STANDARDS

of the Commission on Cancer

Volume II: Registry Operations and Data Standards (ROADS)

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Preface

The *Registry Operations and Data Standards (ROADS)* is Volume II of a three-volume series, *Standards of the Commission on Cancer*. Volume I, *Cancer Program Standards (CPS)*, addresses the standards that a cancer program must meet to be approved by the Commission on Cancer (CoC). The *ROADS* contains detailed specifications on registry operations as well as the data items, coding rules, codes, and definitions. Registries in Commission-approved cancer programs must comply with the standards for operations and must maintain the required data set, including the codes and coding rules as defined in this text.

Data Standards

The new codes have been developed in consultation with physicians, nurses, cancer registrars, administrators, central and national registry organizations, software providers, and the Uniform Data Standards Committee of the North American Association of Central Cancer Registries (NAACCR). The collaborative effort of these individuals and groups has encouraged accurate, uniform data collection. Whenever possible, throughout the text, "None or not done" is coded as 0; "Not applicable" is coded as 8, and code 9 is used to indicate "Unknown."

Data Sets

The data set has been categorized as follows:

Required

These data items must be included in the registry in a Commission-approved cancer program. The CoC coding rules, codes, and definitions must be used. Manual registries must record the appropriate code for the data item. This will promote uniform data collection and will assist facilities if they should elect to computerize their registry.

Supplementary

Registries can extend the versatility and uses of the data by collection of the supplementary data set. Data items in this set may be of interest in most registries, but not useful for all programs. The Commission recommends, but does not require, collection of the supplementary data set.

Optional

The optional data set includes items from earlier editions of the *Cancer Program Manual* (1991) and the *Data Acquisition Manual* (1994). Some of these may have been required, but were recommended for deletion from the new standards. Rather than delete the data items, they were moved to the optional data set, so that registries may continue collection. Also in the optional data set are new data items. Since the 1991 publication of the cancer program manual, many suggestions have been received relative to additions or deletions to the data set. In addition, the Data Set Task Force made suggestions. A rationale for inclusion or exclusion was prepared for every data item in the overall data set. Those items for which the rationales could not support inclusion in the required or supplementary data set were incorporated into the optional category. To ensure uniform data collection of these optional fields, codes, coding rules, and definitions have been established.

Using the Data Standards Section

The header that precedes each data item contains the following information:

Data Item Name	Appears at the left margin. The names of pre-existing data items may have been changed. The previous name for the item appears in parentheses.
Item Length	The total of the numbers and/or letters contained in a field (code) appears at the right margin.
Data Type	This refers to the nature of the field. Alpha = alphabetic only; alphanumeric = a combination of alphabetic and numeric; numeric = numbers only; alpha character = alphabetical or character, such as / or &; and free text = any alphabetic, numeric, or character value. Data type may also provide additional instructions on the use of upper or lower case.
Data Set	Indicates whether an item is from the required, supplementary, or optional data set.

Other

Each institution is assigned a unique identifier used by the Commission in all communication with the institution. Copies of institution identification numbers are available from the Cancer Department on diskette or in hard copy. Instructions for ordering the list on diskette or hard copy appear in the Appendix. Individual programs should call the Cancer Department if they do not know their identification number.

Each approved program has been sent one complimentary copy of the *Registry Operations and Data Standards*. Additional manuals may be ordered from the American College of Surgeons.

Section One: Registry Operations

General Principles

A cancer registry is a system to monitor all types of reportable malignancies diagnosed or treated in an institution. The registry is vital for programmatic and administrative planning and for monitoring patient outcome. It is a valuable resource for research investigations.

The database includes case identification and a description of the patient and the cancer.

Registry responsibilities include lifetime clinical follow up of the cancer patient. Follow up is necessary to evaluate treatment outcome.

The registry staff must be knowledgeable and should include at least one Certified Tumor Registrar (CTR).

Reference Date

The reference date is the start date after which all eligible cases must be included in the registry. This date is a reference point for many standards and activities of the Approvals Program. A program must establish a reference date as of January 1 of a given year.

To be eligible for survey and approval, a program must have one year of documented clinical program activity and two years of data with one year of successful follow up.

Approved programs are encouraged to maintain their original reference date and database whenever possible. Occasionally, circumstances may cause a registry to petition for a change in reference date. Each request is given individual consideration on the basis of whether the program had changes in the population or census, flaws or lapses in data collection, changes in data acquisition methods, or a high lost-to-follow-up rate due to the longevity of the registry. The registry must maintain a five-year database (reference date) and cannot reapply for a change of reference date for five years.

Reportable List

The reportable list identifies diagnoses that will be included in the registry database. Additional tumors may be included at the discretion of the cancer committee.

Reportable Diagnoses

After their reference date, registries in Approved programs must include all reportable malignancies that meet the following criteria:

- Patients were diagnosed or received cancer-directed care in the institution's inpatient or outpatient department or ambulatory care center.[1] Patients were diagnosed at a staff physician's office and received any part of their first course of treatment at the reporting institution.
- Patients were diagnosed and treated only in a staff physician's office.[2]
- Patients were diagnosed with a Behavior Code of 2 or higher as defined in the *International Classification of Diseases for Oncology*, Second Edition (ICD-O-2).[3]
- Patients were diagnosed with basal and squamous cell cancers originating in mucoepidermoid sites; lip (C00.0–C00.9); anus (C21.0); vulva (C51.0–C51.9); vagina (C52.9); penis (C60.0–C60.9); scrotum (C63.2).

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[1] If the medical record is the property of the reporting institution, the case must be included in the database.

[2] Class of case 6 not required until 1998.

[3] Certain exceptions apply. See exclusion section.

- Patients were diagnosed with skin cancer (C44.–) must be included if the histology is 8000–8004, 8010–8045, 8050–8076, 8081–8082, 8090–8110 and at diagnosis the American Joint Committee on Cancer (AJCC®) stage group is II (T3), III, or IV (see General Principles in Coding, Case Eligibility).
- Patients with diagnoses that were not histologically confirmed. Ambiguous terms include:
  - Compatible with
  - Consistent with
  - Most likely
  - Probable
  - Suspect
  - Suspicious

Exclusions

Registries are not required to accession, abstract, or conduct follow up for cases that meet the following criteria:

- Patients are seen in consultation only. A consult may be done to confirm a diagnosis or treatment plan. The reporting institution may provide services not available at the diagnosing or treating facility, such as Computerized Tomography (CT) scans, Magnetic Resonance Imaging (MRI) scans, or placement of venous access devices.
- Patients receive transient care at the reporting institution to prevent interruption of the first course of treatment. The patient may be vacationing or visiting in the area, or equipment failure at the primary treating institution may require the patient to temporarily receive treatment elsewhere.
- Patients who have active, previously diagnosed cancer are admitted to the reporting institution for unrelated medical conditions.
- Patients who have precancerous conditions or benign tumors.[4]
- Patients who have carcinoma-in-situ of the cervix (CIS).
- Patients who have an intraepithelial neoplasia. Diagnoses include:
  - Cervical intraepithelial neoplasia
  - Prostatic intraepithelial neoplasia
  - Vaginal intraepithelial neoplasia
  - Vulvar intraepithelial neoplasia
- Patients who have skin cancers, (C44.–) who do not meet the conditions specified in the reportable diagnosis list.
- Patients who have a history of malignancy who are clinically free of disease.
- Patients are admitted for terminal supportive care, including home care service.
- Patients who are admitted to a designated hospice.
- Patients who are diagnosed at a staff physicians's office and treated in another facility.

Other Case Eligibility Criteria

Approved programs must accession, index, abstract, and follow all analytic cases (class of case 0, 1, and 2). These cases must appear in the patient index. A case may be excluded from the follow-up requirement if the patient resides in a foreign country at the time of diagnosis or follow up. If the patient is not a US citizen but lives in the United States or a US possession, the registry is required to follow the patient.

Non-analytic cases (class of case 3, 4, 5, 8, and 9) do not have to be accessioned, indexed, abstracted, or followed (Table 1).

[4] These cases may be reportable-by-agreement.

Table 1

Registry Functions by Type of Case				
	Accession	Patient Index	Abstract	Followup
Analytic (class of case 0, 1, 2, or 6)	X*	X	X	X
Non-analytic (class of case 3, 4, 5, 8, 9)				
Carcinoma-in-situ of the cervix (CIS)				
Basal or squamous cell carcinoma of a mucoepidermoid site	X	X	X	X
Skin cancer[5]	X	X	X	X
Foreign residents	X	X	X	X[6]

* X identifies required functions.

Reportable-by-Agreement

The cancer committee may choose to collect information on diagnoses not required by the Commission. These reportable-by-agreement diagnoses are added to the reportable list and may include behavior codes of 0 or 1 (benign or uncertain) as defined by the ICD–O–2 or any of the cases described under the exclusion section. An example of a reportable-by-agreement diagnosis would be a benign neoplasm of the central nervous system such as the pituitary gland.

The cancer committee may also determine if nonanalytic cases will be accessioned, indexed, abstracted, or followed.

Casefinding

Casefinding is a systematic method of locating all eligible cases. The method of casefinding must include all points of service from which a patient may enter the health care delivery system for diagnostic or therapeutic services for the management of cancer. Casefinding will identify both new cases and cases already entered into the registry. Readmissions may be a source of follow-up information.

The reporting institution's casefinding procedures must be documented in the procedure manual. Multiple sources must be used to identify the eligible cases. Casefinding sources include:

- Health Information Management Department (HIM). This department maintains the medical records and a disease index that identifies the patient, date of service, and diagnosis.
- Pathology and Cytology Departments. The histology, cytology, bone marrow, and autopsy reports are source documents for identifying eligible cases.
- Oncology-related services. Radiation and medical oncology treatment areas are sources of casefinding.
- Staff physician's office. The physician's office is a source of casefinding.

Suspense System

A suspense system identifies cases that have not been completely abstracted. The cases should be sorted and listed by the date of diagnosis. Cases should be processed in chronological order. Periodically, administrative reports should be produced to assess timeliness of the abstracting process. The abstracting currency

[5] Patients diagnosed with skin cancer (C44.–) must be included if the histology is 8000–8004, 8010–8045, 8050–8076, 8081–8082, 8090–8110 and at the time of diagnosis the AJCC stage group is II (T3), III, or IV. For details, see General Prinicples in Coding, Case Eligibility.

[6] Followup is not required if the patient resides in a foreign country at the time of diagnosis or followup.

must be six months or less from the date of diagnosis. If a registry serves multiple institutions, the register must include an institution identifier.

A suspense list must contain the patient's name, patient identifier, date of diagnosis, and primary site.

Accession Register

The accession register is an annual, sequential listing of all reportable cancers included in the registry. It may be presented either on-screen or as hardcopy, and must be readily accessible. The register must include the accession and sequence numbers, patient name, primary site, and date of initial diagnosis. If a registry serves multiple institutions, the register must include an institution identifier. The accession register is used to audit other registry files, monitor casefinding, assess the workload, and verify patient identification. Reportable-by-agreement cases may also be included in the register.

Detailed information on the assignment of accession and sequence numbers appears in Section Four.

Patient Index

The patient index is an alphabetical list of each patient entered into the registry since the reference date. The list must contain the patient's name, sex, date of birth, primary site(s), laterality, histology(ies), date(s) of diagnosis, accession number, sequence number(s), medical record number, and date of death.

For patients with multiple primaries, the patient index must include the primary site, laterality, histologic type, date of diagnosis, and sequence number of each primary.

Abstract

An abstract must be completed for all analytic cases that meet the criteria for inclusion in the registry. The abstract is a summary of pertinent information about the patient, cancer, treatment, and outcome. Components include patient identification, cancer identification, stage of disease at initial diagnosis, first course of treatment, recurrence, treatment for recurrence or progression, and follow up. The abstract must contain the items in the required data set. Patient name, race, sex, primary site, histology, laterality of disease, first course of treatment, and patient status at last contact must be in natural language.

If a patient has multiple primary malignancies, an abstract must be prepared for each reportable primary diagnosed or treated at the reporting institution after the reference date. Abstracts should be filed in a manner that permits easy retrieval. Abstracting must be completed within six months from the date of initial diagnosis.

The cancer committee must review and approve the abstract form and content. The supplementary data set contains information that will increase the usefulness of the registry. The Commission recommends collection of these data items.

Quality Control

Accuracy and consistency are essential. The cancer committee must supervise the registry for quality and timeliness. A physician member of the cancer committee must be designated to serve as physician advisor to the registry staff. The physician advisor and cancer committee members should be informational resources for the registrar.

The Commission requires a random review by a physician member of the cancer committee of at least 10 percent of all annual analytic accessions. The review should minimally include comparison with source

documentation[7] and encompass class of case, primary site, histology, stage of disease, and first course of treatment. Review procedures may also include visual review of abstracts, review of accession register and abstracts, and periodic reabstracting of cases. Computerized data edits are required in computerized registries. Quality control procedures must be reviewed and approved by the cancer committee and documented in the procedure manual. An annual status report of quality control method(s) used, sites reviewed, number of cases reviewed, and the source of quality assessment, such as a physician, registrar, or central registry personnel, must be reviewed by the cancer committee. The target rate for unknown stage should be less than 10 percent for each site. If the program has more than 10 percent unknown stage in any site, the cancer committee should investigate and resolve the problem as a part of the oncology quality control program.

Follow Up

Systematic annual follow up of patients is an important cancer registry function. Follow up is based on the date of last contact and is delinquent (lost) if no contact has been made within 15 months after the date of last follow-up information. Cases that are lost (delinquent) should remain in the follow-up process until information is obtained.

A 90 percent follow-up rate of all living and deceased patients is required. The required rate of follow up for living patients is 80 percent. Non-analytic cases, foreign residents, benign or borderline malignancies, and localized basal and squamous skin cancers are not included in follow-up calculation. Patients who are delinquent or lost to follow up and whose age exceeds 100 years may be excluded from follow-up calculations.

Follow-up data must include the date(s) and type(s) of treatment for cancer, the site(s) of distant metastasis, the site and histology(ies) of any subsequent primary(ies), the date of last contact, and the status of the patient and the cancer.

Confidentiality and Release of Information

The release of information involves accommodating general, case, and patient-specific data requests. Release of information must be closely supervised by the cancer committee and the cancer registry staff.

Information may be requested by staff physicians, other cancer registries, or by national organizations. Some of the requests will be for general information that does not include patient identification. The cancer committee may authorize the release of general information to specific groups. The registry staff could routinely respond to these requests for information and report the following details to the committee and record in the request log: the request date, requestor's name or organization, information requested, intended use of the data, and the date the information was sent to the requestor.

Other requests may be for information that would specifically identify the patient, physician, or another individual. These types of requests, as well as those received from groups not covered under the cancer committee's authorization, must be presented to the committee for individual consideration and recorded in the request log. Committee decisions for the release of information should be in accordance with the documented policies and procedures of the institution. Each facility should coordinate with appropriate committees to develop and document policies and procedures that address the following:

- Data release criteria
- Patient rights
- Informed consent
- Authorization

[7] Medical record, outpatient files, physician charts, or other documents.

Reporting

Analysis and use of registry data are important end products of data collection. The cancer committee and registry staff should encourage frequent use of the data. Information should be used for cancer conferences and independent studies. Studies should provide the institution with projections and data comparisons.

The data analysis should include comparison of the institution's experience with regional and national data. A critique of the data should identify trends and serve as the basis for quality management and planning.

To assess the use of data and compliance with reporting requirements, a request log or file must be maintained that includes the date of the request, topic, study period, source of the request, and the intent and final use of the data.

Retention of Documents

Retention of the following documentation is required: registry data and files (indefinite); minutes for cancer committee meetings and cancer conference(s) (five years); annual and special reports (five years); and research activities (term of retention determined by the institution).

Procedure Manual

Registries in approved cancer programs are required to maintain a complete, up-to-date procedure manual that documents each phase of its operations. A procedure manual is a valuable and necessary tool used to organize and maintain an effective, efficient program. A complete procedure manual details the overall structure of the cancer program and the day-to-day operations of the registry. Cancer programs differ in policies, procedures, budgets, and other matters. These activities should be documented in the procedure manual under the direction of the cancer committee. When adhered to, this manual will ensure a smooth operation with consistent and accurate abstracting, systematic and continuous follow up, and good reporting. The manual is also invaluable for training new registry personnel.

The procedure manual must contain the following: the objectives of the cancer program, including the registry; job descriptions and specifications of registry positions; case eligibility criteria; the reportable list; procedures for casefinding, maintaining and using the suspense file, and accessioning cases into the registry; a description of the registry filing systems; documentation of data collection methods, including principles of abstracting, detailed definitions for each data item, references used for coding systems, if applicable, and staging systems used in the registry; follow-up procedures, including institution and registry policies for contacting patients and samples of committee-approved follow-up letters; documentation of quality control procedures; a description of reporting mechanisms; procedures governing cancer conferences and meetings of the cancer committee; description of the quality management and improvement system; policy statements about confidentiality and the release of information; and documentation of the date(s) of implementation or changes in policies or registry operations.

Section Two: General Principles in Coding

Case Eligibility

Cases Required

The Commission requires registries in approved programs to include reportable malignancies diagnosed and/or initially treated at the reporting institution, and which meet the criteria for analytic cases (class of case 0, 1, 2, or 6). Inpatients, outpatients, and clinically diagnosed patients (not histologically confirmed) must be included.

Reportable malignancies have an ICD-O-2 behavior code of 2 or 3.[8]

Basal or squamous cell carcinoma originating in the following sites must be included. These sites are:

Lip	C00.0–C00.9
Anus	C21.0
Vulva	C51.0–C51.9
Vagina	C52.9
Penis	C60.0–C60.9
Scrotum	C63.2

Patients diagnosed with skin cancer (C44.–) must be included if the histology is 8000–8004, 8010–8045, 8050–8076, 8081–8082, 8090–8110 and they meet at least one of the following three conditions **at the time of diagnosis:**

- AJCC stage group II
    - T3 N0 M0 (primary tumor more than five centimeters in greatest dimension)
- AJCC stage group III
    - T4 N0 M0 (primary tumor that has invaded deep extradermal structures such as cartilage, skeletal muscle, or bone)
    - Any T N1 M0 (primary tumor with regional node metastases)
- AJCC stage group IV
    - Any T Any N M1 (primary tumor that has metastasized to distant sites)

Cases <u>Not</u> Required

- Non-analytic class of case 3, 4, 5, 8, and 9.
- Patients seen only in consultation to establish or confirm a diagnosis or treatment plan.

[8] Certain exceptions apply. See exclusion section.

Examples: A biopsy is done elsewhere. The reporting institution establishes the diagnosis by interpreting the pathology report.

An outpatient CT scan of the chest reads: probable carcinoma of the right lung. The patient does not return to the reporting institution for diagnostic confirmation or treatment. The diagnosis is confirmed, or treatment is delivered at another institution.

Patient comes to the reporting institution for a second opinion. Staff physicians order diagnostic tests and support the original treatment plan. Patient returns to the referring institution for treatment.

- Patients who receive transient care to avoid interrupting a course of therapy started elsewhere.

  Examples: A patient from out of state is visiting relatives in the area. The oncology department at the reporting facility administers the scheduled chemotherapy.

  Due to equipment failure, an institution refers a patient to the reporting facility for treatment. The reporting institution administers radiation therapy until the equipment is repaired.

- Patients who have active, previously diagnosed cancer who are admitted to the hospital for an unrelated medical condition.

  Example: A patient with active, previously diagnosed prostate cancer enters the cardiac care unit of the reporting institution.

- Patients who have a precancerous condition or a benign tumor.[9]
- Patients who have carcinoma-in-situ of the cervix (CIS).
- Patients who have intraepithelial neoplasia (CIN, PIN, VIN, VAIN).
- Patients who have skin cancer (C44.–) that do not meet the histology and stage requirements listed under cases required.
- Patients who have a history of malignancy who are clinically free of disease.
- Patients who are admitted for terminal supportive care, including home care services.
- Patients who are admitted to a designated hospice.

Reportable-By-Agreement Cases

The cancer committee may request the collection of selected benign or borderline tumors (behavior code 0 and 1) because of their site of origin or disease course. In addition, the institution may be required to report these cases to a central registry.

Examples: A hospital specializes in neurosurgery. The cancer committee elects to include benign meningiomas (9530/0, 9530/1, 9531/0, 9532/0, 9533/0, 9534/0, 9535/0, 9536/0, 9537/0, 9538/1).

The state registry requires the hospital to report endometrioid adenomas with borderline malignancy (8380/1). The cancer committee adds the adenomas to their reportable-by-agreement list and decides to accession and abstract these cases to comply with state requirements.

The cancer committee may also decide to collect malignant tumors not required by the Commission.

Examples: The committee chooses to collect carcinoma-in-situ of the cervix.

The central registry requires reporting malignant "pathology-only" cases. (Biopsies are done elsewhere and the specimen is sent to the reporting institution's pathology department. The

[9] Case may be reportable-by-agreement.

patient never enters the institution.) The cancer committee adds these cases to the reportable-by-agreement list and decides to accession and abstract the cases to comply with the central registry's requirements.

Periodically, the cancer committee should review the reportable-by-agreement list to evaluate the relevancy, use, and continued interest in the collection of these cases.

Ambiguous Terminology

Diagnosis

Terms that Constitute a Diagnosis

Interpret the following terms as a diagnosis of cancer. The database must include patients who have a diagnosis using one or more of these terms.

- Compatible with
- Consistent with
- Most likely
- Probable
- Suspect
- Suspicious

Example: The inpatient discharge summary documents that the patient had a chest x-ray consistent with a carcinoma of the right upper lobe. The patient refused further workup or treatment.

Exception: If the cytology is reported as "suspicious," do not interpret it as a diagnosis of cancer. Abstract the case only if a positive biopsy or a physician's clinical impression of cancer supports the cytology findings.

Terms that <u>Do Not</u> Constitute a Diagnosis

Do **not** interpret the following terms as a diagnosis of malignancy. Do not include patients who have a diagnosis consisting only of these terms.

- Equivocal
- Possible
- Questionable
- Suggests
- Worrisome

Example: Final diagnosis is reported as possible carcinoma of the breast.

Staging

Terms that Constitute Tumor Involvement/Extension

In the absence of cytologic or histologic confirmation, interpret the following terms as evidence of tumor involvement. The description may be taken from clinical, operative, or pathologic documentation.

- Adherent
- Apparent
- Compatible with
- Consistent with
- Encroaching upon
- Fixation, fixed
- Induration
- Into
- Onto
- Out onto
- Probable
- Suspect
- Suspicious
- To

Terms that <u>Do Not</u> Constitute Tumor Involvement/Extension

The following terms are **not** interpreted as tumor involvement:

- Approaching
- Equivocal
- Possible
- Questionable
- Suggests
- Very close to

Revising the Original Diagnosis or Stage

Data are gathered from multiple sources using the most recent and complete information available. Over time, the patient's records may contain new information (tests, scans, consults, etc.). Change the primary site, histology, and stage as the information becomes more complete. There is no time limit for making revisions that give better information about the original diagnosis or stage. Most cases that require revision are unknown primaries.

Example: The institution clinically diagnoses a patient with carcinomatosis. The registry enters the case as an unknown primary (C80.9), carcinoma, NOS (8010/3), stage of disease unknown. Nine months later, a paracentesis shows serous cystadenocarcinoma. The physician says that the patient has an ovarian primary. Change the primary site to ovary (C56.9), histology to serous cystadenocarcinoma (8441/3), and diagnostic confirmation to positive cytologic study, no positive histology (code 2). If enough information is available, change the stage from unknown to the appropriate staging basis; T, N, and M elements; and stage group.

Exception: Do not use information from tests done after the first definitive therapy begins to change the AJCC stage.

Example: A patient has a modified radical mastectomy for breast cancer January 1996. A bone scan done February 1996 reveals bony metastasis.

Example: A physician may decide that a previously clinically diagnosed malignancy is a benign lesion. A patient is referred from a nursing home to the institution. The chest x-ray shows a cavitary lesion in the right lung. The family requests that the patient undergo no additional workup or treatment. Discharge diagnosis is "probable carcinoma of the right lung." The registry abstracts a lung primary (C34.9). Two years later a chest x-ray shows an unchanged lesion. The physician documents "lung cancer ruled out." Delete the case from the database. Adjust the sequence number(s) of any other primaries the patient may have.

