This item is collected during the follow-up process with *Date of Last Contact or Death* (NAACCR Item #1750).
- If a patient has multiple primaries, all records should have the same vital status.

Code	Label
0	Dead
1	Alive

Examples:

Code	Reason
0	Death clearance information obtained from a state central registry confirms the death of the patient within the past year.
1	In response to a follow-up letter to a patient's following physician, it is learned the patient is alive.

CANCER STATUS

Item Length: 1
 Allowable Values: 1, 2, 9
 NAACCR Item #1770
 Revised 01/04

Description

Records the presence or absence of clinical evidence of the patient's malignant or non-malignant tumor as of the *Date of Last Contact or Death* (NAACCR Item #1750).

Rationale

This information is used for patient follow-up and outcomes studies.

Instructions for Coding

- Cancer status is based on information from the patient's physician or other official source such as a death certificate.
- The patient's cancer status should be changed **only** if new information is received from the patient's physician or other official source. If information is obtained from the patient, a family member, or other nonphysician, then cancer status is not updated.
- Cancer status changes if the patient has a recurrence or relapse.
- If a patient has multiple primaries, each primary could have a different cancer status.

Code	Label
1	No evidence of this tumor
2	Evidence of this tumor
9	Unknown, indeterminate whether this tumor is present; not stated in patient record

Examples:

Code	Reason
1	Patient with hematopoietic disease who is in remission.
1	A patient is seen by the physician on February 2, 2004 with no evidence of this tumor. The patient did not return to the physician. The patient was then called by the registry on August 29, 2005. The <i>Date of Last Contact or Death</i> (NAACCR Item #1750) is updated, but the cancer status is not.
2	A patient with prostate cancer is diagnosed with bone metastasis in April 2003. The registrar finds an obituary documenting the patient's death in a nursing home in June 2003.

FOLLOWING REGISTRY

Item Length: 10
 Right Justified, Zero-filled
 NAACCR Item #2440
 Revised 06/05, 09/08

Description

Records the facility identification number of the registry responsible for following the patient.

Rationale

This data item is useful when the same patient is recorded in multiple registries.

Instructions for Coding

- For facilities with seven-digit FINs in the range of 6020009–6953290 that were assigned by the CoC before January 1, 2001, the coded FIN will consist of three leading zeros followed by the full seven-digit number.
- For facilities with eight-digit FINs greater than or equal to 10000000 that were assigned by the CoC after January 1, 2001, the coded FIN will consist of two leading zeros followed by the full eight-digit number.
- As of January 1, 2006, the CoC does not require class 0 cases to be followed.

Code	Definition
(fill spaces)	Ten-digit facility identification number.
0099999999	If the following registry's identification number is unknown.

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

Note: A written agreement may be drawn up between two registries noting which hospital will be responsible for follow-up.

NPI-FOLLOWING REGISTRY

Item Length: 10
 Allowable Value: Ten digits
 NAACCR Item #2445
 Revised 04/07, 09/08

Description

Records the registry responsible for following the patient.

Rationale

This data item is useful when the same patient is recorded in multiple registries.

NPI-Following Registry is the NPI equivalent of *Following Registry* (NAACCR Item #2440). Both are required during a period of transition.

Instructions for Coding

- Record the 10-digit NPI for the facility of the registry responsible for following the patient.
- NPI should be recorded as available for cases diagnosed during 2007, and is required to be recorded for all cases diagnosed January 1, 2008, and later.
- NPI may be blank for cases diagnosed on or before December 31, 2006.
- Check with the registry, billing, or health information departments of the facility to determine its NPI, or search at <https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>.

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

FOLLOW-UP SOURCE

Item Length: 1
 Allowable Values: 0–5, 7–9
 NAACCR Item #1790

Description

Records the source from which the latest follow-up information was obtained.

Rationale

This data item is used by registries to identify the most recent follow-up source.

Instructions for Coding

Code	Label	Definition
0	Reported hospitalization	Hospitalization at another institution/hospital or first admission to the reporting facility.
1	Readmission	Hospitalization or outpatient visit at the reporting facility.
2	Physician	Information from a physician.
3	Patient	Direct contact with the patient.
4	Department of Motor Vehicles	The Department of Motor Vehicles confirmed the patient has a current license.
5	Medicare/Medicaid file	The Medicare or Medicaid office confirmed the patient is alive.
7	Death certificate	Information from the death certificate only.
8	Other	Friends, relatives, employers, other registries, or any sources not covered by other codes.
9	Unknown; not stated in patient record	The follow-up source is unknown or not stated in patient record.

**NEXT FOLLOW-UP SOURCE
(NEXT FOLLOW-UP METHOD)**

Item Length: 1
 Allowable Values: 0–5, 8, 9
 NAACCR Item #1800

Description

Identifies the method planned for the next follow-up.

Rationale

This data item is used by registries to identify the method planned for the next follow-up.

Instructions for Coding

- Registries in CoC-approved cancer programs are not required to follow foreign residents.
- As of January 1, 2006, the CoC does not require class 0 cases to be followed.

Code	Definition
0	Chart requisition
1	Physician letter
2	Contact letter
3	Phone call
4	Other hospital contact
5	Other, NOS
8	Foreign residents (not followed)
9	Not followed. Other cases for which follow-up is not required.