Determining Multiple Primaries

General Principles For Abstracting Multiple Primaries

Enter the case into the database as a single or multiple primary as documented by the physician. If physician determination is absent or unavailable, use the following guidelines which are based on the *International Classification of Diseases for Oncology,* Second Edition (ICD-O-2).

1. Use the instructions under the heading "Site Differences" to decide whether the tumor(s) involve one site or multiple sites.
2. Follow the instructions under the heading "Histology Coding Rules" to decide whether the tumor(s) are a single histology or mixed/multiple histologies.
3. Use the chart under the heading "Determining Multiple Primaries" to decide whether the case should be abstracted as one primary or multiple primaries.

Site Differences

1. Refer to Appendix A which groups multiple ICD-O-2 site codes into categories. Each category is treated as one site when determining multiple primaries.

   Example: A patient has separate, independent tumors in the right kidney and right ureter. Appendix A groups kidney (C60) and ureter (C66) into one category. This patient has multiple tumors in one primary site.

2. The ICD-O-2 topography code has four characters, the letter C followed by three digits (i.e., C61.9).

- A **difference** in the **third** character of the ICD-O-2 topography code designates a separate site.

  Example: A patient has separate, independent tumors on the lower gum (C03.1) and the anterior floor of the mouth (C04.0). The third characters of the ICD-O-2 topography code are different, so the patient has multiple tumors in multiple primary sites.

- For most sites, a **difference** in the **fourth** character of the ICD-O-2 topography code designates a subsite of the same organ.

  Example: The patient has multiple, separate, independent tumors in the trigone of the bladder (C67.0) and the lateral wall of the bladder (C67.2). Code one primary site, bladder, NOS (C67.9).

  Exception: A difference in the fourth character of the ICD-O-2 topography code designates a separate site for the following site groups only:

  Colon (C18.0–C18.9)

  Anus/anal canal (C21.0–C21.8)

  Bone (C40.0–C41.9)

  Melanoma of the skin (C44.0–C44.9)

  Peripheral nerves/autonomic nervous system (C47.0–C47.9)

  Connective tissue (C49.0–C49.9)

  Example: The patient has separate, independent tumors in the sigmoid colon (C18.7) and the transverse colon (C18.4). Abstract two primaries.

  Exception: Colon polyps.

1. Simultaneous lesions and polyps in the same segment of the colon are a single primary.

   Example: A physician detects two lesions in the same segment of the colon. The pathology report identifies the lesions as an adenocarcinoma (8140/3) and an adenocarcinoma in an adenomatous polyp (8210/3). Code the histology to adenocarcinoma (8140/3). Adenocarcinoma in an adenomatous polyp is an earlier stage of disease than an invasive adenocarcinoma.

2. Polyps may be present in more than one segment of the colon. If the diagnosis reads "adenocarcinoma in multiple polyps," it is one primary, colon, NOS (C18.9).

   Familial polyposis is a genetic disease characterized by polyps that increase in numbers and may cover the mucosal surface of the colon. The benign disease usually develops into adenocarcinoma in adenomatous polyposis coli or adenocarcinoma in multiple adenomatous polyps.

   Patients with the histologies "adenocarcinoma in adenomatous polyposis coli" (8220/3) and "adenocarcinoma in multiple adenomatous polyps" (8221/3) have a different disease process than those patients with frank adenocarcinomas of the colon or typical colon polyps. If multiple segments of the colon, or the colon and rectosigmoid, or the colon, rectosigmoid and rectum are involved with adeno-

carcinoma in adenomatous polyposis coli or adenocarcinoma in multiple adenomatous polyps, it is a single primary. Code the primary site to colon, NOS (C18.9).

Histology Coding Rules

1. When multiple terms describe a single histology, record the numerically highest code.

   Example: In the diagnosis "transitional cell epidermoid carcinoma," transitional cell (8120/3) and epidermoid (8070/3) are both adjectives describing carcinoma. Record transitional cell (8120/3).

   Note: If the diagnosis states "transitional cell **and** epidermoid carcinoma," "transitional cell **with areas of** epidermoid carcinoma," or "transitional cell **with a focus of** epidermoid carcinoma," the diagnosis would be interpreted as one of mixed or multiple histologies.

2. The ICD-O-2 morphology code has five digits (i.e., 8500/3).

- The **fifth digit** of the ICD-O-2 morphology code is the behavior code. The behavior code is not used to determine multiple primaries. Lesion(s) may have a single histology (the first three digits of the morphology code are the same) with invasive and in situ components. This is a **single histology**. Code the behavior of the invasive component.

  Examples: Pathology of a breast mass shows infiltrating ductal carcinoma (8500/3) with a large intraductal component (8500/2). This is a single histology. Code the histology as infiltrating ductal (8500) and the malignant behavior, /3.

  A patient has a colectomy and the pathology identifies two lesions in the sigmoid colon. The first lesion is an invasive adenocarcinoma (8140/3) and the second lesion is an adenocarcinoma in situ (8140/2). This is a single histology. Code the histology and behavior as adenocarcinoma, NOS (8140/3).

  Note: This rule is also used when multiple lesions are present. One lesion may be invasive and another lesion in situ, or each of the lesions may have invasive and in situ components.

- When the **first three digits** of the ICD-O-2 morphology codes are **identical**, the lesions are the **same histology**.

  Example: A stomach biopsy is interpreted as adenocarcinoma, NOS (8140/3). The pathology from the resection identifies the tumor as linitis plastica (8142/3). Record the morphology code for linitis plastica (8142/3).

  Exception: Code the following as single primaries with a single histology, even though the first three digits of the ICD-O-2 morphology codes differ:

  Bladder lesions (8120–8130)

  Breast lesions (ductal carcinoma–8500/3) and (lobular carcinoma–8520/3)

- When the **first three digits** of the ICD-O-2 morphology code are **different**, the histologies are not the same. These lesion(s) have a mixed or multiple histology. Code using the coding rules under the "Coding Mixed or Multiple Histologies" section of this chapter.

  Exceptions: Lymphatic and hematopoietic disease (use Appendix B to determine multiple primaries).

  When multiple lesions are present in one site and the first lesion is described as a nonspecific morphology (i.e., carcinoma NOS 8010/3) and the second lesion is a specific carcinoma morphology (i.e., giant cell carcinoma 8031/3), it is a **single histology** and a single primary. In the same manner, code as a single primary when one lesion is described as sarcoma, NOS and the second lesion is a specific sarcoma and when one lesion is described as melanoma, NOS and the second lesion is a specific melanoma.

Code the following as single primaries with a single histology, even though the first three digits of the ICD-O-2 morphology codes differ: bladder lesions with morphology codes 8120–8130, breast lesions with morphology codes 8500/3 (ductal carcinoma) and 8520/3 (lobular carcinoma).

Coding Mixed or Multiple Histologies

To code mixed or multiple histologies existing in one primary, use the following guidelines in this priority order:

1. Select a combination code

   Example: The pathology of a breast cancer describes mixed ductal (8500/3) and lobular carcinoma (8520/3). Record the combination code "ductal carcinoma and lobular carcinoma" (8522/3).

2. Code the histology that comprises the majority of the tumor. Phrases such as "predominantly" and "with features of" are often used to identify the principal histology.

   Example: A lung lesion is predominantly adenocarcinoma (8140/3) with focal areas of bronchioloalveolar adenocarcinoma (8250/3). A combination code does not exist. Record the predominant histology, adenocarcinoma (8140/3).

   Note: The terms "with foci of," "areas of," or "elements of" describe minor areas of involvement. Do not code the histologies described by these terms unless there is a combination code.

3. Code the histology with the highest ICD-O-2 morphology code.

   Example: A patient with breast cancer is diagnosed with a mixed infiltrating ductal carcinoma (8500/3) and medullary carcinoma (8510/3). There is no combination code for these histologies, and the pathology report does not identify a predominant histology. Record the highest morphology code, medullary carcinoma (8510/3).

Paired Organs (Laterality)

Each side of a paired organ is a separate site unless a physician determines one side is metastatic from the other.

Both sides of a paired organ may be simultaneously involved with tumors. If the tumors are of the same histology, the patient may have one or two primaries. Consult the managing physician or the registry advisor. If there are two primaries, complete two abstracts. Code each primary to the appropriate laterality and AJCC stage. If there is one primary, prepare one abstract and code laterality to the side of origin. If there is a single primary and the side of origin cannot be identified, code laterality as bilateral involvement, side of origin unknown, stated to be a single primary (4), and prepare a single abstract.

Exceptions: The following are always single primaries:

Simultaneous bilateral involvement of the ovaries with a single histology

Simultaneous bilateral retinoblastomas

Simultaneous bilateral Wilms' tumors

Note: For coding scheme on laterality refer to Section Four, Cancer Identification.

Lymphatic and Hematopoietic Disease

Appendix B provides guidelines for determining multiple primaries in lymphatic and hematopoietic diseases.

Determining Multiple Primaries

Lesions	Site(s)	Histology	Variables	Primary
Single	Single	Single		Single
	Single	Mixed/multiple		Single
Single or multiple	Single	Single	Different behavior codes, in situ (2) and invasive (3)	Single
	Same as previous site	Same as previous histology	Within two months of diagnosis	Recurrence of the original primary
	Same as previous site	Same as previous histology	More than two months after diagnosis	New primary unless physician states it is metastatic ***Exceptions:*** Basal squamous, basosquamous cell carcinoma of the skin, bladder, Kaposi's sarcoma, adenocarcinoma of prostate
Multiple	Single	Single	Simultaneous	Single
	Multiple	Single	Simultaneous	Multiple **unless** physician states it is metastatic. ***Exceptions:*** Ovaries (simultaneous bilateral), retinoblastoma, and Wilms' tumor are single primaries.
	Single	Mixed/multiple	Simultaneous	Single
	Single	Multiple (Each tumor has a different histology)	Simultaneous	Multiple ***Exceptions:*** Breast (lobular and ductal); bladder (transitional and papillary).
	Multiple	Multiple	Simultaneous	Multiple

See the preceding site and histology rules for definition of "multiple."

Stage of Disease at Initial Diagnosis

Stage is based on the clinical, operative, and pathologic assessment of the anatomic extent of disease, and is used to make appropriate treatment decisions, determine prognosis, and measure end results. Sometimes a complete removal of the malignant tissue is not possible. Operative reports with detailed gross observations at surgery are very important in these cases.

In Commission-approved programs the managing physician must stage all analytic cases according to the staging system of the American Joint Committee on Cancer (AJCC).

The following data must be recorded for all analytic cases (class of case codes 0, 1 or 2):

- T, N, M elements (either clinical or pathologic)
- AJCC stage group (either clinical or pathologic)

The Commission requires General Summary Stage for cases that cannot be staged according to the AJCC. These cases may be excluded because of site or histology.

Example: Sarcoma of the lung (lung scheme is only for carcinomas)

Exception: Pediatric cancers are excluded from the Commission on Cancer's requirement that AJCC staging must be used. Childhood cancers must be staged, but the managing physician may use the staging criteria from accepted protocols such as the Children's Cancer Group (CCG) or the Pediatric Oncology Group (POG).

Information upon which stage is based is taken from the history and physical, diagnostic imaging, tests, operative notes, and pathology reports.

If the pathologic T, N, or M elements cannot be assessed, record the clinical stage.

Example: A patient with a breast mass has a negative metastatic workup and palpation of the axilla. The mammogram indicates a 1-cm mass. Pathology from an excisional biopsy reveals a 1-cm medullary carcinoma. The patient has no further treatment. Pathologic stage is pT1b, pNX, pM0, stage group unknown. Instead of using the unknown stage, clinically stage this case. The clinical stage is cT1b, N0, M0, stage group I.

If a patient has multiple primaries, stage each primary independently. If you cannot determine the stage group, record unknown.

When a patient with multiple primaries develops metastases, a biopsy may distinguish the source of distant disease. In the absence of histologic or cytologic confirmation, consult a physician to decide which primary has metastasized. Stage both primaries as having metastatic disease if the physician is unable to conclude which primary has metastasized. If, at a later time, a physician identifies which primary has metastasized, update the stage(s) as appropriate.

Data Items (See Section Four)

The data items involved in, or related to, the staging process include:

- TNM elements
- AJCC stage group
- Prefix/suffix descriptor
- TNM edition number
- Size of tumor
- Regional nodes positive
- Regional nodes examined
- Site or sites of distant metastasis
- Staged by
- General Summary Stage
- Extension
- Lymph nodes
- Type of staging system (pediatric)
- Pediatric stage
- Other staging system

Time Periods

AJCC Stage

Clinical classification is based on evidence acquired before treatment. It is based on the physical examination, imaging, endoscopy, biopsy, surgical exploration, and other relevant findings. Clinical classification is appropriate for sites accessible for clinical examination. Clinical classification is also used when a pathologic evaluation is not possible or not known.

Pathologic classification is based on evidence acquired before treatment, supplemented with additional information from surgery and pathologic examination of the resected specimen.

General Summary Stage (SEER)

General Summary Stage is limited to all information available within two months of diagnosis.

Exception: General Summary Stage for prostate primaries is limited to all information available within four months of diagnosis for cases diagnosed on or after January 1, 1995.

Exclude metastasis or disease progression that develops after the original diagnosis.

General Summary Stage for all sites is based on pathological, operative, and clinical assessments. The priority for using these reports is:

- Pathologic
- Operative (particularly important when the surgical procedure does not remove all malignant tissue)
- Clinical

Apply the same rules when autopsy reports are used to stage the disease.

First Course of Treatment

First course of treatment includes all methods of treatment recorded in the treatment plan and administered to the patient before disease progression or recurrence.

No therapy is a treatment option (the patient refused treatment, the family/guardian refused treatment, the patient expired before treatment started, or the physician recommended no treatment). Therefore, first course of therapy may be no treatment. Enter the date the decision was made not to treat into the field "Date of Initial Treatment."

Data Items

Several items document the first course of tumor-directed treatment. Section Four consists of definitions, codes, and instructions on collecting this information.

- Date of First Course Treatment
- Date of Non Cancer-Directed Surgery
- Non Cancer-Directed Surgery
- Non Cancer-Directed Surgery at This Facility
- Diagnostic and Staging Procedures
- Date of Cancer-Directed Surgery
- Surgical Approach
- Surgery of Primary Site
- Cancer-Directed Surgery at This Facility
- Surgical Margins
- Scope of Regional Lymph Node Surgery
- Number of Regional Lymph Nodes Removed
- Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)
- Reconstruction/Restoration–First Course
- Reason for No Surgery

- Date Radiation Started
- Radiation
- Radiation at This Facility
- Regional Ddose: cGy
- Number of Treatments to This Volume
- Radiation Elapsed Treatment Time (Days)
- Radiation Treatment Volume
- Location of Radiation Treatment
- Intent of Treatment (Radiation)
- Regional Treatment Modality
- Radiation Therapy to CNS
- Radiation/Surgery Sequence
- Radiation Treatment Completion Status
- Radiation Therapy Local Control Status
- Reason No Radiation
- Date Chemotherapy Started
- Chemotherapy
- Chemotherapy at This Facility
- Chemotherapy-Related Field #1
- Chemotherapy-Related Field #2
- Chemotherapy-Related Field #3
- Reason No Chemotherapy
- Date Hormone Therapy Started
- Hormone Therapy
- Hormone Therapy at This Facility
- Reason No Hormone Therapy
- Date Immunotherapy Started
- Immunotherapy
- Immunotherapy at This Facility
- Date Other Treatment Started
- Other Treatment
- Other Treatment at This Facility
- Protocol Eligibility Status
- Protocol Participation

Treatment Plan

A treatment plan describes the type(s) of therapies intended to modify or control the malignancy. The documentation confirming a treatment plan may be fragmented. It is frequently found in several different sources, ie., medical or clinic record, consultation reports, and outpatient records. All cancer-directed therapies specified in the physician(s) treatment plan are part of the first course of treatment.

A discharge plan must be part of the patient's record in a Commission-approved program and may contain all or part of the treatment plan.

A treatment plan may specify one or more modalities of therapy (such as surgery, radiation, chemotherapy, hormone therapy, immunotherapy, or other therapy). A treatment "regimen" may include combinations of concurrent or adjuvant therapies. In treatment analyses, use only therapies actually administered to the patient.

Example: A patient had a transurethral resection for a bladder lesion with a positive histology. Resection was followed by radiation, ileal loop diversion, and a complete cystectomy with node dissection. Code the procedures as follows:

Data Item	Treatment Codes
Surgery	See Appendix D, Cancer-Directed Surgical Codes
Radiation	1 – Beam radiation
Chemotherapy	0 – None
Hormone therapy	0 – None
Immunotherapy	0 – No immunotherapy
Other treatment	0 – No other cancer-directed therapy

Time Periods

All Malignancies Except Leukemias

First course of treatment includes all cancer-directed therapy planned and administered by the physician(s) during or after the initial diagnosis of cancer. Planned treatment may include multiple modes of therapy and may encompass intervals of a year or more.

If the therapy is part of an established protocol or administered within accepted management guidelines for the disease, it is first course of treatment. When a treatment plan is not available or is unclear, consult the physician advisor.

If there is no treatment plan, established protocol, or management guidelines, and consultation with a physician advisor is not possible, use the principle: "initial treatment must begin within four months of the date of initial diagnosis."

Treatment failure or disease progression may prompt the physician to stop therapy before the full course has been completed. Record any therapy administered after the discontinuation of first course as secondary or subsequent treatment.

Leukemias

First course of treatment includes all cancer-directed therapies planned and administered by the physician(s) during or after the initial diagnosis of leukemia. Record all remission-inducing or remission-maintaining cancer-directed therapy as first course of treatment. Treatment regimens may include multiple modes of therapy. The administration of these therapies can span a year or more.

Example: Certain pediatric leukemia protocols span two years or more from induction to the end of maintenance. Induction, consolidation, and maintenance are all first course of treatment.

If the therapy is part of an established protocol or administered within accepted management guidelines for the disease, it is first course of treatment. When a treatment plan is not available or is unclear, consult the physician advisor.

A patient may relapse after achieving a first remission. All therapy administered after the relapse is secondary or subsequent treatment.

Treatment

Non Cancer-Directed Treatment

Non cancer-directed treatments prolong the patient's life, alleviate pain, make the patient comfortable, or prepare the patient for cancer-directed therapy. They are not meant to destroy or control the tumor or delay the spread of disease. Non cancer-directed procedures include diagnostic tests and supportive care (treatments designed to relieve symptoms and minimize the effects of the cancer). Non cancer-directed therapies are generally not included in statistical analysis of treatment.

Examples: Closure of a colostomy following resection for cancer of the bowel would be a non cancer-directed treatment.

Diagnostic procedures:

Incisional biopsies

Exploratory procedures with or without biopsies

Supportive care/relieving symptoms:

Pain medication

Oxygen

Antibiotics administered for an associated infection

Transfusions

Intravenous therapy to maintain fluid or nutritional balance

Laser therapy directed at relieving symptoms

Megestrol Acetate is hormone therapy designed to improve nutritional status.

Cancer-Directed Treatment

Cancer-directed treatment is tumor directed, and its purpose is to modify, control, remove, or destroy primary or metastatic cancer tissue. Physicians administer the therapy(ies) to remove or minimize the size of tumor or to delay the spread of disease. Record all cancer-directed therapy administered to the patient. For complete treatment information, record therapy(ies) given in other institutions and failed treatments (the patient did not respond).

Examples: Patient is diagnosed with stage IV small cell carcinoma of the lung. The treatment plan recommends radiation to shrink the metastatic tumor and alleviate the pain caused by rib metastases. The reporting institution delivers the radiation. The field "Radiation" is coded 1, beam radiation.

A patient with breast cancer enters the reporting institution for a lumpectomy and axillary node dissection. The physician's treatment plan specifies radiation therapy to the intact breast following surgery. The patient is lost to followup. It is unknown if the patient had radiation. Code the appropriate surgery codes found in Appendix D.
Record the field "Reason No Radiation" as radiation recommended, unknown if done (8) and the field "Radiation" as none (0). When follow-up information becomes available, change the field "Radiation" to the appropriate code, that is, if followup reveals that the patient received radiation at another institution, change to the appropriate radiation code (1-5), and change the field "Reason No Radiation" to radiation treatment performed (0).

A patient enters the reporting institution with acute leukemia. The treatment plan specifies combination chemotherapy. The patient receives two weeks of chemotherapy and the physician documents, "The patient has failed treatment. We will now start a different course of chemotherapy." Record chemotherapy, multiple agents (3) as first course of treatment. The second chemotherapy regimen is subsequent treatment.

Treatment for Recurrence or Progression

Treatment for recurrence or progression of disease (formerly referred to as subsequent therapy) includes all cancer-directed therapies administered after the first course of treatment is complete.

If the patient does not respond or if the disease progresses, a physician may stop the first course of treatment before it is complete. Therapy administered after the first course is stopped is recorded as subsequent treatment.

Section Three: Comparison of Data Sets

Definitions

Required Data Set (R)

Commission-approved programs must record the required data set items using the codes and definitions specified in *ROADS*.

Supplementary Data Set (S)

The supplementary data set contains additional data items that are important for the efficient operation of a cancer registry. The Commission recommends that the supplementary data set be collected.

Optional Data Set (O)

The optional data set includes items that may be of interest to specific institutions or groups.

Surveillance, Epidemiology, and End Results Program (SEER)

Required data elements for a central registry affiliated with the National Cancer Institute's SEER Program.

National Program of Cancer Registries (NPCR)

Required and recommended data elements for state cancer registries participating in the National Program of Cancer Registries of the Centers for Disease Control & Prevention.

Comparison of Data Sets

An (x) indicates that the item is part of the data set.

*At the time of publication, it is unknown if the organization will collect this data item.

Item	CoC			SEER	NPCR
Patient Identification	**R**	**S**	**O**		
Institution ID Number (Required for participants in multiple-hospital registries)	x				
Accession Number	x			x	x
Sequence Number	x			x	x
Year First Seen for This Primary	x				
Medical Record Number	x				x
Social Security Number	x				x
Military Medical Record Number Suffix		x			x
Name Prefix			x		
Name Suffix		x			
Last Name	x				x
First Name	x				x
Middle Name	x				x
Maiden Name		x			x
Alias		x			x

Item	CoC			SEER	NPCR
Patient Identification (cont'd)	**R**	**S**	**O**		
Marital Status at Diagnosis			x	x	x
Patient Address (Number and Street) at Diagnosis	x				x
City/Town at Diagnosis	x				x
State at Diagnosis	x				x
Postal Code at Diagnosis	x				x
County at Diagnosis	x			x	x
Patient Address (Number and Street)–Current	x				
City/Town–Current	x				
State–Current	x				
Postal Code–Current	x				
County–Current			x		
Census Tract			x	x	x
Census Coding System			x	x	x
Telephone	x				
Place of Birth			x	x	x
Date of Birth	x			x	x
Age at Diagnosis		x		x	x
Race	x			x	x
Spanish Origin	x			x	x
Sex	x			x	x
Following Physician	x				
Managing Physician		x			
Primary Surgeon	x				
Physician #3		x			
Physician #4		x			
Primary Payer at Diagnosis	x				
Usual Occupation			x		x
Usual Industry			x		x
Family History of Cancer			x		
Tobacco History			x		
Alcohol History			x		
Type of Reporting Source			x	x	x
Abstracted By	x				

Item	CoC			SEER	NPCR
Cancer Identification	**R**	**S**	**O**		
Class of Case	x				x
Institution Referred From		x			
Institution Referred To		x			
Date of Inpatient Admission		x			
Date of Inpatient Discharge		x			
Inpatient/Outpatient Status			x		
Screening Date			x		
Screening Result			x		
Date of Initial Diagnosis	x			x	x
Primary Site	x			x	x
Laterality	x			x	x
Histology	x			x	x
Behavior Code	x			x	x
Grade/Differentiation	x			x	x
Diagnostic Confirmation	x			x	x
Tumor Marker #1		x		x	
Tumor Marker #2		x		x	
Tumor Marker #3		x		*	*
Presentation at Cancer Conference		x			
Date of Cancer Conference			x		
Referral to Support Services		x			
Stage of Disease at Diagnosis					
Size of Tumor	x			x	x
Extension (SEER EOD)		x		x	
Lymph Nodes (SEER EOD)		x		x	
Regional Nodes Examined	x			x	
Regional Nodes Positive	x			x	
Site of Distant Metastasis #1		x			
Site of Distant Metastasis #2		x			
Site of Distant Metastasis #3		x			
General Summary Stage (SEER) (Required only in the absence of AJCC classification)	x				x
Clinical T	x				

Item	CoC			SEER	NPCR
Stage of Disease at Diagnosis (cont'd)	**R**	**S**	**O**		
Clinical N	x				
Clinical M	x				
Clinical Stage Group	x				
Clinical Stage (Prefix/Suffix) Descriptor		x			
Staged By (Clinical Stage)	x				
Pathologic T	x				
Pathologic N	x				
Pathologic M	x				
Pathologic Stage Group	x				
Pathologic Stage (Prefix/Suffix) Descriptor		x			
Staged By (Pathologic Stage)	x				
Other T		x			
Other N		x			
Other M		x			
Other Stage Group		x			
Other Stage (Prefix/Suffix) Descriptor		x			
Staged By (Other Stage)	x				
Other Staging System			x		
Type of Staging System (Pediatric)	x				
Pediatric Stage	x				
Staged By (Pediatric Stage)	x				
TNM Edition Number	x				
Date of First Positive Biopsy			x		
Diagnostic and Staging Procedures	x				
First Course of Treatment					
Date of First Course Treatment	x			x	x
Date of Non Cancer-Directed Surgery	x				
Non Cancer-Directed Surgery	x				
Non Cancer-Directed Surgery at This Facility		x			
Date of Cancer-Directed Surgery	x				x
Surgical Approach	x			*	*
Surgery of Primary Site	x			*	*
Cancer-Directed Surgery at This Facility		x		*	*

Item	CoC			SEER	NPCR
First Course of Treatment (cont'd)	**R**	**S**	**O**		
Surgical Margins	x			*	*
Scope of Regional Lymph Node Surgery	x			*	*
Number of Regional Lymph Nodes Removed	x			*	*
Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)	x			*	*
Reconstruction/Restoration–First Course	x			*	*
Reason for No Surgery		x		x	x
Date Radiation Started	x				x
Radiation	x			x	x
Radiation at This Facility		x			
Regional Dose: cGy			x		
Number of Treatments to This Volume			x		
Radiation Elapsed Treatment Time (Days)			x		
Radiation Treatment Volume			x		
Location of Radiation Treatment			x		
Intent of Treatment (Radiation)			x		
Regional Treatment Modality			x		
Radiation Therapy to CNS			x	x	x
Radiation/Surgery Sequence			x	x	x
Radiation Treatment Completion Status			x		
Radiation Therapy Local Control Status			x		
Reason for No Radiation		x			
Date Chemotherapy Started	x				x
Chemotherapy	x			x	x
Chemotherapy at This Facility		x			
Chemotherapy Field #1			x		
Chemotherapy Field #2			x		
Chemotherapy Field #3			x		
Chemotherapy Field #4			x		
Reason for No Chemotherapy		x			
Date Hormone Therapy Started	x				x
Hormone Therapy	x			x	x
Hormone Therapy at This Facility		x			

Item	CoC			SEER	NPCR
First Course of Treatment (cont'd)	**R**	**S**	**O**		
Reason for No Hormone Therapy			x		
Date Immunotherapy Started	x				x
Immunotherapy	x			x	x
Immunotherapy at This Facility		x			
Date Other Treatment Started	x				x
Other Treatment	x			x	x
Other Treatment at This Facility		x			
Protocol Eligibility Status		x			
Protocol Participation		x			
Recurrence					
Date of First Recurrence	x				
Type of First Recurrence	x				
Other Type of First Recurrence(s)		x			
Date(s) of Subsequent Treatment(s) for Recurrence or Progression		x			
Type(s) of Subsequent Treatment for Recurrence or Progression		x			
Recurrence Site(s)			x		
Follow-up					
Date of Last Contact or Death	x			x	x
Vital Status	x			x	x
Cancer Status	x				
Quality of Survival			x		
Reconstruction/Restoration–Delayed	x				*
Following Registry			x		
Follow-up Source		x			
Next Follow-up Source		x			
Unusual Follow-up Method			x		
Cause of Death			x	x	x
ICD Revision Number			x	x	x
Autopsy			x		
Commission on Cancer Coding System–Current	x				

Section Four: Coding Instructions

Patient Identification

Institution ID Number

Item Length: 6
Data Type: Numeric
Required Data Set (participants in multiple hospital registries)

Use the Institution ID Number assigned by the Commission on Cancer. Each institution's identification number is unique. It appears on the Commission's mailing labels and survey form. If you need a single hospital ID number, call the American College of Surgeons Cancer Department at 312/202-5085. If you need a list of hospital ID numbers for your state or region, it is available on disk or hard copy from the Commission on Cancer.

This is a required data item for cancer programs that share a single registry. Each institution participating in a shared registry is assigned a unique number.

Record only the last six digits. Over time, some institutions may have been assigned a number that is preceded by an "H" and "6." These two characters should not be recorded.

Example: H6439999, General Hospital, Anytown, Illinois, would be recorded 439999.

Patient Identification

Accession Number

Item Length: 6
Data Type: Numeric
Required Data Set

The first two digits of the Accession Number specify the year in which the patient was first seen at the reporting institution for the diagnosis and/or treatment of cancer. Data collection begins on the registry's reference date. The last four numbers are the numeric order in which the registry entered the case into the database.

Example: A patient is diagnosed at the reporting institution in 1996. The first two digits of the Accession Number are 96. This is the 33rd patient accessioned in 1996, making the last four digits of the accession number 0033. The full Accession Number is 960033.

Assign a unique accession number to each patient. It identifies the patient even if multiple primaries exist. Use the same accession number for all subsequent primaries.

Examples: The registry assigns Accession Number 940133 to a patient with prostate cancer in 1994. This patient reenters the reporting institution in 1996 to have treatment for a primary lung cancer. The Accession Number for this second primary (lung) is 940133.

The registry assigns Accession Number 900150 to a patient with breast cancer in 1990. The patient develops a primary kidney cancer in 1996. The accession number for the kidney tumor is 900150.

Note: Numeric gaps in accession numbers are allowed. When a case is deleted from your database, do not reuse the accession number for another case. This will avoid any chance of two cases having the same accession number.

Class of Case 0, 1, and 6: The first two digits of the accession number are the same as the year in which the patient is seen at the reporting institution *or in a staff physician's office for diagnosis.*[10]

Note: Class of Case is defined in Section Four, Cancer Identification.

Exceptions: A patient enters the reporting institution in December 1995 and is diagnosed with cancer in January 1996. The Accession Number is 96 _ _ _ _.

The registry's reference date is January 1, 1996. A patient is diagnosed with breast cancer and has a partial mastectomy at the reporting institution in December 1995. The patient starts a course of radiation therapy at the reporting institution in January 1996. Assign the Accession Number 96 _ _ _ _.

Class of Case 2 and 3: The first two digits of the accession number are the year the patient is first seen at the reporting institution for treatment **after** the registry's reference date.

Examples: A patient had cancer-directed surgery elsewhere in December 1995. The reporting institution initiated outpatient[10] radiation therapy in January 1996. The Accession Number for this patient is 96 _ _ _ _.

[10]Applies to Class of Case 6, diagnosed and treated in a physician's office only.

Accession Number **(Continued)**

A patient had initial treatment in another institution in 1994. The patient is admitted and treated at the reporting institution in November 1996 for recurrent cancer. The Accession Number is 96 _ _ _ _.

Class of Case 4: The first two digits are the first year in which the reporting institution saw the patient for the management and/or treatment of active cancer **after** the registry's reference date.

Example: The registry's reference date is January 1, 1995. The reporting institution treated a patient for cancer of the larynx in 1994. The patient returns in March 1996 for treatment of recurrent laryngeal cancer. The Accession Number is 96 _ _ _ _.

Class of Case 5: The first two digits of the accession number are the year of the patient's death.

Example: An accident victim enters the intensive care unit from the emergency department on December 31, 1995. The patient expires the following day, January 1, 1996. An autopsy shows a previously unsuspected bladder cancer. Accession Number is 96 _ _ _ _.

Patient Identification

Sequence Number

Item Length: 2
Data Type: Alphanumeric
Required Data Set

The Sequence Number represents the order of all primary malignant and/or benign tumor diagnoses during the patient's lifetime. It counts the occurrence of *independent, primary tumors* except basal and squamous cell cancer of the skin (C44.–) that do not meet Commission histology and staging requirements.

Example: If a patient has a history of skin cancer, and information on histology and staging is unavailable, do not sequence.

Malignant Tumors

Codes (malignant primaries):

00 One primary only

01 First of two or more primaries

02 Second of two or more primaries

03 Third of three or more primaries

.. (Actual number of this primary)

99 Unspecified sequence number

The Sequence Number 00 indicates that this patient has only one primary malignancy. Change the Sequence Number from 00 to 01 if the patient develops another primary malignancy. The sequence 01 indicates that this case is the first of multiple primaries.

Example: In January 1995, the registry assigns a 00 sequence number to a patient with malignant melanoma. The patient develops a second primary cancer of the lung in July 1996. Assign an 02 sequence number to the second cancer (lung). Change the sequence number of the first cancer (malignant melanoma) to 01.

When malignancies occur simultaneously, assign the first sequence number (01) to the primary with the worse prognosis. When you cannot determine the severity of the prognosis, the assignment of a sequence number is arbitrary.

Examples: A patient enters the reporting institution with simultaneous carcinoma in situ of the cervix and invasive adenocarcinoma of the colon. Assign sequence number 01 to the colon primary.

A patient has simultaneous adenocarcinoma in situ in a colon polyp and squamous cell carcinoma in situ in a vocal cord polyp. Assign sequence numbers in any order, since both primaries have similar prognoses.

The sequence number counts the patient's independent, primary malignancies regardless of the location(s) or institution(s) where those primaries were diagnosed and treated.

Example: The reporting institution diagnoses colon cancer. The patient has a history of kidney cancer diagnosed and treated elsewhere. The colon cancer is the second of this patient's multiple primary cancers. Assign a sequence number 02 to the colon cancer.

Sequence Number (Continued)

These sites/histologies are single primaries. Any reappearance of the original disease is documented as a recurrence. Assign a sequence number to the first disease occurrence. Do not assign another sequence number to any subsequent occurrences.

- Bladder primaries with morphology codes 8120–8130
- Kaposi's sarcoma (9140/3)

Note: Report Kaposi's sarcoma as one primary. Refer to Section Four, Cancer Identification and Primary Site for coding rules.

- Patients diagnosed with skin cancer (C44.–) must be included if the histology is 8000–8004, 8010–8045, 8050–8076, 8081–8082, 8090–8110 and the AJCC Stage Group at diagnosis is II (T3), III, or IV. For details, see General Principles in Coding, Case Eligibility.

Note: Each occurrence of melanoma of the skin is a new/separate primary **unless** a physician states otherwise.

Nonmalignant Tumors (Benign and Borderline)

AA One benign tumor only

BB Second of two or more benign tumors

CC Third of two or more benign tumors

DD Fourth of three or more benign tumors

.. (Letters representing actual number of benign tumors)

XX Unspecified number of benign tumors

The benign sequence code does not affect the malignant sequence code. They are independent.

Example: A patient develops colon cancer in 1995. The sequence number is 00. The patient develops a benign meningioma in 1996. Meningiomas are reportable-by-agreement in the reporting facility, so the registry assigns the sequence number AA (one benign tumor only). The sequence number for the first primary (carcinoma of the colon) remains 00.

Use the sequence number 99 when it is impossible to estimate whether the patient has been diagnosed with an earlier malignancy (primary). If more information becomes available, change the sequence number(s).

Example: A patient is diagnosed in the reporting hospital with colon cancer. The medical record contains the statement "The patient recently had a salivary gland tumor removed. The patient does not know if the lesion was malignant." The registry assigns a 99 sequence number to the colon primary. The patient returns to the reporting facility a year later for treatment of prostate cancer. The medical record says "The patient has a history of a malignant salivary gland tumor." Change the sequence number of the colon cancer from 99 to 02. Assign the sequence number 03 to the prostate cancer.

Patient Identification

Year First Seen for This Primary
(Accession Year)

Item Length: 4
Data Type: Numeric
Required Data Set

The Year First Seen for This Primary (formerly Accession Year) is the year the patient was first seen at the reporting institution for diagnosis and/or treatment of this primary, since the reference date of the registry. It is **not** the year that the registrar accessioned the case. The Year First Seen for This Primary relates only to one primary tumor. A patient with multiple primaries can have a different Year First Seen for This Primary on each abstract.

The data item is used to produce an accession register. The accession register identifies all primaries first treated or seen at the reporting institution for a given year.

Record the first year in which the patient was seen at the reporting institution for diagnosis and/or treatment of this primary after the registry's reference date.

Examples: A patient had surgery for rectal carcinoma at another institution in December 1995 and started radiation therapy at the reporting institution in January 1996. Assign 1996 as the Year First Seen for This Primary.

A patient with breast cancer had initial therapy at another institution in July 1994. The patient enters the reporting institution in April 1996 for treatment of recurrent breast cancer. Assign 1996 as the Year First Seen for This Primary.

The registry's reference date is January 1, 1994. A patient entered the reporting institution with cancer of the larynx in July 1993. The patient returns to the reporting institution in August 1996 with recurrent laryngeal cancer. Assign 1996 as the Year First Seen for This Primary.

If the patient has a previous accession (another primary), the Year First Seen for This Primary may differ from the first two digits of the Accession Number.

Example: The patient had a breast primary in 1990 and was assigned an accession number 900150 and the Year First Seen for This Primary was recorded as 1990. The patient developed a second primary (right kidney) in 1996. Designate 1996 as the year first seen for the kidney primary, but keep the same Accession Number.

Patients first seen at the end of the year may present unusual problems. A patient may have inconclusive scans or tests in December and be diagnosed in January. Use the year of diagnosis as the Year First Seen for This Primary.

Example: A patient is admitted to the reporting institution in December 1995 and is diagnosed in January 1996. Assign 1996 as the Year First Seen for This Primary.

Patient Identification

Medical Record Number

Item Length: 11
Data Type: Alphanumeric
Required Data Set
Right Justified
Leading Blanks

The Medical Record Number is a patient identification number usually assigned by the reporting institution's health information management (HIM) department. If the medical record number is fewer than 11 characters, right justify the characters and allow leading blanks.

Example: Medical Record Number 811234 would be recorded _ _ _ _ _811234.

Record standard abbreviations for departments that do not use HIM medical record numbers.

Examples: Radiation therapy _ _ _ _ _ _ _ _ _ RT

One-day surgery clinic _ _ _ _ _ _ _ _ _ SU

If the Medical Record Number is unknown, record _ _ _ _ _ _ _ _ UNK

When a patient enters a military hospital as a family member of a military sponsor, see data item Military Medical Record Number Suffix. Do not code the patient's relationship to the military sponsor in this field.

Patient Identification

Social Security Number

Item Length: 9
Data Type: Numeric
Required Data Set

Record the patient's Social Security Number (SSN) without dashes. When a patient does not have a Social Security Number, or the information is not available, code 999999999.

Do not record a Social Security Number that ends with B or D. This is the spouse's Social Security Number. The patient receives benefits under the spouse's number.

Military Medical Record Number Suffix

Item Length: 2
Data Type: Numeric
Supplementary Data Set

The Military Medical Record Number Suffix is a patient identifier used by military hospitals. It records the relationship of the patient to the sponsor.

Code

01-19	Child
20	Sponsor
30-39	Spouse
40-44	Mother
45-49	Father
50-54	Mother-in-law
55-59	Father-in-law
60-69	Other eligible dependents
98	Civilian emergency (AF/Navy)
99	Not classified elsewhere/stillborn

The first spouse is always designated as 30. If the sponsor remarries, the second spouse would be designated 31, the third spouse 32, etc.

These are the Family Member Prefix (FMP) codes assigned by individual military medical facilities.

Patient Identification

Name Prefix

Item Length: 3
Data Type: Alpha
Mixed Case
Optional Data Set
Left Justified

Name Prefix is a title that would precede the name in a letter. It helps distinguish between patients with the same names. Do not use punctuation. Leave blank if the patient does not have a name prefix or if you choose not to collect this data item.

Suggested abbreviations:

Title	Abbreviation
Brother	Br
Doctor	Dr
Honorable	Hon
Missus	Mrs
Mister	Mr
Miss/Missus	Ms
Reverend	Rev
Sister	Sr

Patient Identification

Name Suffix

Item Length: 3
Data Type: Alpha
Mixed Case
Supplementary Data Set
Left Justified

Name Suffix is the title following a person's last name.

Example: Robert Jones, **Jr**.

A name suffix is frequently a generation identifier which helps to distinguish patients with the same last name. Do not use punctuation. Leave blank if the patient does not have a name suffix or if you choose not to collect this data item.

Suggested abbreviations:

Title	**Abbreviation**
Doctor	MD, PhD
Junior	Jr
Senior	Sr
Third	III
Fourth	IV

If multiple suffixes are used, the generation specific suffix is to be recorded.

Example: The patient's name is John C. Smith III, M.D. Record the III.

Patient Identification

Last Name

Item Length: 25
Data Type: Alpha
Required Data Set
Left Justified

Record the last name of the patient. Abbreviate the name if more than 25 letters long. Blanks, spaces, hyphens, special characters, and punctuation marks are allowed.

Example: Van Horn is recorded Van Horn. O'Hara is recorded O'Hara.

Do not leave blank. If the last name of the patient is unknown, enter UNKNOWN.

This field may be updated, if the last name changes.

Example: Janet White marries and changes her name to Janet Black. In the Last Name field, change the name to Black and record White in the Maiden Name field.

Patient Identification

First Name

Item Length: 14
Data Type: Alpha
Mixed Case
Required Data Set
Left Justified

Record the patient's full first name. Truncate names longer than 14 characters.

Example: Patient is admitted as Michael Hogan. Enter Hogan as the last name and Michael as the first name.

Leave blank if the first name is not known. If only a title is known, record the title under the data item Name Prefix.

Middle Name
(Middle Initial)

Item Length: 14
Data Type: Alpha
Mixed Case
Required Data Set
Left Justified
Blank Fill

Record the patient's middle name. Leave blank if the patient does not have a middle name or initial or if the middle name or initial are unknown.

This field has been expanded to accommodate a patient's full middle name. This will help distinguish between patients with identical names.

Maiden Name

Item Length: 15
Data Type: Alpha
Supplementary Data Set
Left Justified
Blank Fill

Record the maiden name of female patients who are, or have been married. Blanks, spaces, hyphens, special characters, and punctuation marks are allowed. This item is useful for matching multiple records for the same patient.

Leave this field blank if the patient does not have a maiden name or the information is not available.

This item is different from Alias.

Patient Identification

Alias

Item Length: 15
Data Type: Alpha
Supplementary Data Set
Left Justified
Blank Fill

A patient may use a different name or nickname. These different names are aliases. Leave the field blank if the patient does not have an alias or if an alias is not known. This item is useful for matching multiple records for the same patient.

If the patient uses an alias for a first name only, record the last name followed by the first name alias.

Example: Ralph Williams uses the name Bud Williams. Record Williams Bud in the alias field.

If the patient uses only a last name alias, record the last name alias followed by a blank space and the actual first name.

Example: Janice Smith uses the name Janice Brown. Record Brown Janice.

If the patient uses an alias for the first and last name, record the last name alias followed by a blank space and the first name alias.

Example: Samuel Clemens uses the name Mark Twain. Record Twain Mark in the alias field.

Patient Identification

Marital Status at Diagnosis
(Marital Status at Initial Diagnosis)

Item Length: 1
Data Type: Numeric
Allowable Values: 1-5, 9
Optional Data Set

Code the patient's Marital Status at Diagnosis for each primary tumor. The data may be corrected, but never change or update this data item.

Code

1 Single (never married)

2 Married (including common law)

3 Separated

4 Divorced

5 Widowed

9 Unknown

Note: If a patient is younger than 15 years of age, assume he/she is single and code 1.

Patient Identification

Patient Address

Use the guidelines on this page for all patient address data items.

Normally a residence is the home named by the patient. Legal status and citizenship are not factors in residency decisions. Rules of residency are identical to or comparable with the rules of the Census Bureau whenever possible. The registry can resolve residency questions by using the Census Bureau's definition "the place where he or she lives and sleeps most of the time or the place the person considers to be his or her usual home." Vital statistic rules may differ from census rules. Do not record residence from the death certificate. Review each case carefully.

For analytic cases (Class 0, 1, 2, and 6), the address would be the patient's home at the time he/she was diagnosed with cancer.

The address for nonanalytic cases (Class 3, 4, 5) is the patient's place of residence at the time he/she was seen at the reporting institution for this primary.

Rules for Persons without Apparent Residences

Persons With More Than One Residence (summer and winter homes): Use the address the patient specifies if a usual residence is not apparent.

Persons With No Usual Residence (transients, homeless): Use the address of the place they were staying when the cancer was diagnosed. This could be a shelter or the diagnosing institution.

Persons Away at School: College students are residents of the school area. Boarding school children below college level are residents of their parents' home.

Persons in Institutions: The Census Bureau states "Persons under formally authorized, supervised care or custody" are residents of the institution. This includes the following:

- Incarcerated persons
- Persons in nursing, convalescent, and rest homes
- Persons in homes, schools, hospitals, or wards for the physically disabled, mentally retarded, or mentally ill
- Long-term residents of other hospitals, such as Veterans Administration (VA) hospitals

Persons in the Armed Forces and on Maritime Ships: Members of the armed forces are residents of the installation area. Use the stated address for military personnel and their family. Military personnel may use the installation address or the surrounding community's address.

The Census Bureau has detailed residency rules for Naval personnel, Coast Guard, and maritime ships. Refer to Census Bureau publications for the detailed rules.

Patient Address at Diagnosis
(Number and Street)

Item Length: 25
Data Type: Alphanumeric
Required Data Set
Left Justified

Record the number and street address of the patient's usual residence when the tumor was diagnosed and treated. Leave a blank between numbers and words if space permits. Do not use punctuation. The use of capital letters is preferred by the US Postal Service; it also guarantees consistent results in queries and reporting. Abbreviate where necessary. If the patient has multiple tumors, the address may be different for subsequent primaries. If the patient address is not known, record UNKNOWN.

Example: The address 103 First Avenue S.W., Apartment #102 may be recorded as 103 FIRST AVE SW APT 102

The address is a part of the patient's demographic data and has multiple uses. It will provide a referral pattern report and allow analysis of cancer clusters or environmental studies. Do not update this field if the patient's address changes over time. See Patient Address for detailed residency rules.

City/Town at Diagnosis
(City or Town)

Item Length: 20
Data Type: Alpha
Required Data Set
Left Justified

Record the city or town of the patient's usual residence when the tumor was diagnosed and treated. If patient resides in a rural area, record the name of the city or town used in his or her mailing address. Do not use punctuation or special characters. The use of capital letters is preferred by the US Postal Service. It also guarantees consistent results in queries and reporting. Abbreviate when necessary. If the patient has multiple tumors, the address may be different for each primary. If the city is not known, record UNKNOWN.

The address is a part of the patient's demographic data and has multiple uses. It will provide a referral pattern report and allow analysis of cancer clusters or environmental studies. Do not update this field. Changing this field would destroy its usefulness. See Patient Address for detailed residency rules.

Patient Identification

State at Diagnosis
(State)

Item Length: 2
Data Type: Alpha
Upper Case
Required Data Set

Record the US postal service abbreviation for the state or Canadian province of the patient's usual residence when the tumor was diagnosed and treated. If the patient has multiple tumors, the address may be different for subsequent primaries. If the patient is a resident of a country other than Canada or the United States, record XX. If it is known that the patient is not a resident of Canada or the United States, and the country of residence is unknown, code YY. For unknown state, code ZZ.

Common abbreviations (Refer to the Zip Code directory for further listings):

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

State at Diagnosis **(Continued)**

The following are abbreviations for Canadian provinces:

Province		Province	
Alberta	AB	Nova Scotia	NS
British Columbia	BC	Ontario	ON
Labrador	LB	Prince Edward Island	PE
Manitoba	MB	Quebec	PQ
New Brunswick	NB	Saskatchewan	SK
Newfoundland	NF	Yukon	YT
Northwest Territories	NT		

The address is a part of the patient's demographic data and has multiple uses. It will provide a referral pattern report and allow analysis of cancer clusters or environmental studies. Do not update this field. Changing this field would destroy its usefulness. The data field County at Diagnosis is not useful for foreign residents. The registry identifies a foreign resident by entering XX into the State at Diagnosis field. The data field County at Diagnosis then becomes **Country** at Diagnosis. A Geocode will appear and the country code may be entered to identify the residence. See Patient Address for detailed residency rules.

Patient Identification

Postal Code at Diagnosis
(Zip Code)

Item Length: 9
Data Type: Alphanumeric
Required Data Set
Left Justified

For US residents, record the patient's nine-digit extended postal code at the time of diagnosis and treatment for this primary. When the nine-digit extended code is unavailable, record the five-digit postal code, left justified, followed by blanks. For Canadian residents, record the six-character postal code. Do not record hyphens. If the patient has multiple tumors, the postal code may be different for subsequent primaries. When available, record the postal code for other countries. Record 8's when the postal code is not known.

Example: The extended postal code 60611-2797 is recorded as 606112797. When only five digits, 60611, are available, record 60611 _ _ _ _ .

Codes:

888888888 Permanent address in a country other than Canada, United States, or US possessions **and** postal code is unknown.

999999999 Permanent address in Canada, United States, or US possession **and** postal code is unknown.

The address is a part of the patient's demographic data and has multiple uses. It will provide a referral pattern report and allow analysis of cancer clusters or environmental studies. Do not update this field. Changing this field would destroy its usefulness. See Patient Address for detailed residency rules.

Patient Identification

County at Diagnosis
(County)

Item Length: 3
Data Type: Numeric
Required Data Set

Record the county of the patient's usual residence when the tumor was diagnosed. This data item is required for residents of the reporting institution's state only. If the patient has multiple tumors, the county may be different for subsequent primaries.

A list of counties and their codes is usually available from central registries or state health departments. If not available, use the codes issued by the Bureau of Standards in the Federal Information Processing Standards (FIPS). The FIPS list of county codes is available in the publication *Counties and Equivalent Entities of the United States, Its Possessions, and Associated Areas*. This publication may be available in a reference library.

Code

998 Patient resides outside of the state of the reporting institution

999 Unknown county/country

When the registry records an XX code in the field State at Diagnosis, it prompts the Geocode to appear in the County at Diagnosis field. Enter the Geocode to identify the country in which the patient resides. If the country of residence is unknown, code 999. See Patient Address for detailed residency rules.

Patient Address (Number and Street)–Current

Item Length: 25
Data Type: Alphanumeric
Required Data Set
Left Justified

Record the number and street address of the patient's usual residence. Leave a blank between numbers and words if space permits. Do not use punctuation. The use of capital letters is preferred by the US Postal Service; it also guarantees consistent results in queries and reporting. Abbreviate where necessary.

Example: The address 103 First Avenue S. W., Apartment #102 may be recorded as 103 FIRST AVE SW APT 102

This item is different from Patient Address at Diagnosis. It provides a current address for follow-up purposes and should be updated. See Patient Address for detailed residency rules.

City/Town–Current

Item Length: 20
Data Type: Alpha
Required Data Set
Left Justified

Record the city or town of the patient's usual residence. If the patient resides in a rural area, record the name of the city or town used in his or her mailing address. Do not use punctuation or special characters. The use of capital letters is preferred by the US Postal Service; it also guarantees consistent results in queries and reporting. Abbreviate when necessary.

This item is different from City/Town at Diagnosis. It provides a current city/town for follow-up purposes and should be updated. See Patient Address for detailed residency rules.

Patient Identification

State–Current

Item Length: 2
Data Type: Alpha
Required Data Set
Upper Case

Record the US Postal Service abbreviation for the state or the Canadian province of the patient's usual residence. If the patient is a resident of a country other than Canada or the United States, record XX. If you know the patient is not a resident of Canada or the United States and the country of residence is unknown, code YY. For unknown state, code ZZ.

Common abbreviations:

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

State–Current **(Continued)**

The registry identifies a foreign resident by entering XX into the State–Current field. The data field County–Current then becomes Country–Current. A Geocode will appear and the country code may be entered to identify the residence. See “Patient Address” for detailed residency rules.

The following are abbreviations for Canadian provinces:

Province		Province	
Alberta	AB	Nova Scotia	NS
British Columbia	BC	Ontario	ON
Labrador	LB	Prince Edward Island	PE
Manitoba	MB	Quebec	PQ
New Brunswick	NB	Saskatchewan	SK
Newfoundland	NF	Yukon	YT
Northwest Territories	NT		

This item is different from State at Diagnosis. It provides a current state for follow-up purposes and should be updated.

Postal Code–Current

Item Length: 9
Data Type: Alphanumeric
Required Data Set
Left Justified

Record the US Postal Service nine-digit extended postal code for the city and state of the patient's residence. When the nine-digit extended code is unavailable, record the five-digit postal code, left justified, followed by blanks. Do not record hyphens. When available, record the postal code for other countries. Record 8s, when the postal code is not known.

Example: The extended postal code 60611-2797 is recorded as 606112797. When only five digits, 60611, are available, record 60611 _ _ _ _ .

This item is different from Postal Code at Diagnosis. It provides a current postal code for follow-up purposes and should be updated.

Code

888888888 Permanent address in a country other than Canada, United States, or US possessions and postal code is unknown.

999999999 Permanent address in Canada, United States, or US possession and postal code is unknown.

See Patient Address for detailed residency rules.

County–Current

Item Length: 3
Data Type: Numeric
Optional Data Set

Record the county of the patient's usual residence.

A list of counties and their codes is usually available from central registries or state health departments. If not available, use the codes issued by the Bureau of Standards in the Federal Information Processing Standards (FIPS). The FIPS list of county codes is available in the publication *Counties and Equivalent Entities of the United States, Its Possessions, and Associated Areas.* This publication may be available in a reference library.

This item is different from County at Diagnosis. It provides a current county that may be helpful in providing marketing information for administrative use and should be updated.

County–Current may be used in administrative reports to define your referral area. It may be used by marketing and in epidemiologic studies.

See Patient Address for detailed residency rules.

When the registry records a 99 code in the field State–Current, it prompts Geocodes to appear in the County–Current field. Enter the Geocode to identify the country in which the patient resides. If the country of residence is unknown, code 999.

Patient Identification

Census Tract

Item Length: 6
Data Type: Numeric
Optional Data Set
Zero Fill

Census Tract identifies the patient's usual residence at the time the tumor was diagnosed. The central registry usually codes this item and reports it to the institution's registry. Collection may be required by central registries.

A census tract is a small statistical subdivision of a county. Census tract codes originate from the Bureau of the Census and are constructed using the patient's address. Codes are available from state health departments or the Bureau of the Census. Census tracts change as the population changes.

To code census tract, assume that the decimal point is between the fourth and fifth positions of the field. Add zeros to fill all six positions.

Example: Census tract 409.6 would be coded 040960, and census tract 516.21 would be coded 051621.

Code

000000 Area is not census tracted

999999 Area is census tracted, but census tract is not available

Patient Identification

Census Coding System
(Coding System for Census Tract)

Item Length: 1
Data Type: Numeric
Values 0-3
Optional Data Set

The Census Coding System identifies which set of Census Bureau definitions was used to code the record. The Census Bureau periodically changes the census tract boundaries. This is usually coded by, and may be required by, central registries.

Code

0 Not census tracted

1 1970 census tract definitions

2 1980 census tract definitions

3 1990 census tract definitions

Telephone

Item Length: 10
Data Type: Numeric
Required Data Set

The first three digits of the telephone number are the area code. The last seven digits are the telephone number. Record the area code even if the patient is a local resident.

Do not use dashes or slashes, or leave spaces.

If the patient does not have a telephone, code 0000000000.

If telephone number is unavailable or unknown, code 9999999999.

Place of Birth

Item Length: 3
Data Type: Numeric
Optional Data Set

Record the patient's place of birth using the SEER Geocodes for Place of Birth in Appendix C. These codes include states of the United States as well as foreign countries. Use the most specific code possible.

At the time SEER assigned Geocodes in the 1970s, the United States owned or controlled islands in the Pacific. Many of these islands are now independent. Some are controlled by countries other than the United States. The original codes are used for these islands to preserve historic information. The names have been annotated to show the new political designation. The alphabetic list displays the correct code.

Code

998 Place of birth outside of the United States, Geocode unknown

999 Place of birth unknown

Patient Identification

Date of Birth

Item Length: 8
Data Type: Numeric
Required Data Set

Record the patient's date of birth in month, day, year format (MMDDCCYY). Record the month in the first two spaces, the day in the third and fourth spaces, and the year in the last four spaces. A zero must precede single-digit months and days. Do not create alternate codes.

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	25		
07	July	..		
08	August	31		
09	September	99	Day unknown	
10	October			
11	November			
12	December			
99	Month unknown			

Example: June 30, 1906 would be recorded 06301906.

Estimate date of birth when information is not available. It is better to estimate than to code as an unknown value.

Examples: The patient is admitted on June 15, 1996 and states her age as 60 years old. The medical record does not have a birth date. Record unknown month (99) and day (99). Estimate the year as 1936 (99991936).

Record the patient's date of birth as 99991927 when the medical record contains only the year of birth (1927).

Age at Diagnosis

Item Length: 3
Data Type: Numeric
Supplementary Data Set
Right Justified
Zero Fill

Age at Diagnosis is the patient's age at his or her last birthday before diagnosis.

000 Less than one year old

001 One year old, but less than two years old

002 Two years old

... (Actual age in years)

101 One hundred one years old

...

120 One hundred twenty years old

999 Unknown age

Patient Identification

Race

Item Length: 2
Data Type: Numeric
Allowable Values: 01-14, 20-22, 25-28, 30-32, 96-99
Required Data Set

Race is analyzed with the data item Spanish/Hispanic origin. Both items must be recorded.

Code

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

- White includes Mexican, Puerto Rican, Cuban, and all other Caucasians.
- Black includes the designations Negro or African-American.
- A combination of white and any other race is coded to the other race.
- A mixture of Hawaiian and any other race is coded Hawaiian (07).
- A combination of nonwhite races is coded to the first nonwhite race documented.
- Race is based on birthplace information when place of birth is given as China, Japan, or the Philippines, and race is reported only as Asian, Oriental, or Mongolian.

Example: Code Race 05 (Japanese) if the patient is reported as Oriental and the place of birth is Japan.

Note: Codes 20-97 were adopted for use effective with 1991 diagnoses and code 14 for 1994 and later cases.

Patient Identification

Spanish Origin–All Sources
(Spanish/Hispanic Origin)

Item Length: 1
Data Type: Numeric
Allowable Values: 0-7, 9
Required Data Set

Code the Spanish/Hispanic origin. This item identifies persons of Spanish/Hispanic surname or ethnicity. A person of Spanish/Hispanic origin may be any race.

Code

0 Non-Spanish; non-Hispanic

1 Mexican (includes Chicano)

2 Puerto Rican

3 Cuban

4 South or Central American (except Brazil)

5 Other specified Spanish/Hispanic origin (includes European)

6 Spanish, NOS; Hispanic, NOS; Latino, NOS (There is evidence other than surname or maiden name that the person is Hispanic, but he/she cannot be assigned to any category of 1-5)

7 Spanish surname only (The only evidence of the person's Hispanic origin is surname or maiden name and there is no contrary evidence that the person is not Hispanic)

9 Unknown whether Spanish or not

Code Portuguese and Brazilians as non-Spanish (0)

Patient Identification

Sex

Item Length: 1
Data Type: Numeric
Allowable Values: 1-4, 9
Required Data Set

Code the patient's sex.

Code

1 Male

2 Female

3 Other (hermaphrodite)

4 Transsexual

9 Not stated

Following Physician
(Follow-up Physician)

Item Length: 8
Data Type: Alphanumeric
Required Data Set
Left Justified

The Following Physician is the person currently responsible for the patient's medical care. Follow-up letters will be directed to this physician. The registry assigns a unique number to the follow-up physician. The identification number may include numbers and letters. Many registries use the physician's state medical license number.

Change this data item when follow-up becomes the responsibility of another physician.

Code 99999999 when the following physician is unknown or when an identification number is not assigned.

Managing Physician
(Attending Physician)

Item Length: 8
Data Type: Alphanumeric
Supplementary Data Set
Left Justified

Managing Physician is the person responsible for the overall management of the patient during diagnosis and/or treatment for this primary. The registry assigns a unique number to the physician. The identification number may include numbers and letters. Many registries use the physician's state medical license number.

The information should not be changed or updated even if the patient receives care from another physician. Administrative, physician, and service referral reports are based on this item.

Code 99999999 when the managing physician is unknown or when an identification number is not assigned.

Primary Surgeon

Item Length: 8
Data Type: Alphanumeric
Required Data Set
Left Justified

Use this data item to identify the surgeon who performed the most definitive surgical procedure.

The registry assigns a unique number to the primary surgeon. The identification number may include numbers and letters. Many registries use the physician's state medical license number.

If the patient did not have cancer-directed surgery, code the surgeon who performed any non cancer-directed surgery or did a surgical consultation.

Once the registry has designated a primary surgeon for the patient, the information should not be changed or updated even if the patient receives care from another physician. Administrative, physician, and service referral reports are based on this data item.

Code 00000000 if the patient had no surgery (non cancer-directed or cancer-directed) and no surgical consultation.

Code 88888888 if the physician who performed a surgical procedure was not a surgeon (radiation oncologist, general practitioner, and so on).

Code 99999999 when the primary surgeon is unknown or when an identification number is not assigned.

Patient Identification

Physician #3
(Other Physician)

Item Length: 8
Data Type: Alphanumeric
Supplementary Data Set
Left Justified

This data item identifies another physician involved in the care of the patient. The registry assigns a unique number to the physician. The identification number may include numbers and letters. Many registries use the physician's state medical license number.

Hospitals may elect to limit the use of this field to record radiation oncologists for internal analysis. The data will not be valid for comparison because the use will vary from institution to institution.

Physician name may be used for in-house quality control, follow up, administrative planning, and/or facility/personnel planning.

Code 00000000 (none) if no other physician was involved in the patient's care.

Code 99999999 when the physician is unknown or when an identification number is not assigned.

Physician #4
(Other Physician)

Item Length: 8
Data Type: Alphanumeric
Supplementary Data Set
Left Justified

This data item identifies another physician involved in the care of the patient. The registry assigns a unique number to the physician. The identification number may include numbers and letters. Many registries use the physician's state medical license number.

Hospitals may elect to limit the use of this field to record medical oncologists for internal analysis. The data will not be valid for comparison because the use will vary from institution to institution.

Physician name may be used for in-house quality control, follow up, administrative planning, and/or facility/personnel planning.

Code 00000000 (none) if no other physician is involved in the patient's care.

Code 99999999 when the physician is unknown or when an identification number is not assigned.

Primary Payer at Diagnosis

Item Length: 2
Data Type: Numeric
Allowable Values: 00-02, 10, 20-22
30-32, 40-47, 88, 99
Required Data Set

Code the patient's primary payer/insurance carrier at the time of initial diagnosis and/or treatment. This item is used in financial analysis and as an indicator for quality and outcome analyses.

Do not update this item.

Code

00 Not insured, NOS

01 Not insured, charity write-off

02 Not insured, self-pay

10 Private insurance

20 Managed care provider, NOS

21 Health Maintenance Organization (HMO)

22 Preferred Provider Organization (PPO)

30 State funded, NOS

31 Medicaid

32 Welfare

40 Federally funded, NOS

41 Medicare

42 Medicare with supplement

43 Champus

44 Military

45 Veterans Administration

46 Indian Health Service

47 Public Health Service

88 Insured, NOS

99 Unknown

Primary Payer at Diagnosis (Continued)

Clarification of code definitions:

Code	Definitions
00	Patient has no insurance. Unknown if account paid by patient or if it was a charity write-off.
01	Charity or write-off cases. The patient has no insurance and does not have personal funds to pay the account.
02	The patient has no insurance but assumes personal responsibility to pay the account.
10	Insurance carried by the patient or patient's family other than those listed in codes 20-47.
20	Patient has insurance with a managed care provider; unknown what type (HMO, PPO, etc.)
21	An organization that provides, offers, or arranges comprehensive health care services to a voluntarily enrolled membership for a prepaid fee.
22	A group of participating providers who have agreed to furnish services to covered persons at negotiated fees.
30	The medical care was paid from special state funds available to cover medical care for certain diseases or groups of people. Include care by state funds of unknown type.
31	State-funded medical insurance for persons who are uninsured, below poverty level, covered under entitlement programs, etc.
32	Some states have both medicaid and welfare programs.
40	Patient's account was paid by a federally funded agency; unknown which agency.
41	Government insurance for persons who are retired or disabled.
42	Patient has Medicare and another insurance to pay costs not covered by Medicare.
43	Military personnel or their dependents who procured a certificate of nonavailability and opted to seek medical attention at a nonmilitary facility.
44	Military personnel or their dependents who are treated in a military facility.
45	Veterans who are treated in Veterans Administration facilities.
46	Patient received care at an Indian Health Service facility or received care at another facility and medical costs were reimbursed by the Indian Health Service.
47	Patient received care at a public health service facility or received care at another facility and medical costs were reimbursed by the Public Health Service.
88	The patient is insured, but the insurance type is unknown.
99	It is unknown if the patient is insured.

Patient Identification

Usual Occupation

Item Length: 40
Data Type: Free Text
Upper and Lower Case
Optional Data Set

Usual Occupation is that which appears on death certificates and conforms to the 1989 revision of the US Standard Certificate of Death. See also: *Guidelines for Reporting Occupation and Industry on Death Certificates*, National Center for Health Statistics, CDC. DHHS Pub. No. (PHS) 88-1149.

Record the patient's usual occupation (that is, the kind of work performed during most of the patient's working life before diagnosis of this tumor). Do **not** record "retired."

If **usual** occupation is not available or is unknown, record the patient's current or most recent occupation or any known occupation.

Update this field if better information is obtained as to the usual occupation of the patient. However, it is **not** the responsibility of facility registrars to update abstracts with information provided on death certificates. Comparison with death certificate information should be the function of a central or regional registry.

If the patient was a housewife/househusband and also worked outside the home most of her/his adult life, record the usual occupation outside the home. If the patient was a housewife/househusband and did **not** work outside the home for most of her/his adult life, record "housewife" or "househusband."

If the patient was not a student or housewife and never worked, record "never worked" as the usual occupation.

If no information is available, record "unknown."

This data item applies only to patients who are 14 years or older at the time of diagnosis.

Patient Identification

Usual Industry

Item Length: 40
Data Type: Free Text
Upper and Lower Case
Optional Data Set

Both occupation and business/industry are required to accurately describe an individual's occupation.

The data item Usual Industry (a.k.a. Kind of Business/Industry) is that which appears on death certificates and conforms to the 1989 revision of the US Standard Certificate of Death. See also: *Guidelines for Reporting Occupation and Industry on Death Certificates*, National Center for Health Statistics, CDC. DHHS Pub. No. (PHS) 88-1149.

Record the primary type of activity carried on by the business/industry where the patient was employed for the most number of years before diagnosis of this tumor.

Be sure to distinguish among "manufacturing," "wholesale," "retail," and "service" components of an industry that performs more than one of these components.

If the primary activity carried on at the location where the patient worked is unknown, it may be sufficient to record the name of the company (with city or town) for which the patient performed his/her usual occupation. In these situations, if resources permit, a central or regional registry may be able to use the employer name and city/town to determine the type of activity conducted at that location.

If current or most recent occupation, rather than usual occupation was recorded, record the patient's current or most recent business/industry.

Update this field if better information is obtained as to the usual industry of the patient. However, it is **not** the responsibility of facility registrars to update abstracts with industry information provided on death certificates. Comparison with death certificate information should be the function of a central or regional registry.

There should be an entry for Usual Industry if any occupation is reported. If no information is available regarding the industry in which the reported occupation was carried out, record "unknown."

This data item applies only to patients who are 14 years or older at the time of diagnosis.

Family History of Cancer

Item Length: 1
Data Type: Numeric
Allowable Values: 0, 1, 9
Optional Data Set

Code whether the patient has a family history of any reportable malignancy.

Code

0 No

1 Yes

9 Unknown

Tobacco History

Item Length: 1
Data Type: Numeric
Allowable Values: 0-5, 9
Optional Data Set

Code the patient's past or current use of tobacco.

Code

0 Never used

1 Cigarette smoker, current

2 Cigar/pipe smoker, current

3 Snuff/chew/smokeless, current

4 Combination use, current

5 Previous use

9 Unknown

Alcohol History

Item Length: 1
Data Type: Numeric
Allowable Values: 0-2, 9
Optional Data Set

Code the patient's past or current consumption of alcoholic beverages including wine or beer.

Code

0 No history of alcohol use

1 Current use of alcohol

2 Past history of alcohol use, does not currently use

9 Alcohol usage unknown

Patient Identification

Type of Reporting Source

Item Length: 1
Data Type: Numeric
Allowable Values: 1, 3-7
Optional Data Set

Code the source of documents used to abstract the cancer being reported. This item is used by central registries.

Code

1 Hospital inpatient, hospital outpatient, clinic

3 Laboratory only (hospital or private)

4 Physician office/private medical practitioner

5 Nursing home, convalescent home, convalescent hospital, hospice

6 Autopsy only

7 Death certificate only

Patient Identification

Abstracted By

Item Length: 3
Data Type: Alphanumeric
Required Data Set

Enter the initials or assigned code of the individual who abstracted this case. Do not code the data entry person **unless** that person is also the abstractor. This item is most useful for multistaffed registries and can be used for quality control and management.

Cancer Identification

Class of Case

Item Length: 1
Data Type: Numeric
Allowable Values: 0-6, 8, 9
Required Data Set

Class of Case divides the data into analytic and nonanalytic categories.

Code

0 First diagnosed at the reporting institution since the registry's reference date and all of the first course of therapy elsewhere

1 First diagnosed and all or part of the first course of therapy at the reporting institution

2 First diagnosed elsewhere and treatment plan developed and documented and/or the first course of therapy given at the reporting institution after the registry's reference date

3 First diagnosed and all of the first course of therapy elsewhere

4 First diagnosed and first course of therapy at the reporting institution before the reference date of the registry

5 First diagnosed at autopsy

6 Diagnosed and all of the first course of treatment only in a staff physician's office

8 Diagnosis established only by death certificate

9 Unknown

Analytic cases (0, 1, 2, and 6) are:

- Patients diagnosed at the reporting institution since the registry's reference date regardless of whether or not the patient was treated at the reporting facility.
- Patients who received all or part of their first course of treatment at the reporting institution since the registry's reference date.
- Patients diagnosed prior to the registry's reference date whose first course of treatment continues at the reporting institution after the reference date.
- Patients diagnosed and treated only in a staff physician's office.

Note: These cases are included in treatment and survival statistics.

Non analytic cases (3, 4, 5, 8, and 9) are:

- Patients diagnosed and received all of their first course of treatment at another institution.
- Patients diagnosed and/or received all or part of the first course of treatment at the reporting institution before the registry's reference date.
- Patients diagnosed at autopsy.
- Diagnoses based on death certificates only.

Note: These cases are not usually included in routine treatment or survival statistics.

Class of Case **(Continued)**

Class 0 cases are diagnosed at the reporting institution and are treated elsewhere. Cases include:

- Patients who choose to be treated elsewhere.
- Patients who are referred elsewhere for treatment.

  Examples: Lack of special equipment; proximity of a patient's residence to the treatment center; financial, social, or rehabilitative considerations.

Class 1 cases are diagnosed at the reporting institution. They also fulfill one of the following treatment situations:

- Patient received all or part of his or her first course of treatment at the reporting institution.
- Patient refused any therapy.
- Patient was untreatable because of age, advanced disease, or other medical conditions.
- Specific therapy was recommended but not received at the reporting institution and it is unknown if therapy was ever administered.
- It is unknown if therapy was recommended or administered.
- Patient was diagnosed at the reporting institution prior to the registry's reference date and all or part of first course of treatment was received at the reporting institution after the registry's reference date.
- Patient was first diagnosed and had staging workup at the reporting institution and all or part of the first course of treatment was received in a staff physician's office.
- Patient was diagnosed in a staff physician's office and then treated at the reporting institution.
- Patient was diagnosed and a treatment plan was developed and documented at the reporting institution. Therapy was delivered elsewhere in accordance with the treatment plan.

Class 2 cases are diagnosed elsewhere. They also fulfill one of the following treatment situations:

- The reporting institution administered all or part of the first course of treatment.
- The reporting institution developed and documented a treatment plan or made the management decisions.

Class 3 cases are patients who were diagnosed and received all of their first course of treatment elsewhere. They are then seen at the reporting institution for additional therapy or management, and have active disease. This class of case includes:

- No information is available on his or her first course of treatment, patient is now treated or managed at the reporting institution.
- The reporting institution is treating or managing the recurrence, progression, or subsequent treatment of a previously diagnosed malignancy.

Class 4 includes cases that were diagnosed and/or received their first course of treatment at the reporting institution **before** the registry's reference date. The reporting institution manages or treats a recurrence or progression of that cancer **after** the registry's reference date.

Class of Case (Continued)

- Assign a class of case 4 if it is unknown whether the reporting institution delivered the first course of treatment.

Class 5 refers to an incidental finding of cancer at autopsy. There was no suspicion of cancer before the autopsy.

Class 6 includes patients who were both diagnosed and received all of their first course of treatment in a staff physician's office.[12]

Class 8 should be used only by a central registry and includes:

- Diagnoses based on death certificates only

Class 9 should be used only by a central registry and includes:

- Unknown if previously diagnosed
- Unknown if previously treated
- Previously diagnosed, date unknown

[12]The requirement extends to those physicians who are members of the institution's medical staff. If a physician holds multiple staff appointments, the physician must assign reporting responsibility to one of the institutions.

Cancer Identification

Institution Referred From

Item Length: 6
Data Type: Numeric
Supplementary Data Set
Right Justified

Institution Referred From identifies the facility that referred the patient to the reporting institution. Each institution's identification number is unique.

Institutions should use the ID number assigned by the Commission on Cancer.

Record only the last six digits. Over time, some institutions may have been assigned a number that is preceded by an "H" and "6." These two characters should not be recorded. Right justify the six-digit number.

Example: H6439999, General Hospital, Anytown, Illinois, would be recorded 439999.

Code 000000 if the patient was not referred to the reporting institution from another institution

Code 999999 if the patient was referred but the referring institution's ID number is unknown.

If you need a single hospital ID number, call the Cancer Department of the American College of Surgeons. A list of hospital ID numbers for your state or region is available on disk or hard copy from the Cancer Department of the American College of Surgeons.

Cancer Identification

Institution Referred To

Item Length: 6
Data Type: Numeric
Supplementary Data Set
Right Justified

Institution Referred To identifies the institution to which the patient was referred for further care after discharge from the reporting institution. Each institution's identification number is unique.

Institutions should use the ID number assigned by the Commission on Cancer.

Record only the last six digits. Over time, some institutions may have been assigned a number that is preceded by an "H" and "6." These two characters should not be recorded. Right justify the six-digit number.

Example: H6439999, General Hospital, Anytown, Illinois, would be recorded 439999.

Code 000000 if the patient was not referred to another institution.

Code 999999 if the patient was referred but the institution's ID number is unknown.

If you need a single hospital ID number, call the Cancer Department of the American College of Surgeons. A list of hospital ID numbers for your state or region is available on disk or hard copy from the Cancer Department of the American College of Surgeons.

Date of Inpatient Admission

Item Length: 8
Data Type: Numeric
Supplementary Data Set

Record the date of the inpatient admission to the facility for the most definitive surgery. If the patient does not have surgery, use the inpatient admission date for any other cancer-directed therapy. If the patient has no cancer-directed therapy, use the date of inpatient admission for diagnostic evaluation.

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			

Example: Record June 30, 1996 as 06301996.

Code 9 for unknowns:

- Code 99 for unknown month.
- Code 99 for unknown day.
- Code 9999 for unknown year.

If the patient was never an inpatient, code as 00000000.

Date of Inpatient Discharge

Item Length: 8
Data Type: Numeric
Supplementary Data Set

Record the date of the inpatient discharge from the facility for the most definitive surgery. If the patient did not have surgery, use the inpatient discharge date for any other cancer-directed therapy. If the patient has no cancer-directed therapy, use the date of inpatient discharge for diagnostic evaluation.

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			

Example: Record June 30, 1996 as 06301996.

Code 9 for unknowns:

- Code 99 for unknown month.
- Code 99 for unknown day.
- Code 9999 for unknown year.

If the patient was never an inpatient, code as 00000000.

Cancer Identification

Inpatient/Outpatient Status

Item Length: 1
Data Type: Numeric
Allowable Values: 1-3, 8, 9
Optional Data Set

Inpatient/Outpatient Status allows the facility to identify points of access used to initially diagnose and/or treat the patient.

Code the access point from which the patient first entered the hospital system for either the initial diagnosis or treatment. If the patient was initially diagnosed or treated (all first course) before entering the reporting facility, code 8 (other).

Code

1 Inpatient only

2 Outpatient only

3 In and outpatient*

8 Other, including physician's office

9 Unknown

* This applies to patients who entered the institution as an outpatient and were admitted as an inpatient on the same day.

Screening Date

Item Length: 8
Data Type: Numeric
Optional Data Set

Record the most recent date on which the patient participated in a screening program related to this primary cancer.

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			

Example: Record June 30, 1996 as 06301996.

Code 9 for unknowns:

- Code 99 for unknown month.
- Code 99 for unknown day.
- Code 9999 for unknown year.

If the patient did not participate in a screening program related to this primary, code as 00000000.

Cancer Identification

Screening Result

Item Length: 1
Data Type: Numeric
Allowable Values: 0-4, 8, 9
Optional Data Set

This item categorizes findings from the most recent screening(s), serves as a triage for patient notification, and acts as a tickler file to aid the institution in meeting patient notification requirements.

Code

0 Within normal limits

1 Abnormal/not suggestive of cancer

2 Abnormal/suggestive of cancer

3 Equivocal/no followup necessary

4 Equivocal/evaluation recommended

8 Not applicable

9 Unknown result, not specified

Cancer Identification

Date of Initial Diagnosis

Item Length: 8
Data Type: Numeric
Required Data Set

Date of Initial Diagnosis is the month, day, and year (MMDDCCYY) that this primary cancer was first diagnosed by a recognized medical practitioner.

The first two digits record the month, the third and fourth digits record the day, and the last four digits record the year of diagnosis.

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			

Example: Record June 30, 1996 as 06301996.

Code 9 for unknowns:

- Code 99 for unknown month
- Code 99 for unknown day
- Code 9999 for unknown year

The first diagnosis is often clinical and may never be histologically confirmed. Do not change the date of diagnosis when a later biopsy or cytology provides confirmation of a clinical diagnosis.

Examples: A March 12, 1996 mammogram reveals a mass in the upper-outer quadrant of a patient's right breast compatible with carcinoma. On March 20, 1996, the patient has an excisional breast biopsy that confirms infiltrating ductal carcinoma. Date of initial diagnosis is 03121996.

A physician notes a prostate nodule that is suspicious for cancer during a May 12, 1996 physical examination. On June 15, 1996 an ultrasound guided needle biopsy of the prostate provides histologic confirmation of adenocarcinoma. Date of initial diagnosis is 05121996.

Date of Initial Diagnosis **(Continued)**

If the physician states that in retrospect the patient had cancer at an earlier date, then use the earlier date as the date of initial diagnosis.

Example: A patient has a total abdominal hysterectomy for endometriosis in January 1995. The patient is admitted to the hospital with abdominal pain and distention in November 1996. A laparoscopy with omental biopsy shows metastatic cystadenocarcinoma. Pathologists review the 1995 hysterectomy specimen. They identify an area of cystadenocarcinoma in the left ovary. Date of Initial Diagnosis is 01991995.

The Date of Death is the Date of Initial Diagnosis for a Class of Case 5.

Estimate the date of initial diagnosis if you do not know the exact date. Approximation is preferable to recording the date as unknown.

Example: If the patient is diagnosed elsewhere before entering the reporting institution and the date of initial diagnosis is unknown, record the date the patient was first seen at the reporting institution as the date of initial diagnosis.

Use the date therapy was started as the date of initial diagnosis if the patient receives cancer-directed treatment before a definitive diagnosis.

If information is limited to a description, use the following:

Descriptive Term Used	Date Code
"Spring"	April
"The middle of the year"	July
"The fall of the year"	October
"The winter of"	Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

Primary Site

Item Length: 4
Data Type: Alphanumeric
Allowable Values: "C" followed by three digits
Required Data Set

Record the ICD-O-2 topography code for the site of origin. Consult the physician advisor to identify the primary site or the most definitive site code if the medical record does not contain that information. Primary site codes may be found in the ICD-O-2 Topography, Numerical List section (pages 1–20) and in the Alphabetic Index (pages 51–136). Follow the ICD-O-2 coding rules outlined on pages xx-xxiii.

The topography codes are indicated by a C preceding the three-digit code number. Do not record the decimal point.

Example: Breast, upper-outer quadrant appears in the ICD-O-2 as C50.4 and is recorded C504.

Use the subcategory 8 for single tumors that overlap the boundaries of two or more subsites and the point of origin is not known.

Examples: Code overlapping lesion (C10.8) when a large tumor involves both the lateral wall of the oropharynx (C10.2) and the posterior wall of the oropharynx (C10.3) and the point of origin is not stated.

Code overlapping lesion of the bladder (C67.8) when a single lesion involves the dome (C67.1) and the lateral wall (C67.2) and the point of origin is not stated.

Use the subcategory 9 for multiple tumors that originate in one organ.

Example: Code bladder, NOS (C67.9) when multiple lesions arise in both the trigone (C67.0) and lateral wall (C67.2).

Code adenocarcinoma in multiple polyps as a single primary even if they involve more than one segment of the colon.

Example: Familial polyposis with carcinoma and carcinoma in situ throughout the transverse (C18.4) and descending colon (C18.6) would be one primary and coded to colon, NOS (C18.9). For a full explanation see General Coding Principles: Determining Multiple Primaries.

Code leukemias to bone marrow (C42.1).

Exceptions: Myeloid sarcoma and leukemic reticuloendotheliosis. See ICD-O-2 for coding rules.

Lymphoma

Most lymphomas arise in lymph nodes (C77.–), or lymphatic tissue, such as tonsils, spleen, Waldeyer's ring, or thymus. Lymphomas arising in lymphatic tissue are coded to the site of origin (tonsil C09.–, spleen C42.2, Waldeyer's ring C14.2, or thymus C37.9), but analyzed with the "nodal" group. "Extranodal" lymphomas arise from lymphatic cells in organs such as intestine or stomach. Extranodal lymphomas are coded to the organ of origin and are analyzed separately.

Example: A lymphoma of the stomach would be coded stomach (C16.–).

Primary Site **(Continued)**

Lymphoma may be present in both an extralymphatic organ and at least one lymph node chain. Carefully identify the origin of the tumor. Do not code the biopsy site or a metastatic site. Code the primary site as the extranodal organ or the lymph nodes as directed by the managing physician or physician advisor. Code to lymph nodes, NOS (C77.9) if the site of origin is not identified.

Code to lymph nodes, NOS (C77.9) when:

- A patient has diffuse lymphoma and a primary site is unknown or not specified.
- A mass is identified as "retroperitoneal," "inguinal," "mediastinal," or "mesentery" and no specific information is available to indicate what tissue is involved.
- Bone marrow metastases are present and the primary site is unknown or not specified.

Code to lymph nodes, multiple regions (C77.8) when multiple lymph node chains are involved with disease. Do **not** code a specific lymph node chain.

Code mycosis fungoides and cutaneous lymphomas to skin (C44.–).

Kaposi's Sarcoma

Code Kaposi's sarcoma to the site in which it arises. Code to skin (C44.9), if Kaposi's sarcoma arises simultaneously in the skin and another site and the primary site is not identified.

Melanomas

Each occurrence of melanoma of the skin is a new/separate primary **unless** a physician says otherwise. If a patient is diagnosed with metastatic melanoma and the primary site is not identified, code to skin, NOS (C44.9).

Laterality

Item Length: 1
Data Type: Numeric
Allowable Values: 0-4, 9
Required Data Set

Laterality refers to a side of the body. It applies to the primary site only. Do not code metastatic sites.

Code

0 Not a paired site

1 Right: origin of primary

2 Left: origin of primary

3 Only one side involved, right or left origin unspecified

4 Bilateral involvement, side of origin unknown, stated to be a single primary

Including:

Both ovaries simultaneously involved with a single histology

Bilateral retinoblastomas

Bilateral Wilms' tumors

9 Paired site, but lateral origin unknown; midline tumor

Record laterality for unknown primary site (C80.9) as 0 (not a paired site).

Use codes 1-9 for the following sites, except as noted. The listing includes major categories. Code laterality for all subheadings included in the ICD-O-2 under these headings, unless specifically excluded. Exclusions should be coded as 0.

ICD-O-2	Site
C07.9	Parotid gland
C08.0	Submandibular gland
C08.1	Sublingual gland
C09.0	Tonsillar fossa
C09.1	Tonsillar pillar
C09.9	Tonsil, NOS
C30.0	Nasal cavity (excluding nasal cartilage and nasal septum code 0)
C30.1	Middle ear
C31.0	Maxillary sinus
C31.2	Frontal sinus
C34.0	Main bronchus (excluding carina)

Laterality **(Continued)**

ICD-O-2	Site
C34.1–C34.9	Lung
C38.4	Pleura
C40.0	Long bones of upper limb and scapula
C40.1	Short bones of upper limb
C40.2	Long bones of lower limb
C40.3	Short bones of lower limb
C41.3	Rib and clavicle (excluding sternum code 0)
C41.4	Pelvic bones (excluding sacrum, coccyx, and symphysis pubis code 0)
C44.1	Skin of eyelid
C44.2	Skin of external ear
C44.3	Skin of other and unspecified parts of face (midline code 9)
C44.5	Skin of trunk (midline code 9)
C44.6	Skin of upper limb and shoulder
C44.7	Skin of lower limb and hip
C47.1	Peripheral nerves and autonomic nervous system of upper limb and shoulder
C47.2	Peripheral nerves and autonomic nervous system of lower limb and hip
C49.1	Connective, subcutaneous, and other soft tissues of upper limb and shoulder
C49.2	Connective, subcutaneous, and other soft tissues of lower limb and hip
C50.0–C50.9	Breast
C56.9	Ovary
C57.0	Fallopian tube
C62.0–C62.9	Testis
C63.0	Epididymis
C63.1	Spermatic cord
C64.9	Kidney, NOS
C65.9	Renal pelvis
C66.9	Ureter
C69.0–C69.9	Eye and lacrimal gland
C74.0–C74.9	Adrenal gland
C75.4	Carotid body

Histology

Item Length: 4
Data Type: Numeric
Required Data Set

Record the histology using the ICD-O-2 codes in the Morphology–Numeric section (pages 25–49) and in the Alphabetic Index (pages 51–136). The ICD-O-2 identifies the morphology codes with an M preceding the code number. Do not record the M. Follow the coding rules outlined on pages xxiv–xxxi of the ICD-O-2.

Review all pathology reports. Reports based on specimens from the definitive cancer-directed surgery are usually the most explicit.

Exception: When the biopsy removes all of the tumor.

Example: The pathology report from a skin biopsy identifies superficial malignant melanoma (8720/3). At wide excision, no residual tumor was found. Code the histology superficial malignant melanoma (8720/3) as reported in the biopsy.

Code the **final** pathologic diagnosis.

Exception: At times the final diagnosis is "Not Otherwise Specified" (carcinoma, NOS, melanoma, NOS, sarcoma, NOS, lymphoma, NOS, or malignant tumor, NOS). Code the histology from the microscopic description or comment if it identifies a more specific histologic type (higher ICD-O-2 code) such as adenocarcinoma, amelanotic melanoma, spindle cell sarcoma.

Example: Final pathologic diagnosis is carcinoma, NOS (8010/3) of the prostate. Microscopic diagnosis specifies adenocarcinoma (8140/3) of the prostate. Record adenocarcinoma (8140/3).

Note: The codes for cancer, NOS (8000/3) and carcinoma, NOS (8010/3) are **not** interchangeable. If the physician says that the patient has carcinoma, code carcinoma, NOS (8010/3).

Lymphomas may be classified by the Rappaport classification or the Working Formulation. If both systems are used to classify the disease, the term used to describe the lymphoma may differ, and the Working Formulation term should take precedence.

Example: In the pathology report, the Working Formulation describes malignant lymphoma, diffuse, large cell, cleaved (9681/3). The Rappaport classification describes malignant lymphoma, diffuse, histiocytic (9680/3). Code 9681/3.

Histology Coding Rules

Note: See Section Two for detailed instructions.

Same Histology

- Multiple terms may describe a single histology.
- If the first three digits of the ICD-O-2 morphology codes are identical, the histology is the same.
- Lesion(s) may have both invasive and in situ components. This is a single primary. Code the histology of the invasive component.

Note: This rule is also used when multiple lesions are present. One lesion may be invasive and another lesion in situ, or each of the lesions may have invasive and in situ components.

Histology **(Continued)**

Mixed or Multiple Histologies

- A difference in the first three digits of the ICD-O-2 morphology code indicates a different histologic type.

Exception: Lymphatic and hematopoietic disease. See Appendix B.

- A single lesion with mixed histologic types is one primary.
- To code multiple or mixed histologies existing in one primary, use the following guidelines in this priority order.

  1) Select a combination code.

  2) Code the histology that comprises the majority of the tumor. Phrases such as "predominantly" and "with features of" are often used to identify the principal tumor type.

Note: The terms "with foci of," "areas of," or "elements of" do not describe the majority of the tumor. Do not code the histologies described by these terms unless there is a combination code.

  3) Code the histology with the highest ICD-O-2 morphology code.

Single Primary

Same Histology

- A single lesion is one primary even if the lesion crosses site boundaries.
- Lesion(s) with the same histology that recur at the same site as an earlier malignancy would be:
  - The same primary tumor if diagnosed within two months.
  - A new primary tumor if diagnosed after two months, unless a physician says that it is recurrent or metastatic.

  Exceptions: The following are recurrences of the original disease without time limits.

  - Bladder primaries with morphology codes 8120–8130.
  - Kaposi's sarcoma (9140/3).

    Note: Report Kaposi's sarcoma as one primary. Refer to Cancer Identification and Primary Site for coding rules.

  - Basal or squamous cell cancers of the skin as described in Section One in the reportable list.

    Note: Each occurrence of melanoma of the skin is a new/separate primary **unless** a physician states otherwise.

- Simultaneous multiple lesions with the same histologic type in the same site are a single primary. If one lesion has a behavior code of in situ (2) and the other a behavior code of malignant (3), this is still a single primary. The behavior is invasive (3).

Histology **(Continued)**

Multiple Primaries

Same Histology

- Multiple lesions with the same histology occurring in different sites are individual primaries **unless** a physician says they are metastatic.

Mixed or Multiple Histologies

- Multiple lesions with different histologies in a single site are separate primaries, whether they occur simultaneously or at different times.

  Exception: Within each breast, combinations of ductal and lobular carcinoma occurring within two months of each other are a single primary and the histology coded according to ICD-O-2.

- Multiple lesions with different histologies occurring in different sites are separate primaries, **unless** a physician says otherwise.

Behavior is a separate data item.

Behavior Code
(Separate From Histology)

Item Length: 1
Data Type: Numeric
Required Data Set

The fifth digit of the morphology code, which appears after the slash, is the behavior code.[13] The Commission requires the inclusion of tumors ending in a fifth digit behavior code of 2 or 3. Since tumor registries include only primary sites, Behavior Codes 6 and 9 are not used. The Behavior Code 6 identifies a metastatic site. If the only specimen is from a metastatic site, code the histology of the metastatic site and use code 3 for the Behavior Code.

Example: If the patient had a biopsy of the lung showing metastatic adenocarcinoma (8140/6), the primary site is unknown (C80.9). Code the histology as adenocarcinoma (8140/3).

The following terms are synonymous with in situ (Behavior Code 2):

- Adenocarcinoma in an adenomatous polyp with no invasion of stalk
- Bowen's disease
- Clark's level 1 for melanoma (limited to epithelium)
- Comedocarcinoma, noninfiltrating (C50.–)
- Confined to epithelium
- Hutchinson's melanotic freckle, NOS (C44.–)
- Intracystic, noninfiltrating
- Intraductal
- Intraepidermal, NOS
- Intraepithelial, NOS
- Involvement up to but not including the basement membrane
- Lentigo maligna (C44.–)
- Lobular neoplasia (C50.–)
- Lobular, noninfiltrating (C50.–)
- Noninfiltrating
- Noninvasive
- No stromal involvement
- Papillary, noninfiltrating or intraductal
- Precancerous melanosis (C44.–)
- Queyrat's erythroplasia (C60.–)

Code behavior as malignant (3) if any invasion is present, no matter how limited.

Example: The pathology report reads "intraductal carcinoma (8500/2) with focal areas of invasion." Code to the invasive component, infiltrating ductal carcinoma (8500/3).

[13]*International Classification of Diseases for Oncology*, 1990 (ICD-O-2) p. xxiv.

Grade/Differentiation

Item Length: 1
Data Type: Numeric
Allowable Values: 1- 9
Required Data Set

Grade/Differentiation of the tumor describes the tumor's resemblance to normal tissue. Well differentiated (grade I) is the most like normal tissue. The codes, as defined in the ICD-O-2 are:

Code	Grade/Cell	Description
1	grade I	Well differentiated, differentiated, NOS
2	grade II	Moderately differentiated, moderately well differentiated, intermediate differentiation
3	grade III	Poorly differentiated
4	grade IV	Undifferentiated, anaplastic
5	T-cell	Lymphomas and leukemias, T-cell
6	B-cell	Lymphomas and leukemias, B-cell, Pre-B, B-precursor
7	Null cell	Leukemias only, Null cell, Non T-non B
8	Natural killer cell	Lymphomas and leukemias
9	Grade/differentiation unknown	Grade/cell type not determined, not stated, or not applicable

Codes 5-7 define T-cell or B-cell origin for leukemias and lymphomas. T-cell, B-cell, or null cell classifications have precedence over grading or differentiation. **Do not** use "high grade," "low grade," or "intermediate grade" descriptions for lymphomas as a basis for differentiation. The terms are categories in the Working Formulation of Lymphoma Diagnoses and do not relate to the grade.

Code the grade or differentiation as stated in the **final** pathologic diagnosis.

Example: Microscopic Description: Moderately differentiated squamous cell carcinoma with poorly differentiated areas.

Final Pathologic Diagnosis: Moderately differentiated squamous cell carcinoma.

Code: Moderately differentiated (2)

Exception: If the differentiation is **not** stated in the final pathologic diagnosis, use the information from the microscopic description or comments.

Code the grade or differentiation from the pathologic examination of the primary tumor, not from metastatic sites. If the primary site is unknown, code the grade/differentiation as unknown (9).

When the pathology report(s) lists more than one grade of tumor, code to the highest grade, even if the highest grade is only a focus. (Rule 6, page xxvii in ICD-O-2).

Examples: Code moderately to poorly differentiated carcinoma to poorly differentiated (3).

Code a combination of grades I and II carcinoma to moderately differentiated (2).

Grade/Differentiation **(Continued)**

Code the grade for in situ lesions if the information is available.

Note: The grade of a tumor can be established through Magnetic Resonance Imaging (MRI) or Positron Emission Tomography (PET) when there is no tissue diagnosis. Brain tumors can be graded using these methods.

Table of Codes, Grades, and Terminology

When there is variation in the usual terms for degree of differentiation, use the following conversions:

Code	Grade	Terminology
2	I-II	Low grade, partially well-differentiated
3	II-III	Medium grade
	III	Moderately undifferentiated, relatively undifferentiated
4	III-IV	High grade

A tumor grade may be described as I/IV or 1/4 which means grade one in a four-grade system. Occasionally a three-grade system is used. If the grade is written II/III or 2/3, this is a grade 2 of a three-grade system. Use the information in the following table to convert the values into valid *ROADS* codes.

Documented	Use *ROADS* Code
I/III or 1/3	2
II/III or 2/3	3
III/III or 3/3	4

Prostate

Both the tumor differentiation and Gleason's score and/or pattern may be given. Code the tumor grade/ differentiation when it is available. Use the following conversion when the reports give only the Gleason's score (2-10) or Gleason's pattern (1-5).

Code	Score	Pattern	Grades	
1	2, 3, 4	1, 2	I	Well differentiated
2	5, 6, 7	3	II	Moderately differentiated
3	8, 9, 10	4, 5	III	Poorly Differentiated

Grade/Differentiation **(Continued)**

Breast

The differentiation of a breast tumor may be described using the Scarff Bloom-Richardson (SBR) grading system (a.k.a. Bloom-Richardson, modified Bloom-Richardson (BR), SBR Grading, BR Grading, Elston-Ellis modification of Bloom Richardson grading system, Nottingham grade, Nottingham modification of Bloom-Richardson grading system). Use the following table to convert Bloom-Richardson values into *ROADS* codes.

BR Scores	BR Grade	Differentiation	*ROADS* Code
3, 4, 5	Low grade	Well-differentiated	1
6, 7	Intermediate grade	Moderately differentiated	2
8, 9	High grade	Poorly differentiated	3

AJCC Staging

The *AJCC Cancer Staging Manual*, Fifth Edition identifies the following sites in which tumor grade/differentiation is used to assign the AJCC Stage Group:

Site	ICD-O-2
Heart, mediastinum, and pleura (soft tissue)	C38.0–C38.8
Bone	C40.0–C41.9
Peripheral nerves and autonomic nervous system (soft tissue)	C47.0–C47.9
Retroperitoneum and peritoneum (soft tissue)	C48.0–C48.8
Connective, subcutaneous and other soft tissues	C49.0–C49.9
Prostate (Stage Ia only)	C61.9
Thyroid (Undifferentiated carcinoma only)	C73.9

Diagnostic Confirmation

Item Length: 1
Data Type: Numeric
Allowable Values: 1, 2, 4-9
Required Data Set

Diagnostic Confirmation specifies whether a malignancy was confirmed microscopically **at any time** during the disease course. This is a priority coding scheme with code 1 taking precedence. A low number takes priority over all higher numbers.

This data item is dynamic and must be changed to the lower code if a more definitive method confirms the diagnosis at any time during the course of the disease.

Example: A chest x-ray dated 12/1/95 diagnoses a probable lung cancer. The patient refuses a diagnostic workup. The registry codes the diagnostic confirmation to radiography (7). The patient allows a lymph node biopsy on 2/3/96. The biopsy confirms a small cell carcinoma. Change the diagnostic confirmation code to positive histology (1).

Code

Microscopically Confirmed

1 Positive histology

2 Positive cytology, no positive histology

4 Positive microscopic confirmation, method not specified

Not Microscopically Confirmed

5 Positive laboratory test/marker study

6 Direct visualization without microscopic confirmation

7 Radiography and other imaging techniques without microscopic confirmation

8 Clinical diagnosis only (other than 5, 6, or 7)

Confirmation Unknown

9 Unknown whether or not microscopically confirmed

Diagnostic Confirmation **(Continued)**

Clarification of code definitions:

Code	Definitions
1	Tissue specimens from biopsy, frozen section, surgery, autopsy, or dilatation and curettage. Bone marrow biopsy and bone marrow aspiration. Hematologic confirmation of leukemia (i.e., a peripheral blood smear).
2	Microscopic examination of cells removed from a neoplasm. Fine needle aspiration (FNA) is frequently used to obtain a cytologic specimen. Cells may be recovered from exudate, secretions, or washings from tissue. *Examples:* Sputum smears, bronchial brushings, bronchial washings, tracheal washings, prostatic secretions, breast secretions, gastric fluid, spinal fluid, peritoneal fluid, pleural fluid, urinary sediment, cervical and vaginal smears. Positive cytology also includes paraffin-block specimens from concentrated spinal, pleural, or peritoneal fluid.
4	The case is reported as microscopically confirmed, but no information is provided about the method (histology, cytology).
5	Diagnosis of cancer based on certain laboratory tests or marker studies that are **Clinically Diagnostic** such as an abnormal electrophoretic spike for multiple myeloma or Waldenstrom's macroglobulinemia. PSA is not clinically diagnostic for prostate cancer.
6	Use this code only in the absence of positive histology or cytology. Diagnosis confirmed by surgical exploration or by endoscopy (colposcope, mediastinoscope, peritoneoscope). Autopsy only case (only information is from gross autopsy report, diagnosis not confirmed by microscopic tissue analysis).
7	Use this code only in the absence of positive histology or cytology. Diagnosed by radiology including ultrasound, computerized (axial) tomography (CT or CAT scans) and magnetic resonance imaging (MRI).
8	Use this code only in the absence of positive histology or cytology. Cases diagnosed by clinical methods not mentioned previously.
9	Death certificate-only cases. Method of confirmation is unknown.

Tumor Marker One

Item Length: 1
Data Type: Numeric
Allowable Values: 0-6, 8, 9
Supplementary Data Set

Tumor Marker One records prognostic indicators for specific sites or histologies.

Code

0 None done (test was not ordered and was not performed)

1 Positive/elevated

2 Negative/normal

3 Borderline, undetermined whether positive or negative

Three-tiered system (testis only)

4 Range 1 (See table)

5 Range 2 (See table)

6 Range 3 (See table)

8 Ordered, but results not in chart

9 Unknown or no information (all sites other than those specified in the table)

This table lists the site/histology for which the tumor marker is collected.

Site/Histology		Marker #1
Breast	(C50.0–C50.9)	Estrogen Receptor Assay (ERA)
Colorectal	(C18.0–18.9, C19.9, C20.9)	Carcinoembryonic Antigen (CEA)
Liver	(C22.0, C22.1)	Alpha Fetoprotein (AFP)
Neuroblastoma	(9500/3)	Urine catecholamine
Ovary	(C56.9)	Carbohydrate Antigen 125 (CA-125)
Prostate	(C61.9)	Acid Phosphatase (PAP)
Testis	(C62.0, C62.1, C62.9)	Alpha Fetoprotein (AFP) Range 1 <1,000 ng/ml Range 2 1,000–10,000 ng/ml Range 3 >10,000 ng/ml

For testicular cancer, the valid range of codes is 0, 4–6, 8, 9.

Tumor Marker Two

Item Length: 1
Data Type: Numeric
Allowable Values: 0-6, 8, 9
Supplementary Data Set

Tumor Marker Two records prognostic indicators for specific sites or histologies.

Code

0 None done (not ordered and was not performed)

1 Positive/elevated

2 Negative/normal

3 Borderline, undetermined whether positive or negative

Three-tiered system (testis only)

4 Range 1 (See table)

5 Range 2 (See table)

6 Range 3 (See table)

8 Ordered, but results not in chart

9 Unknown or no information (all sites other than those specified in the table)

Site		Marker #2
Breast	(C50.0–50.9)	Progesterone Receptor Assay (PRA)
Prostate	(C61.9)	Prostatic Specific Antigen (PSA)
Testis	(C62.0. C62.1, C62.9)	Human chorionic gonadotropin (hCG) Range 1 <5,000 mIU/ml Range 2 5,000–50,000 mIU/ml Range 3 >50,000 mIU/ml

For testicular cancer, the valid range of codes is 0, 4–6, 8, 9.

Tumor Marker Three

Item Length: 1
Data Type: Numeric
Allowable Values: 0-6, 8, 9
Supplementary Data Set

Tumor Marker Three records prognostic indicators for testicular cancer only.

Code

0 None done (test was not ordered and was not performed)

1 Positive/elevated

2 Negative/normal

3 Borderline, undetermined whether positive or negative

Three-tiered system (testis only)

4 Range 1 (See table)

5 Range 2 (See table)

6 Range 3 (See table)

8 Ordered, but results not in chart

9 Unknown or no information (all sites other than testes)

This table lists the site/histology for which the tumor marker is collected.

Site/Histology	Marker #3
Testis (C62.0, C62.1, C62.9)	LDH Range 1 <1.5 x N* Range 2 1.5–10 x N* Range 3 >10 x N* * N equals the upper limit of normal for the LDH

For testicular cancer, the valid range of codes is 0, 4-6, 8, 9.

Presentation at Cancer Conference

Item Length: 1
Data Type: Numeric
Allowable Values: 0-9
Supplementary Data Set

Presentation at Cancer Conference documents a case presentation at a cancer conference and the type or format of presentation. The number of cancer conferences, sites presented, types of presentation can be analyzed and reported for administrative use, quality control, and survey preparation.

Code

0 Not presented

1 Prospective presentation (diagnostic)

2 Prospective presentation (treatment)

3 Prospective presentation (follow-up care)

4 Prospective presentation (combinations of 1, 2, or 3)

5 Prospective, NOS

6 Retrospective presentation

7 Follow-up presentation (unknown if prospective or retrospective)

8 Presentation, NOS

9 Unknown

Clarification of code definitions:

Code	Definitions
0	Case was not presented at cancer conference.
1, 2, 3, 4, 5	Presentation at a time when the multidisciplinary discussion could influence treatment choices.
6	The case is presented at a cancer conference after all treatment decisions have been made. The cancer conference participants discuss appropriateness or effectiveness of treatment.
7	The case is presented after a disease-free interval or disease progression.
8	The case was presented at cancer conference, but it is unknown whether the conference was prospective, retrospective, or follow-up review.
9	It is unknown if the case was presented at cancer conference.

Date of Cancer Conference

Item Length: 8
Data Type: Numeric
Optional Data Set

Enter the date on which the case was first presented at a cancer conference in a month, day, year (MM/DD/CCYY) format. The number of cancer conferences, sites presented, types of presentations, and dates can be analyzed and reported for administration, quality control, and Commission on Cancer survey preparation. Update this item if a patient is presented at a subsequent cancer conference.

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			

Example: Record June 30, 1996 as 06301996.

Code 9 for unknowns:

- Code 99 for unknown month.
- Code 99 for unknown day.
- Code 9999 for unknown year.

If the patient was never presented at a cancer conference, code as 00000000.

Referral to Support Services

Item Length: 1
Data Type: Numeric
Allowable Values: 0, 1, 9
Supplementary Data Set

Code

0 No

1 Yes

9 Unknown, not specified

Record if the patient was referred to any of the following services:

Enterostomal/stomal therapy

Home care

Hospice

Infusion/parenteral therapy

Nutritionist

Occupational therapy

Other

Patient services (American Cancer Society)

Patient services (other)

Patient support group (American Cancer Society)

Patient support group (hospital operated)

Patient support group (other organization/agency)

Physical therapy

Referral; service unspecified

Rehabilitation facility

Respiratory therapy

Speech therapy

Visiting nurse assistance

Institutions may elect to record an individual response for each service.

Stage of Disease at Diagnosis

Size of Tumor

Item Length: 3
Data Type: Numeric
Required Data Set
Right Justified

Size of tumor is the largest dimension, or the diameter of the **primary tumor**, and is always recorded in millimeters.

Conversion/Rounding

- To convert centimeters to millimeters, move the decimal point one digit to the right (or multiply the centimeters by 10).

  Example: 3.2 cm becomes 32 mm and is recorded as 032 mm.

- Round off decimals to the nearest tenth.

  Example: 3.21 cm becomes 3.2 cm and is recorded as 032.

  2.16 cm becomes 2.2 cm and is recorded as 022.

General Size Rules

- Differentiate between tumor size and specimen size.

  Examples: The pathology report describes a specimen that measures 2 x 3 cm with a focus (microscopic) of infiltrating carcinoma. Record tumor size for focus (microscopic) as given in the conversion chart (001 mm).

  The pathology report describes the breast biopsy specimen as 2 x 3 cm with most of the specimen involved with tumor. Record the clinical size from the mammogram or physical examination.

- Record the largest size when the tumor has multiple measurements.

  Example: The pathology report describes the tumor size as 3 x 4.4 x 2.5 cm. Record size as 044 mm.

- Record the size of the largest tumor when a patient has multiple tumors in one primary site.

  Example: The patient has a 1 cm nodule in the right upper lobe and a 1.3 cm nodule in the right middle lobe of the lung. Record size as 013 mm.

- Record the size of the invasive component only when a tumor has both in situ and invasive components.

  Examples: The pathology report describes a breast mass as a 2 x 1.5 cm intraductal carcinoma and a 1 cm nodule of infiltrating ductal carcinoma. Record tumor size as 010 mm.

  The pathology report describes a 3.3 cm intraductal carcinoma in the upper-outer quadrant of the right breast and a 1.6 cm infiltrating ductal carcinoma in the lower-inner quadrant of the right breast. Record tumor size as 016 mm.

Size of Tumor **(Continued)**

Recording Pathologic Size or Clinical Size

- Record the size documented on the pathology report when:
  - The pathologist identifies the size of a completely excised primary tumor.
  - The surgical margins were grossly free of disease (there may be microscopic involvement).
- Record the clinical size when:
  - The primary tumor was not surgically excised.
  - The primary tumor was excised, but the margins were grossly involved.
  - The primary tumor was excised, but the pathology report does not specify tumor size.
  - The patient was treated with radiation therapy, chemotherapy, hormone therapy, or immunotherapy before the primary was surgically excised.
- Record the clinical tumor size documented in the following reports/examinations (listed in preference order):
  - Operative report
  - Scans
  - X-rays
  - Physical examination

Code

- Record 000 when a primary tumor is not identified (AJCC T0).

  Note: Use this code only for solid tumors.

  Example: A patient has a biopsy of an axillary mass. The pathology report identifies infiltrating ductal carcinoma in an axillary node. Workup reveals no breast lesion.

- Record 998 when the following terms describe tumor involvement in these specific sites:

Esophagus (C15.0–C15.9):	Entire circumference
Stomach (C16.0–C16.9):	Diffuse; widespread, 3/4 or more; linitis plastica
Colorectal (C18.0–C20.9):	Familial/multiple polyposis (histology 8220 or 8221 with a behavior code of 2 or 3)
Lung (C34.0–C34.9):	Diffuse, entire lobe of lung
Breast (C50.0–C50.9):	Diffuse; widespread, 3/4 or more; inflammatory carcinoma

Size of Tumor **(Continued)**

- Record 999 when:
    - Tumor size is not recorded or not available.
    - Prostatic chips or bladder chips are the only measurement (Do **not** add). Transurethral resections of the prostate or bladder produce chips and fragments of tissue. Do not estimate a size from those chips or fragments. A clinical size may be possible from physical examination, ultrasound of the prostate, or cystoscopy of the bladder.
- Reocrd 999 for the following sites and diseases:
    - Hematopoietic neoplasms
    - Hodgkin's and non-Hodgkin's lymphomas; mycosis fungoides of skin
    - Kaposi's sarcoma
    - Letterer-Siwe's disease
    - Leukemia
    - Multiple myeloma
    - Reticuloendotheliosis
    - Unknown or ill-defined primary site or sites

Malignant Melanoma

Record the depth of invasion for malignant melanoma in the Size of Tumor field. If the tumor size is recorded as ≤ .049 mm, code 999. If the tumor size is recorded as < .05 and > 1 mm, code to 1.0 mm.

Size of Tumor **(Continued)**

Size Conversion

Use the following list for size conversion when tumor size is described.

Object	mm	Object	mm	Object	mm
Fruits		Hazel	020	**Money**	
Apple	070	Hickory	030	Dime	010
Apricot	040	Peanut	010	Dollar, silver	040
Cherry	020	Pecan	030	Dollar, half	030
Date	040	Walnut	030	Nickel	020
Fig, dried	040	**Vegetables**		Quarter	020
Grape	020	Bean	010	Penny	010
Grapefruit	100	Bean, lima	020	**Other**	
Kumquat	050	Pea	009	Ball, golf	040
Lemon	080	Pea, split	009	Ball, ping-pong	030
Olive	020	**Miscellaneous Food**		Ball, tennis	060
Orange	090	Doughnut	090	Baseball	070
Peach	060	Egg	050	Fist	090
Pear	090	Egg, bantam	040	Marble	010
Plum	030	Egg, goose	070	Match head	009
Tangerine	060	Egg, hen	030	Pencil eraser	009
Nuts		Egg, pigeon	030	1 cm	010
Almond	030	Egg, robin	020	1 inch	025
Chestnut	040	Lentil	009	.394 inches	010
Chestnut, horse	040	Millet	009	Microscopic (focus)	001

Size of Tumor **(Continued)**

AJCC sites that require tumor size

Staging criteria in the *AJCC Cancer Staging Manual,* Fifth Edition requires a tumor size for the following sites to assign a value for T:

ICD-O-2 Code	Site
C00.0–C00.9	Lip and oral cavity (T1, T2, T3)
C01.9	Base of tongue, NOS (T1, T2, T3)
C02.0–C02.9	Other and unspecified parts of tongue (T1, T2, T3)
C03.0–C03.9	Gum (T1, T2, T3)
C04.0–C04.9	Floor of mouth (T1, T2, T3)
C05.0–C05.9	Palate (T1, T2, T3)
C06.0–C06.9	Other and unspecified parts of mouth (T1, T2, T3)
C07.9	Parotid gland (T1, T2, T3, T4)
C08.0–C08.9	Other and unspecified major salivary glands (T1, T2, T3, T4)
C09.0–C09.9	Tonsil (T1, T2, T3)
C10.0–C10.9	Oropharynx (T1, T2, T3) (excludes anterior surface of epiglottis C10.1)
C13.0–C13.9	Hypopharynx (T1, T2, T3)
C14.0–C14.8	Pharynx (T1, T2, T3)
C21.0–C21.8	Anus and anal canal (T1, T2, T3)
C22.0–C22.1	Liver and intrahepatic bile ducts (T1, T2, T3)
C25.0–C25.9	Pancreas (T1, T2) (excludes islets of Langerhans C25.4)
C34.0–C34.9	Bronchus and lung (T1, T2)
C38.0	Heart (soft tissue) (T1, T2)
C38.1	Anterior mediastinum (soft tissue) (T1, T2)
C38.2	Posterior mediastinum (soft tissue) (T1, T2)
C38.3	Mediastinum, NOS (soft tissue) (T1, T2)
C38.8	Overlapping lesion of heart, mediastinum, and pleura (soft tissue) (T1, T2)
C44.0, C44.2–C44.9	Skin (excluding melanoma) (T1, T2, T3)
C44.1	Carcinoma of eyelid (T1, T2, T3)
C47.0–C47.9	Peripheral nerves and autonomic nervous system (soft tissue) (T1, T2)
C48.0–C48.8	Retroperitoneum and peritoneum (soft tissue) (T1, T2)

Size of Tumor **(Continued)**

AJCC sites that require tumor size

ICD-O-2 CODE	Site
C49.0–C49.9	Connective, subcutaneous and other soft tissues (T1, T2)
C50.0–C50.9	Breast (T1, T2, T3)
C51.0–C51.9	Vulva (T1, T2)
C53.0–C53.9	Cervix uteri (T1)
C63.2	Scrotum (skin of) (T1, T2, T3)
C64.9	Kidney (T1, T2)
C69.0	Conjunctiva (T1, T2) (excluding melanoma)
C69.3	Choroid (T1, T2, T3) (excluding melanoma)
C69.5	Lacrimal gland (carcinoma) (T1, T2, T3, T4)
C69.6	Orbit, NOS (sarcoma) (T1, T2)
C69.8	Overlapping lesion of eye and adnexa (sarcoma) (T1, T2)
C73.9	Thyroid gland (T1, T2, T3)

Extension (SEER EOD)

(Extension)

Item Length: 2
Data Type: Numeric
Supplementary Data Set

Extension (SEER EOD) describes the primary tumor growth within the organ of origin or its extension to neighboring organs, or its metastasis to distant sites as summarized in a two-digit code.

Registries in Approved Programs are not required to collect this supplementary data set item. The information is primarily collected by SEER registries. Refer to *The SEER Extent of Disease 1988: Codes and Coding Instructions: Second Edition, June 1992*.

Lymph Nodes (SEER EOD)

(Lymph Nodes)

Item Length: 1
Data Type: Numeric
Supplementary Data Set

Regional lymph nodes are listed for each site and then, as necessary, the regional (first station) lymph nodes are classified in terms of size, laterality, number of involved nodes, and distance of the lymph nodes from the primary site. Lymph Nodes (SEER EOD) is a one-digit field, a hierarchical code.

Registries in Approved Programs are not required to collect this supplementary data set item. The information is primarily collected by SEER registries. Refer to *The SEER Extent of Disease 1988: Codes and Coding Instructions: Second Edition, June 1992*.

Regional Nodes Examined

Item Length: 2
Data Type: Numeric
Required Data Set

Regional Nodes Examined describes the total number of regional lymph nodes examined by a pathologist. Use only regional lymph nodes (identify regional nodes using the pN classification from the *AJCC Cancer Staging Manual,* Fifth Edition) or *ROADS* Appendix D, Cancer-Directed Surgical Codes.

Removal of the primary tumor and a lymph node dissection or sampling may be done in one procedure. The nodes may also be removed in a separate procedure.

- Record in Regional Nodes Examined if the lymph node removal is documented in the treatment plan as part of the first course of therapy.
- Do not record in Regional Nodes Examined if the removal of lymph nodes is not a part of the first course of therapy (nodes removed to establish recurrence or progression of disease).

Code

00 No regional lymph nodes removed

01 One regional lymph node removed

02 Two regional lymph nodes removed

..

90 Ninety or more regional lymph nodes removed

95 No regional lymph node(s) removed, but aspiration of regional lymph node(s) was performed

96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated

97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated

98 Regional lymph nodes surgically removed, but number of lymph nodes unknown/not stated and not documented as sampling or dissection

99 Unknown; not stated; death certificate **only**

Use code 95 for a lymph node aspiration when the cytology or histology is positive for malignant cells.

Use code 99 if information about regional lymph nodes is unknown, or if the field is not applicable for that site or histology. Patient was previously treated with radiation, chemotherapy, hormone therapy or immunotherapy.

Examples: Brain
Leukemia
Lymphoma
Multiple myeloma
Reticuloendotheliosis
Letterer-Siwe's disease
Unknown primaries

Regional Nodes Positive

Item Length: 2
Data Type: Numeric
Required Data Set

Regional Nodes Positive describes the number of regional nodes examined by the pathologist and reported as containing tumor. Code only regional lymph nodes. Identify regional nodes using the pN classification from the AJCC *Cancer Staging Manual,* Fifth Edition.

Code

00 All nodes examined negative

01 One positive lymph node

02 Two positive lymph nodes

..

10 Ten positive lymph nodes

..

96 96 or more positive lymph nodes

97 Positive nodes but number not specified

98 No nodes examined

99 Unknown if nodes are positive or negative, not applicable

Example: The pathology report reads 11/17 nodes examined were found to contain a metastatic squamous cell carcinoma. Record 11 in the field Regional Nodes Positive.

Use code 97 when the cytology or histology from a lymph node aspiration is positive for malignant cells.

Use code 98 when no nodes are removed or examined.

Use code 99 if information about regional nodes is unknown or if it is not applicable for that site or histology.

Examples: Brain

Leukemia

Lymphoma

Multiple myeloma

Reticuloendotheliosis

Letterer-Siwe's disease

Unknown primaries

The number of positive lymph nodes cannot exceed the number of regional lymph nodes examined.

Stage of Disease at Diagnosis

Site of Distant Metastasis #1

Item Length: 1
Data Type: Numeric
Allowable Values: 0-9
Supplementary Data Set

Code only the site(s) of distant metastasis identified during initial diagnosis and workup. Do not update this field over the course of the patient's disease. Use the *AJCC Cancer Staging Manual*, Fifth Edition to identify distant sites. Cases with sites of distant metastasis would be coded M1. Do not code sites of regional or local metastasis defined in the "T" field. Do not leave blanks. If there are more than three sites of distant metastasis, code three of the sites. Record 0 in this field if there are no distant metastases. Record 9 if carcinomatosis is present, for disseminated disease, leukemias, and if the site is unknown. Do not code specific metastatic sites for unknown primaries (C80.9).

Code

0 None

1 Peritoneum

2 Lung

3 Pleura

4 Liver

5 Bone

6 Central nervous system

7 Skin

8 Lymph nodes (distant)

9 Other, generalized, carcinomatosis, disseminated, not specified, unknown

Site of Distant Metastasis #1 (Continued)

Clarification of code definitions:

Code	Definitions
0	No distant metastases present.
1	Peritoneum, including peritoneal surfaces of all structures within the abdominal cavity and/or positive ascitic fluid.
2	Lung, including the visceral pleura
3	Pleura, including the pleural surface of all structures within the thoracic cavity and/or positive pleural fluid
4	Liver only
5	Bones other than the primary site
6	Includes brain and spinal cord, but **not** the external eye
7	Skin other than the primary site
8	Includes lymph nodes not classified as regional. Refer to the staging scheme for a description of lymph nodes that are distant for a particular site. (Use the *AJCC Cancer Staging Manual*, Fifth Edition to identify distant nodes.)
9	Bone marrow metastases, carcinomatosis, generalized disease, unknown primary

A biopsy may distinguish the source of distant disease in a patient with multiple primaries. If there is no histologic or cytologic confirmation, consult the physician to help identify which primary has metastasized. If the physician is unable to decide which primary has metastasized, code both primaries as having metastatic disease. If at a later date, the primary is identified, update the codes as appropriate.

Stage of Disease at Diagnosis

Site of Distant Metastasis #2

Item Length: 1
Data Type: Numeric
Allowable Values: 0-9
Supplementary Data Set

Code the second site of distant metastasis identified during initial diagnosis and workup. Do not update this field over the course of the patient's disease. Use the *AJCC Cancer Staging Manual*, Fifth Edition to identify distant sites. Cases with sites of distant metastasis would be coded M1. Do not code any sites of regional or local metastasis defined in the "T" field. Do not leave blanks. Record 0 in this field if there is no second site of distant metastases. Record 9 if carcinomatosis is present, for disseminated disease, leukemias, and if the site is unknown. Do not code specific metastatic sites for unknown primaries (C80.9).

Code

0 None, no second site of distant metastasis

1 Peritoneum

2 Lung

3 Pleura

4 Liver

5 Bone

6 Central nervous system

7 Skin

8 Lymph nodes (distant)

9 Other, generalized, carcinomatosis, disseminated, not specified, unknown

Site of Distant Metastasis #2 **(Continued)**

Clarification of code definitions:

Code	Definitions
0	No second site of distant metastasis present
1	Peritoneum, including peritoneal surfaces of all structures within the abdominal cavity and/or positive ascitic fluid
2	Lung, including the visceral pleura
3	Pleura, including the pleural surface of all structures within the thoracic cavity and/or positive pleural fluid
4	Liver only
5	Bones other than the primary site
6	Includes brain and spinal cord, but **not** the external eye
7	Skin other than the primary site
8	Includes lymph nodes not classified as regional. Refer to the staging scheme for a description of lymph nodes that are distant for a particular site. (Use the *AJCC Cancer Staging Manual*, Fifth Edition to identify distant nodes.)
9	Bone marrow metastases, carcinomatosis, generalized disease, unknown primary

A biopsy may distinguish the source of distant disease in a patient with multiple primaries. If there is no histologic or cytologic confirmation, consult the physician to help identify which primary has metastasized. If the physician is unable to decide which primary has metastasized, code both primaries as having metastatic disease. If at a later date, the primary is identified, update the codes as appropriate.

Stage of Disease at Diagnosis

Site of Distant Metastasis #3

Item Length: 1
Data Type: Numeric
Allowable Values: 0-9
Supplementary Data Set

Code the third site of distant metastasis identified during initial diagnosis and workup. Do not update this field over the course of the patient's disease. Use the *AJCC Cancer Staging Manual*, Fifth Edition to identify distant sites. Cases with sites of distant metastasis would be coded M1. Do not code any sites of regional or local metastasis defined in the "T" field. Do not leave blanks. Record 0 in this field if there is no third site of distant metastases. Record 9 if carcinomatosis is present, for disseminated disease, leukemias, and if the site is unknown. Do not code specific metastatic sites for unknown primaries (C80.9).

Code

0 None, no third site of distant metastasis

1 Peritoneum

2 Lung

3 Pleura

4 Liver

5 Bone

6 Central nervous system

7 Skin

8 Lymph nodes (distant)

9 Other, generalized, carcinomatosis, disseminated, not specified, unknown

Site of Distant Metastasis #3 **(Continued)**

Clarification of code definitions:

Code	Definitions
0	No third site of distant metastasis present
1	Peritoneum, including peritoneal surfaces of all structures within the abdominal cavity and/or positive ascitic fluid
2	Lung, including the visceral pleura
3	Pleura, including the pleural surface of all structures within the thoracic cavity and/or positive pleural fluid
4	Liver only
5	Bones other than the primary site
6	Includes brain and spinal cord, but **not** the external eye
7	Skin other than the primary site
8	Includes lymph nodes not classified as regional. Refer to the staging scheme for a description of lymph nodes that are distant for a particular site. (Use the *AJCC Cancer Staging Manual*, Fifth Edition to identify distant nodes.)
9	Bone marrow metastases, carcinomatosis, generalized disease, unknown primary

A biopsy may distinguish the source of distant disease in a patient with multiple primaries. If there is no histologic or cytologic confirmation, consult the physician to help identify which primary has metastasized. If the physician is unable to decide which primary has metastasized, code both primaries as having metastatic disease. If at a later date, the primary is identified, update the codes as appropriate.

Stage of Disease at Diagnosis

General Summary Stage (SEER)

(Required only in the absence of AJCC classification)

Item Length: 1
Data Type: Numeric
Allowable Values: 0-5, 7, 9
Required Data Set
Left Justified

General Summary Stag" is limited to all information available within two months of diagnosis.

Exception: General Summary Stage for prostate primaries is limited to all information available within the first four months of diagnosis for cases diagnosed on or after January 1, 1995.

Exclude metastasis or disease progression that develops after the original diagnosis.

General Summary Stage for all sites is based on pathological, operative, and clinical assessments. The priority for using these reports is:

- Pathologic
- Operative (Particularly important when the surgical procedure does not remove all malignant tissue.)
- Clinical

Apply the same rules when autopsy reports are used to stage the disease.

Code

0 In situ

1 Localized

2 Regional by direct extension

3 Regional to lymph nodes

4 Regional (both 2 and 3)

5 Regional, NOS

7 Distant metastases/systemic disease

9 Unstaged, unknown, or unspecified

Code the following primary sites as distant metastases/systemic disease (7):

- Leukemia
- Multiple myeloma
- Reticuloendotheliosis
- Letterer-Siwe's disease

Code the following unstaged, unknown, or unspecified (9):

- Unknown primaries
- Class 3 or 4 cases when the stage at initial diagnosis is unknown

General Summary Stage (SEER) **Continued**

Note: Refer to *SEER Book 6* or the *Summary Staging Guide 1977* for site-specific schemes for General Summary Stage. In this manual, localized, regional, direct extension, and distant are subdivided and coded as follows:

L1, L2, L3, LX Code 1 (localized)

R1, R2 Code 2 (regional by direct extension)

D1, D2 Code 7 (distant metastases/systemic disease)

The Commission on Cancer requires General Summary Stage only for sites that do not have AJCC site-specific staging schemes.

Those sites are:

Site Code	Site Group	Subsite
C17.3	Small Intestine	Meckel's diverticulum
C25.4	Pancreas	Islets of Langerhans
C26.0	Other and Ill-Defined Digestive Organs	Intestinal tract, NOS
C26.8		Overlapping lesion of digestive system
C26.9		Gastrointestinal tract, NOS
C30.0	Nasal Cavity and Middle Ear	Nasal cavity
C30.1		Middle ear
C31.2	Accessory Sinuses	Frontal sinus
C31.3		Sphenoid sinus
C31.8		Overlapping lesion of accessory sinuses
C31.9		Accessory sinus, NOS
C33.9	Trachea	Trachea
C37.9	Thymus	Thymus
C39.0	Other and Ill-Defined Sites Within Respiratory System and Intrathoracic Organs	Upper respiratory tract, NOS
C39.8		Overlapping lesion of respiratory system and intrathoracic organs
C39.9		Ill-defined sites within respiratory system

General Summary Stage (SEER) **(Continued)**

Site Code	Site Group	Subsite
C57.1	Other and unspecified female genital organs	Broad ligament
C57.2		Round ligament
C57.3		Parametrium
C57.4		Uterine adnexa
C57.7		Other specified parts of female genital organs
C57.8		Overlapping lesion of female genital organs
C57.9		Female genital tract, NOS
C58.9	Placenta	Placenta
C63.0	Other and unspecified male genital organs	Epididymis
C63.1		Spermatic cord
C63.7		Other specified parts of male genital organs
C63.8		Overlapping lesion of male genital organs
C63.9		Male genital organs, NOS
C69.1	Eye, brain, and other parts of central nervous system	Cornea, NOS
C69.9		Eye, NOS
C70.0	Meninges	Spinal/cerebral meninges
C70.9		Meninges, NOS
C71.0	Brain	Cerebrum
C71.1		Frontal lobe
C71.2		Temporal lobe
C71.3		Parietal lobe
C71.4		Occipital lobe
C71.5		Ventricle, NOS
C71.6		Cerebellum, NOS
C71.7		Brain stem
C71.8		Overlapping lesion of brain
C71.9		Brain, NOS

General Summary Stage (SEER) **(Continued)**

Site Code	Site Group	Subsite
C72.0	Spinal cord, cranial nerves, and other parts of central nervous system	Spinal cord
C72.1		Cauda equina
C72.2		Olfactory nerve
C72.3		Optic nerve
C72.4		Acoustic nerve
C72.5		Cranial nerve, NOS
C72.8		Overlapping lesion of brain and central nervous system
C72.9		Nervous system, NOS
C74.0	Adrenal gland	Cortex of adrenal gland
C74.1		Medulla of adrenal gland
C74.9		Adrenal gland, NOS
C75.0	Other endocrine glands and related structures	Parathyroid gland
C75.1		Pituitary gland
C75.2		Craniopharyngeal duct
C75.3		Pineal gland
C75.4		Carotid body
C75.5		Aortic body and other paraganglia
C75.8		Overlapping lesion of endocrine glands and related structures
C75.9		Endocrine gland, NOS
C76.0	Other and ill-defined sites	Head, face or neck, NOS
C76.1		Thorax, NOS
C76.2		Abdomen, NOS
C76.3		Pelvis, NOS
C76.4		Upper limb, NOS
C76.5		Lower limb, NOS
C76.7		Other ill-defined sites
C76.8		Overlapping lesion of ill-defined sites
C80.9	Unknown primary site	Unknown primary site

Stage of Disease at Diagnosis

AJCC Staging System

cTNM

pTNM

The staging basis (clinical, pathologic, other) sets the parameters for staging cancer. Refer to the *AJCC Cancer Staging Manual*, Fifth Edition for coding rules. The Commission requires that approved programs collect either clinical or pathologic stage for the sites included in the *AJCC Cancer Staging Manual*, Fifth Edition.

The clinical and pathologic staging elements are now separate fields. The Commission requires Commission-approved programs to collect either clinical or pathologic stage. Separate fields will allow the institution a choice of collecting the most appropriate stage as required or collecting both the clinical and pathologic stage. The separation also aids data retrieval, merging, and may also reduce data collection errors.

Clinical classification is based on information and evidence obtained before treatment. Use it for sites that are accessible for clinical examination, including cervix, oral cavity, and larynx. Use clinical classification where only clinical findings are used or available to evaluate the extent of disease. The physical examination, imaging, endoscopy, biopsy, surgical exploration, and other relevant findings are the basis of clinical staging. Evaluate the clinical stage of disease using all information available before the first cancer-directed treatment.

Pathologic classification is based on information obtained before treatment and is supplemented by additional evidence from surgery and the pathologic examination of the resected specimen. It is a combination of all findings. The pathologic stage provides the most precise data to estimate prognosis and calculate end results. Pathologic assessment of the primary tumor requires either a resection of the primary tumor or a biopsy adequate to evaluate the highest pT category. The pathologic assessment of the regional lymph nodes requires the surgical removal and pathologic examination of enough nodes to confirm the absence of regional lymph node metastasis or evaluate the highest pN category.

Pathologic staging takes precedence over clinical.

Exceptions: There are some diseases and sites for which clinical staging takes precedence. Clinical staging takes precedence when the patient has radiation or chemotherapy preoperatively and when the patient does not have cancer-directed surgery.

Examples: Cervical cancer treated preoperatively with radiation

Breast cancer treated preoperatively with chemotherapy and radiation

Prostate cancer biopsied and treated with hormones

Small cell carcinoma of the lung biopsied and treated with chemotherapy

Pancreas primary diagnosed without histologic confirmation

Clinical T

Item Length: 2
Data Type: Alphanumeric
Upper Case
Required Data Set
Left Justified
Blank Fill

The T evaluates the primary tumor and reflects tumor size and/or extension.

The Clinical T classification is based on information and evidence obtained before treatment. Use for sites that are accessible for clinical examination, including cervix, oral cavity, and larynx. Use clinical classification where only clinical findings are used or available to evaluate the extent of disease. The physical examination, imaging, endoscopy, biopsy, surgical exploration, and other relevant findings are the basis of clinical staging. Evaluate the clinical stage of disease using all information available before the first cancer-directed treatment.

If the value is only one digit, record to the left and leave the second space blank. Truncate the least significant subdivision of the category from the right as needed. Choose the lower (less advanced) T category when there is any uncertainty. Refer to the *AJCC Cancer Staging Manual*, Fifth Edition for coding rules.

The addition of code 88 to the "T" enables the registry to distinguish cases in which the site or histologic type has no AJCC staging scheme from cases that could not be staged because the information was incomplete. The registry can use this item for quality control, survey preparation, and for quality assurance programs.

- Record 88 when the site or histologic type does not have an AJCC staging scheme.

  Examples: Leukemia, fallopian tube, dermatofibrosarcoma, unknown primary site, and so on.

  The pathology report identifies a breast mass as sarcoma. The breast staging scheme in the *AJCC Cancer Staging Manual*, Fifth Edition applies only to carcinomas. Record T88.

- Record X when the site or histologic type has an AJCC staging scheme, but there is not enough information to assign a T value.

  Example: A patient has a fine-needle biopsy of a breast mass. The cytology identifies infiltrating ductal carcinoma. The patient is lost to follow up. AJCC staging requires tumor size and palpation of axillary lymph nodes for clinical staging. Record TX NX MX.

Clinical T **(Continued)**

The following general definitions are used throughout the TNM classification:

TX Primary tumor cannot be assessed or is unknown

T0 No evidence of a primary tumor

Tis Carcinoma in situ

T1, T2, T3, and T4 describe increasing size and/or local extent of the primary tumor

Tumor size is necessary to classify T for several sites. See data item Size of Tumor for a table identifying those sites.

Code

TX	=	X
T0	=	0
Ta	=	A
Tis	=	IS
Tispu	=	SU
Tispd	=	SD
T1mic	=	1M
T1	=	1
T1A	=	1A
T1A1	=	A1
T1A2	=	A2
T1B	=	1B
T1B1	=	B1
T1B2	=	B2
T1C	=	1C
T2	=	2
T2A	=	2A
T2B	=	2B
T2C	=	2C
T3	=	3
T3A	=	3A
T3B	=	3B
T3C	=	3C
T4	=	4
T4A	=	4A
T4B	=	4B
T4C	=	4C
T4D	=	4D
Not applicable	= 88	

Clinical N

Item Length: 2
Data Type: Alphanumeric
Upper Case
Required Data Set
Left Justified
Blank Fill

Clinical N identifies the presence or absence of regional lymph node metastases and describes the extent of regional lymph node metastases.

If the value is only one digit, record to the left and leave the second space blank. Truncate the least significant subdivision of the category from the right as needed. Choose the lower (less advanced) N category when there is any uncertainty. Refer to the *AJCC Cancer Staging Manual,* Fifth Edition for coding rules.

The addition of code 88 enables the registry to distinguish cases where the site or histology has no AJCC staging scheme, from cases that could not be staged due to incomplete information. The registry can use this item for quality control, survey preparation, and for quality assurance programs.

- Record 88 when the site or histology does not have an AJCC staging scheme.

  Examples: Leukemia, dermatofibrosarcoma, etc.

  Pathology identifies a breast mass as sarcoma. The breast staging scheme in the *AJCC Cancer Staging Manual,* Fifth Edition applies only to carcinomas. Record N88.

- Record X when the site or histology has an AJCC staging scheme, but there is not enough information to assign an N value.

  Example: A patient has a biopsy of testicular mass. The biopsy identifies an embryonal carcinoma. The patient is lost to follow up. There is no clinical AJCC stage for testis. Record cTX NX MX.

The following general definitions are used throughout the TNM classification:

NX Regional lymph nodes cannot be assessed or status is unknown.

N0 Nodes were assessed and there was no evidence of regional lymph node metastasis.

N1, N2, and N3 indicate increasing involvement of regional lymph nodes.

Clinical N **(Continued)**

Classify a primary tumor that directly extends into lymph nodes as lymph node metastasis.

Code

NX	=	X
N0	=	0
N1	=	1
N1A	=	1A
N1B	=	1B
N2	=	2
N2A	=	2A
N2B	=	2B
N2C	=	2C
N3	=	3

Not applicable = 88

Clinical M

Item Length: 2
Data Type: Alphanumeric
Upper Case
Required Data Set
Left Justified
Blank Fill

Clinical M records the presence or absence of distant metastases. Choose the lower (less advanced) M category when there is any uncertainty.

The following general definitions are used throughout the TNM classification:

MX The presence of distant metastasis cannot be assessed or is unknown.

M0 No known distant metastasis.

M1 Distant metastases are present.

Truncate the least significant subdivision of the category from the right as needed. Refer to the *AJCC Cancer Staging Manual*, Fifth Edition for coding rules.

The addition of code 88 to the "M" enables the registry to distinguish cases in which the site or histologic type has no AJCC staging scheme from cases that could not be staged because the information was incomplete. The registry can use this item for quality control, survey preparation, and for quality assurance programs.

- Record 88 when the site or histologic type does not have an AJCC staging scheme.

  Examples: Leukemia, fallopian tube, dermatofibrosarcoma, unknown primary site, etc.

  The pathology report identifies a breast mass as sarcoma. The breast staging scheme in the *AJCC Cancer Staging Manual*, Fifth Edition applies only to carcinomas. Record M88.

- Record X when the site or histologic type has an AJCC staging scheme, but there is not enough information to assign an M value.

  Example: A patient has a fine-needle biopsy of a breast mass. The cytology identifies infiltrating ductal carcinoma. The patient is lost to follow up. AJCC staging requires tumor size and palpation of axillary nodes for clinical staging. Record TX NX MX.

Clinical M **(Continued)**

Code

MX = X

M0 = 0

M1 = 1

M1A = 1A

M1B = 1B

M1C = 1C

Not applicable = 88

Prostate cancer has codes M1a, b, and c. Codes indicate metastases to:

M1a Nonregional lymph node(s)

M1b Bone(s)

M1c Other site(s)

Malignant melanoma of the skin and of the eyelid have codes M1a and b. Codes indicate metastases to:

M1a Skin or subcutaneous tissue or lymph node(s) beyond the regional lymph nodes

M1b Visceral metastases

Clinical Stage Group

Item Length: 2
Data Type: Alphanumeric
Upper Case
Required Data Set
Left Justified
Blank Fill

Clinical Stage Group defines the anatomic extent of disease based on the previously coded T, N, and M elements.

If the stage is only one digit, record to the left and blank fill. Truncate the least significant subdivision of the category from the right as needed. Choose the lower (less advanced) stage grouping when there is any uncertainty. Refer to the *AJCC Cancer Staging Manual*, Fifth Edition for specific coding rules.

Convert all Roman numerals to Arabic numerals and use uppercase (capital letters) only.

Examples: Stage IV converts to stage 4

Stage IIA converts to stage 2A

The addition of code 88 to the stage group enables the registry to distinguish cases in which the site or histologic type has no AJCC staging scheme from cases that could not be staged because the information was incomplete. The registry can use this item for quality control, survey preparation, and for quality assurance programs.

- Record 88 when the site or histologic type does not have an AJCC staging scheme.

  Examples: Leukemia, fallopian tube, dermatofibrosarcoma, unknown primary site, etc.

  The pathology report identifies a breast mass as sarcoma. The staging scheme in the *AJCC Cancer Staging Manual*, Fifth Edition applies only to carcinomas. Record Stage 88.

- Record 99 when the site or histologic type has an AJCC staging scheme, but there is not enough information to assign a stage.

Example: A nursing home resident enters your facility for a needle biopsy of the breast. The pathology report identifies infiltrating ductal carcinoma. The medical record does not describe tumor size. The AJCC staging elements are TX NX MX. The stage group cannot be assigned. Record 99.

Clinical Stage Group **(Continued)**

Codes:

Stage 0 = 0

Stage 0A = 0A

Stage 0is = 0S

Stage I = 1

Stage IA = 1A

Stage IA1 = A1

Stage IA2 = A2

Stage IB = 1B

Stage IB1 = B1

Stage IB2 = B2

Stage IC = 1C

Stage 1S = 1S

Stage II = 2

Stage IIA = 2A

Stage IIB = 2B

Stage IIC = 2C

Stage III = 3

Stage IIIA = 3A

Stage IIIB = 3B

Stage IIIC = 3C

Stage IV = 4

Stage IVA = 4A

Stage IVB = 4B

Stage IVC = 4C

Not applicable = 88

Recurrent, unknown, stage X = 99

Occult = OC

There are several sites in which the size of tumor or the grade/differentiation is necessary to determine the stage grouping. See data items Size of Tumor and Grade/Differentiation for tables identifying these sites.

Clinical Stage (Prefix/Suffix) Descriptor

Item Length: 1
Data Type: Numeric
Allowable Values: 0-6, 9
Supplementary Data Set

Stage descriptors identify special cases that need separate data analysis. The descriptors are adjuncts to and do not change the stage group.

The institution can produce more detailed survival analysis by using clinical stage prefix/suffix descriptors.

Code

0	None	
1	E	(Extranodal, lymphomas only)
2	S	(Spleen, lymphomas only)
3	M	(Multiple primary tumors in a single site)
5	E&S	(Extranodal and spleen, lymphomas only)
6	M&Y	(Multiple primary tumors and initial multimodality therapy)
9	Unknown	

Clarification of code definitions:

Code	Definitions
0	There are no prefix or suffix descriptors that would be used for this case.
1	A lymphoma case involving an extranodal site. (See the *AJCC Cancer Staging Manual*, Fifth Edition.)
2	A lymphoma case involving the spleen. (See the *AJCC Cancer Staging Manual*, Fifth Edition.)
3	This is one primary with multiple tumors in the primary site **at the time of diagnosis**.
4	Not applicable for clinical stage.
5	A lymphoma case with involvement of both an extranodal site and the spleen. (See the *AJCC Cancer Staging Manual*, Fifth Edition.)
6	A case meeting the parameters of both codes 3 (multiple primary tumors in a single site) and 4 (classification during or after initial multimodality therapy).
9	A prefix or suffix would describe this stage, but it is not known which would be correct.

Staged By (Clinical Stage)

Item Length: 1
Data Type: Numeric
Allowable Values: 0-9
Supplementary Data Set

Staged By (Clinical Stage) identifies the person who documented the clinical AJCC staging elements and the stage group. The Commission requires analytic cases to be staged by the managing physician. Compliance with Commission-approved program requirements can be analyzed using this data item.

Code

0 Not staged

1 Managing physician

2 Pathologist

3 Other physician

4 Any combination of 1, 2, or 3

5 Registrar

6 Any combination of 5 with 1, 2, or 3

7 Other

8 Staged, individual not specified

9 Unknown if staged

Clarification of Codes:

Code	Definitions
0	Staging was not done
1	Staged by the managing physician only
2	Staged by the pathologist only
3	Staged by a physician other than the managing physician or pathologist
4	Staged by more than one of the individuals specified in codes 1–3
5	Staged by the cancer registrar only
6	Staged by the cancer registrar and one of the physicians specified in codes 1–3
7	Staged by someone other than a physician or the cancer registrar (resident, student, physician's assistant, etc.)
8	The case has been staged; the individual who did the staging is not identified
9	Unknown if case was staged

Pathologic T

Item Length: 2
Data Type: Alphanumeric
Upper Case
Required Data Set
Left Justified
Blank Fill

Pathologic T evaluates the primary tumor and identifies tumor size and/or extension.

Pathologic classification is based on information obtained before treatment and supplemented by additional evidence from surgery and pathologic examination of the resected specimen. It is a combination of all findings. The pathologic stage provides the most precise data to estimate prognosis and calculate end results. Pathologic assessment of the primary tumor requires a resection of the primary tumor or a biopsy specimen adequate to evaluate the highest pT category. The pathologic assessment of the regional lymph nodes requires the removal of enough nodes to confirm the absence of regional lymph node metastasis or evaluate the highest pN category.

Pathologic staging takes precedence over clinical.

Exceptions: There are some diseases and sites for which clinical staging takes precedence. Clinical staging takes precedence when the patient has radiation or chemotherapy preoperatively and when the patient does not have cancer-directed surgery.

Examples: Cervical cancer treated preoperatively with radiation, breast cancer treated preoperatively with chemotherapy and radiation, biopsy of prostate cancer done and patient treated with hormones, biopsy of small cell carcinoma of the lung and patient treated with chemotherapy.

If the value is only one digit, record to the left and leave the second space blank. Truncate the least significant subdivision of the category from the right as needed. Choose the lower (less advanced) T category when there is any uncertainty. Refer to the *AJCC Cancer Staging Manual*, Fifth Edition for coding rules.

The addition of code 88 to the "T" enables the registry to distinguish cases in which the site or histologic type has no AJCC staging scheme from cases that could not be staged because the information was incomplete. The registry can use this item for quality control, survey preparation, and for quality assurance programs.

- Record 88 when the site or histologic type does not have an AJCC staging scheme.

  Examples: Leukemia, fallopian tube, dermatofibrosarcoma, unknown primary site, etc.

  The pathology report identifies a breast mass as sarcoma. The breast staging scheme in the *AJCC Cancer Staging Manual*, Fifth Edition applies only to carcinomas. Record T88.

- Record X when the site or histologic type has an AJCC staging scheme, but there is not enough information to assign a T value.

Pathologic T **(Continued)**

Example: A patient has a biopsy of a breast mass. The biopsy identifies infiltrating ductal carcinoma. The patient is lost to follow up. AJCC staging requires a pathologic tumor size and examination of at least one axillary node for pathologic staging. Record TX NX MX.

The following general definitions are used throughout the TNM classification.

TX Primary tumor cannot be assessed or is unknown.

T0 No evidence of a primary tumor.

Tis Carcinoma in situ.

T1, T2, T3, and T4 describe increasing size and/or local extent of the primary tumor.

A microscopic deposit, up to 2 or 3 millimeters, in the connective tissue of a lymph drainage area without histologic evidence of residual lymph node, is classified in the T category as discontinuous extension.

Tumor size is necessary to classify T for several sites. See data item Size of Tumor for a table identifying these sites.

Code

TX	=	X	T2	=	2
T0	=	0	T2A	=	2A
Ta	=	A	T2B	=	2B
Tis	=	IS	T2C	=	2C
Tispu	=	SU	T3	=	3
Tispd	=	SD	T3A	=	3A
T1mic	=	1M	T3B	=	3B
T1	=	1	T3C	=	3C
T1A	=	1A	T4	=	4
T1A1	=	A1	T4A	=	4A
T1A2	=	A2	T4B	=	4B
T1B	=	1B	T4C	=	4C
T1B1	=	B1	T4D	=	4D
T1B2	=	B2	Not applicable = 88		
T1C	=	1C			

Pathologic N

Item Length: 2
Data Type: Alphanumeric
Upper Case
Required Data Set
Left Justified
Blank Fill

Pathologic N identifies the absence or presence of regional lymph node metastases and describes the extent of regional lymph node metastases.

If the value is only one digit, then record to the left and leave the second space blank. Truncate the least significant subdivision of the category from the right as needed. Choose the lower (less advanced) N category when there is any uncertainty. Refer to the *AJCC Cancer Staging Manual,* Fifth Edition for coding rules.

The addition of code 88 enables the registry to distinguish cases where the site or histology has no AJCC staging scheme, from cases that could not be staged due to incomplete information. The registry can use this item for quality control, survey preparation, and for quality assurance programs.

- Record 88 when the site or histology does not have an AJCC staging scheme.

  Examples: Leukemia, dermatofibrosarcoma, etc.

  Pathology identifies a breast mass as sarcoma. The breast staging scheme in the *AJCC Cancer Staging Manual,* Fifth Edition applies only to carcinomas. Record N88.

- Record X when the site or histology has an AJCC staging scheme, but there is not enough information to assign an N value.

  Example: A patient has a biopsy of a testicular mass. The biopsy identifies embryonal carcinoma. The patient is lost to follow up. AJCC staging requires a radical orchiectomy with lymph node dissection for pathologic staging. Record pTX NX MX.

The following general definitions are used throughout the TNM classification:

NX Regional lymph nodes cannot be or were not assessed, or status is unknown.

N0 Nodes were assessed and there was no evidence of regional lymph node metastasis.

N1, N2, and N3 indicate increasing involvement of regional lymph nodes.

Classify a primary tumor that directly extends into lymph nodes as lymph node metastasis.

Classify a metastatic nodule as lymph node metastasis when:

- It is removed from the connective tissue in a lymph drainage area.
- The nodule is larger than 2-3 millimeters.
- There is no histologic evidence of residual lymph node.
- The nodule is grossly recognizable.

Note: Evaluate the nodule in the T category (discontinuous extension) if it is microscopic (up to 2–3 millimeters).

Pathologic N **(Continued)**

Code

NX	=	X
N0	=	0
N1	=	1
N1A	=	1A
N1B	=	1B
N2	=	2
N2A	=	2A
N2B	=	2B
N2C	=	2C
N3	=	3

Not applicable = 88

Pathologic M

Item Length: 2
Data Type: Alphanumeric
Upper Case
Required Data Set
Left Justified
Blank Fill

Pathologic M records the presence or absence of distant metastases. Choose the lower (less advanced) M category when there is any uncertainty.

The following general definitions are used throughout the TNM classification:

MX The presence of distant metastasis cannot be assessed or is unknown.

M0 No known distant metastasis.

M1 Distant metastases are present.

Truncate the least significant subdivision of the category from the right as needed. Refer to the *AJCC Cancer Staging Manual*, Fifth Edition for coding rules.

The addition of code 88 to the "M" enables the registry to distinguish cases in which the site or histologic type has no AJCC staging scheme from cases that could not be staged because the information was incomplete. The registry can use this item for quality control, survey preparation, and for quality assurance programs.

- Record 88 when the site or histologic type does not have an AJCC staging scheme.

  Examples: Leukemia, fallopian tube, dermatofibrosarcoma, unknown primary site, etc.

  The pathology report identifies a breast mass as sarcoma. The breast staging scheme in the *AJCC Cancer Staging Manual*, Fifth Edition applies only to carcinomas. Record M88.

- Record X when the site or histologic type has an AJCC staging scheme, but there is not enough information to assign an M value.

  Example: A patient has a fine-needle biopsy of a breast mass. The cytology identifies infiltrating ductal carcinoma. The patient is lost to follow up. AJCC staging requires tumor size and palpation of axillary nodes for clinical staging. Record TX NX MX.

Pathologic M **(Continued)**

Code

MX = X

M0 = 0

M1 = 1

M1A = 1A

M1B = 1B

M1C = 1C

Not applicable = 88

Prostate cancer has codes M1a, b, and c. Codes indicate metastases to:

M1a Non-regional lymph node(s)

M1b Bone(s)

M1c Other sites(s)

Malignant melanoma of the skin and of the eyelid have codes M1a and b. Codes indicate metastases to:

M1a Skin or subcutaneous tissue or lymph node(s) beyond the regional lymph nodes

M1b Visceral metastases

Pathologic Stage Group

Item Length: 2
Data Type: Alphanumeric
Upper Case
Required Data Set
Left Justified
Blank Fill

Pathologic Stage Group defines the anatomic extent of disease based on the T, N, and M elements.

If the stage is only one digit, then record to the left and blank fill. Truncate the least significant subdivision of the category from the right as needed. Choose the lower (less advanced) stage grouping when there is any uncertainty. Refer to the *AJCC Cancer Staging Manual*, Fifth Edition for specific coding rules.

Convert all Roman numerals to Arabic numerals and use upper case (capital letters) only.

Examples: Stage IV converts to stage 4

Stage IIA converts to stage 2A

The addition of code 88 to the stage group enables the registry to distinguish cases in which the site or histologic type has no AJCC staging scheme from cases that could not be staged because the information was incomplete. The registry can use this item for quality control, survey preparation, and for quality assurance programs.

- Record 88 when the site or histologic type does not have an AJCC staging scheme.

  Examples: Leukemia, fallopian tube, dermatofibrosarcoma, unknown primary site, etc.

  The pathology report identifies a breast mass as sarcoma. The breast staging scheme in the *AJCC Cancer Staging Manual*, Fifth Edition applies only to carcinomas. Record 88.

- Record 99 when the site or histologic type has an AJCC staging scheme, but there is not enough information to assign a stage.

  Example: A nursing home resident enters your facility for a needle biopsy of the breast. The pathology report identifies infiltrating ductal carcinoma. The medical record does not describe tumor size. The AJCC staging elements are TX NX MX. The stage group cannot be assigned. Record 99.

Pathologic Stage Group **(Continued)**

Code

Stage 0 = 0

Stage 0A = 0A

Stage 0is = 0S

Stage I = 1

Stage IA = 1A

Stage IA1 = A1

Stage IA2 = A2

Stage IB = 1B

Stage IB1 = B1

Stage IB2 = B2

Stage IC = 1C

Stage 1S = 1S

Stage II = 2

Stage IIA = 2A

Stage IIB = 2B

Stage IIC = 2C

Stage III = 3

Stage IIIA = 3A

Stage IIIB = 3B

Stage IIIC = 3C

Stage IV = 4

Stage IVA = 4A

Stage IVB = 4B

Stage IVC = 4C

Not applicable = 88

Recurrent, unknown, stage X = 99

Occult = OC

There are several sites in which the size of tumor or the grade/differentiation is necessary to determine the stage grouping. See data items Size of Tumor and Grade/Differentiation for tables identifying these sites.

Pathologic Stage (Prefix/Suffix) Descriptor

Item Length: 1
Data Type: Numeric
Allowable Values: 0-6, 9
Supplementary Data Set

Stage descriptors identify special cases that need separate data analysis. The descriptors are adjuncts to and do not change the stage group.

The institution can produce more detailed survival analysis by using pathologic stage prefix/suffix descriptors.

Code

0 None

1 E (Extranodal, lymphomas only)

2 S (Spleen, lymphomas only)

3 M (Multiple primary tumors in a single site)

4 Y (Classification during or after initial multimodality therapy—pathologic staging only

5 E&S (Extranodal and spleen, lymphomas only)

6 M&Y (Multiple primary tumors and initial multimodality therapy)

9 Unknown

Clarification of code definitions:

Code	Definitions
0	There are no prefix or suffix descriptors that would be used for this case.
1	A lymphoma case involving an extranodal site. (See the *AJCC Cancer Staging Manual*, Fifth Edition.)
2	A lymphoma case involving the spleen. (See the *AJCC Cancer Staging Manual*, Fifth Edition.)
3	This is one primary with multiple tumors in the primary site **at the time of diagnosis**.
4	The first method of therapy is other than cancer-directed surgery. The patient is first treated with radiation therapy, chemotherapy, hormone therapy, immunotherapy, other therapy, or any combination of these therapies. The stage is based on a pathologic resection of the primary done after at least one of the other therapies has started. The other therapy may or may not be complete. This stage should supplement the clinical AJCC stage, not replace it.
5	A lymphoma case with involvement of both an extranodal site and the spleen. (See the *AJCC Cancer Staging Manual*, Fifth Edition.)
6	A case meeting the parameters of both codes 3 (multiple primary tumors in a single site) and 4 (classification during or after initial multimodality therapy).
9	A prefix or suffix would describe this stage, but it is not known which would be correct.

Stage of Disease at Diagnosis

Staged By (Pathologic Stage)

Item Length: 1
Data Type: Numeric
Allowable Values: 0-9
Required Data Set

Staged By (Pathologic Stage) identifies the person who documented the pathologic AJCC staging elements and the stage group. The Commission requires analytic cases to be staged by the managing physician. Compliance with Commission-approved program requirements can be analyzed using this data item.

Code

0 Not staged

1 Managing physician

2 Pathologist

3 Other physician

4 Any combination of 1, 2, or 3

5 Registrar

6 Any combination of 5 with 1, 2, or 3

7 Other

8 Staged, individual not specified

9 Unknown if staged

Clarification of Codes:

Code	Definitions
0	Staging was not done
1	Staged by the managing physician only
2	Staged by the pathologist only
3	Staged by a physician other than the managing physician or pathologist
4	Staged by more than one of the individuals specified in codes 1–3
5	Staged by the cancer registrar only
6	Staged by the cancer registrar and one of the physicians specified in codes 1–3
7	Staged by someone other than a physician or the cancer registrar (resident, student, physician's assistant, etc.)
8	The case has been staged; the individual who did the staging is not identified
9	Unknown if case was staged

Other T

Item Length: 2
Data Type: Alphanumeric
Upper Case
Supplementary Data Set
Left Justified
Blank Fill

The "other" AJCC staging elements and group allow the institution to collect AJCC retreatment stages. Cases with AJCC retreatment stages must be analyzed separately. The "other" group will also facilitate data conversion by providing a category for historical surgical-evaluative cases.

Other T evaluates the primary tumor and identifies tumor size and/or extension.

If the value is only one digit, then record to the left and leave the second space blank. Truncate the least significant subdivision of the category from the right as needed. Choose the lower (less advanced) T category when there is any uncertainty. Refer to the *AJCC Cancer Staging Manual,* Fifth Edition for coding rules.

- Record 88 when the site or histologic type does not have an AJCC staging scheme.

  Examples: Leukemia, fallopian tube, dermatofibrosarcoma, unknown primary site, etc.

  The pathology report identifies a breast mass as sarcoma. The breast staging scheme in the *AJCC Cancer Staging Manual,* Fifth Edition applies only to carcinomas. Record T88.

- Record X when the site or histologic type has an AJCC staging scheme, but there is not enough information to assign a T value.

  Example: A patient has a fine-needle biopsy of a breast mass. The cytology identifies infiltrating ductal carcinoma. The patient is lost to follow up. AJCC staging requires tumor size and palpation of axillary nodes for clinical staging. Record TX NX MX.

The following general definitions are used throughout the TNM classification:

TX Primary tumor cannot be assessed or is unknown.

T0 No evidence of a primary tumor.

Tis Carcinoma in situ.

T1, T2, T3, and T4 describe increasing size and/or local extent of the primary tumor.

A microscopic deposit, up to 2 or 3 mm, in the connective tissue of a lymph drainage area without histologic evidence of residual lymph node is classified in the T category as discontinuous extension.

Tumor size is necessary to classify T for several sites. See data item Size of Tumor for a table identifying these sites.

Other T (Continued)

Code

TX	=	X
T0	=	0
Ta	=	A
Tis	=	IS
Tispu	=	SU
Tispd	=	SD
T1mic	=	1M
T1	=	1
T1A	=	1A
T1A1	=	A1
T1A2	=	A2
T1B	=	1B
T1B1	=	B1
T1B2	=	B2
T1C	=	1C
T2	=	2
T2A	=	2A
T2B	=	2B
T2C	=	2C
T3	=	3
T3A	=	3A
T3B	=	3B
T3C	=	3C
T4	=	4
T4A	=	4A
T4B	=	4B
T4C	=	4C
T4D	=	4D

Not applicable = 88

Other N

Item Length: 2
Data Type: Alphanumeric
Upper Case
Supplemental Data Set
Left Justified
Blank Fill

The "other" AJCC staging elements, group, and basis allow the institution to collect AJCC retreatment or autopsy stages. Cases with AJCC retreatment or autopsy stages must be analyzed separately. The "Other" data items will also facilitate data conversion by providing a separate category for historical cases which were based on parameters other than clinical or pathologic, e.g., surgical-evaluative.

Other N identifies the absence or presence of regional lymph node metastases and describes the extent of regional lymph node metastases.

If the value is only one digit, then record to the left and leave the second space blank. Truncate the least significant subdivision of the category from the right as needed. Choose the lower (less advanced) N category when there is any uncertainty. Refer to the *AJCC Cancer Staging Manual,* Fifth Edition for coding rules.

The addition of code 88 enables the registry to distinguish cases in which the site or histology has no AJCC staging scheme from cases that could not be staged because the information was incomplete. The registry can use this item for quality control, survey preparation, and for quality assurance programs.

- Record 88 when the site or histology does not have an AJCC staging scheme.

  Examples: Leukemia, dermatofibrosarcoma, unknown primary site, etc.

  Pathology identifies a breast mass as sarcoma. The breast staging scheme in the *AJCC Cancer Staging Manual,* Fifth Edition applies only to carcinomas. Record N88.

- Record X when the site or histology has an AJCC staging scheme, but there is not enough information to assign an N value.

  Example: A patient has a biopsy of a testicular mass. The biopsy identifies embryonal carcinoma. The patient is lost to follow up. AJCC staging requires a radical orchiectomy with lymph node dissection for pathologic staging. Record TX NX MX.

The following general definitions are used throughout the TNM classification:

NX Regional lymph nodes cannot be assessed or status is unknown.

N0 Nodes were assessed and there was no evidence of regional lymph node metastasis.

N1, N2, and N3 indicate increasing involvement of regional lymph nodes.

Other N **(Continued)**

Classify a primary tumor that directly extends into lymph nodes as lymph node metastasis.

Classify a metastatic nodule as lymph node metastasis when:

- It is removed from the connective tissue in a lymph drainage area.
- The nodule is larger than 2–3 mm.
- There is no histologic evidence of residual lymph node.
- The nodule is grossly recognizable.

Note: Evaluate the nodule in the T category (discontinuous extension) if it is microscopic (up to 2–3 mm).

Code

NX	=	X
N0	=	0
N1	=	1
N1A	=	1A
N1B	=	1B
N2	=	2
N2A	=	2A
N2B	=	2B
N2C	=	2C
N3	=	3

Not applicable = 88

Other M

Item Length: 2
Data Type: Alphanumeric
Upper Case
Supplementary Data Set
Left Justified
Blank Fill

The "other" AJCC staging elements and group allow the institution to collect AJCC retreatment stages. Cases with AJCC retreatment stages must be analyzed separately. The "other" group will also facilitate data conversion by providing a category for historical surgical-evaluative cases.

Other M records the presence or absence of distant metastases. Choose the lower (less advanced) M category when there is any uncertainty.

The following general definitions are used throughout the TNM classification:

MX The presence of distant metastasis cannot be assessed or is unknown.

M0 No known distant metastasis.

M1 Distant metastases are present.

Refer to the *AJCC Cancer Staging Manual*, Fifth Edition for coding rules.

The addition of code 88 to the "M" enables the registry to distinguish cases in which the site or histologic type has no AJCC staging scheme from cases that could not be staged because the information was incomplete. The registry can use this item for quality control, survey preparation, and for quality assurance programs.

- Record 88 when the site or histologic type does not have an AJCC staging scheme.

  Examples: Leukemia, fallopian tube, dermatofibrosarcoma, unknown primary site, etc.

  The pathology report identifies a breast mass as sarcoma. The breast staging scheme in the *AJCC Cancer Staging Manual*, Fifth Edition applies only to carcinomas. Record M88.

- Record X when the site or histologic type has an AJCC staging scheme, but there is not enough information to assign an M value.

  Example: A patient has a fine-needle biopsy of a breast mass. The cytology identifies infiltrating ductal carcinoma. The patient is lost to follow- up. AJCC staging requires tumor size and palpation of axillary nodes for clinical staging. Record TX NX MX.

Other M **(Continued)**

Code

MX = X

M0 = 0

M1 = 1

M1A = 1A

M1B = 1B

M1C = 1C

Not applicable, unstaged = 88

Prostate cancer has codes M1a, b, and c. Codes indicate metastases to:

M1a Non-regional lymph node(s)

M1b Bone(s)

M1c Other site(s)

Malignant melanoma of the skin and of the eyelid have codes M1a and b. Codes indicate metastases to:

M1a Skin or subcutaneous tissue or lymph node(s) beyond the regional lymph nodes

M1b Visceral metastases

Other Stage Group

Item Length: 2
Data Type: Alphanumeric
Upper Case
Supplementary Data Set
Left Justified
Blank Fill

The "other" AJCC staging elements and group allow the institution to collect AJCC retreatment stages. Cases with AJCC retreatment stages must be analyzed separately. The "other" group will also facilitate data conversion by providing a category for historical surgical-evaluative cases.

Other Stage Group defines the anatomic extent of disease based on the T, N, and M elements.

If the stage is only one digit, then record to the left and blank fill. Truncate the least significant subdivision of the category from the right as needed. Choose the lower (less advanced) stage grouping when there is any uncertainty. Refer to the *AJCC Cancer Staging Manual*, Fifth Edition for specific coding rules.

Convert all Roman numerals to Arabic numerals and use uppercase only.

Examples: Stage IV converts to stage 4

Stage IIA converts to stage 2A

The addition of code 88 to the stage group enables the registry to distinguish cases in which the site or histologic type has no AJCC staging scheme from cases that could not be staged because the information was incomplete. The registry can use this item for quality control, survey preparation, and for quality assurance programs.

- Record 88 when the site or histologic type does not have an AJCC staging scheme.

  Examples: Leukemia, fallopian tube, dermatofibrosarcoma, unknown primary site, etc.

  The pathology report identifies a breast mass as sarcoma. The breast staging scheme in the *AJCC Cancer Staging Manual*, Fifth Edition applies only to carcinomas. Record 88.

- Record 99 when the site or histologic type has an AJCC staging scheme, but there is not enough information to assign a stage.

  Example: A nursing home resident enters your facility for a needle biopsy of the breast. The pathology report identifies infiltrating ductal carcinoma. The medical record does not describe tumor size. The AJCC staging elements are TX NX MX. The stage group cannot be assigned. Record 99.

Other Stage Group **(Continued)**

Code

Stage 0 = 0

Stage 0A = 0A

Stage 0is = 0S

Stage I = 1

Stage IA = 1A

Stage IA1 = A1

Stage IA2 = A2

Stage IB = 1B

Stage IB1 = B1

Stage IB2 = B2

Stage IC = 1C

Stage 1S = 1S

Stage II = 2

Stage IIA = 2A

Stage IIB = 2B

Stage IIC = 2C

Stage III = 3

Stage IIIA = 3A

Stage IIIB = 3B

Stage IIIC = 3C

Stage IV = 4

Stage IVA = 4A

Stage IVB = 4B

Stage IVC = 4C

Not applicable = 88

Recurrent, unknown, stage x = 99

Occult = OC

There are several sites in which the size of tumor or the grade/differentiation is necessary to determine the stage grouping. See data items Size of Tumor and Grade/Differentiation for tables identifying these sites.

Other Stage (Prefix/Suffix) Descriptor

Item Length: 1
Data Type: Numeric
Allowable Values: 0-6, 9
Supplementary Data Set

Stage descriptors identify special cases that need separate data analysis. The descriptors are adjuncts to and do not change the stage group.

The institution can produce more detailed survival analysis by using other stage prefix/suffix descriptors.

Code

0 None

1 E (Extranodal, lymphomas only)

2 S (Spleen, lymphomas only)

3 M (Multiple primary tumors in a single site)

4 Y (Classification during or after initial multimodality therapy—pathologic staging only)

5 E&S (Extranodal and spleen, lymphomas only)

6 M&Y (Multiple primary tumors and initial multimodality therapy)

9 Unknown

Clarification of code definitions:

Code	Definitions
0	There are no prefix or suffix descriptors that would be used for this case.
1	A lymphoma case involving an extranodal site. (See the *AJCC Cancer Staging Manual,* Fifth Edition.)
2	A lymphoma case involving the spleen. (See the *AJCC Cancer Staging Manual,* Fifth Edition.)
3	This is one primary with multiple tumors in the primary site **at the time of diagnosis**.
4	Not applicable for “other” stage.
5	A lymphoma case with involvement of both an extranodal site and the spleen. (See the *AJCC Cancer Staging Manual,* Fifth Edition.)
6	A case meeting the parameters of both codes 3 (multiple primary tumors in a single site) and 4 (classification during or after initial multimodality therapy).
9	A prefix or suffix would describe this stage, but it is not known which would be correct.

Stage of Disease at Diagnosis

Staged By (Other Stage)

Item Length: 1
Data Type: Numeric
Allowable Values: 0-9
Required Data Set

Staged By (Other Stage) identifies the person who documented the other AJCC staging elements and the stage group. The Commission requires analytic cases to be staged by the managing physician. Compliance with Commission-approved program requirements can be analyzed using this data item.

Code

0 Not staged

1 Managing physician

2 Pathologist

3 Other physician

4 Any combination of 1, 2, or 3

5 Registrar

6 Any combination of 5 with 1, 2, or 3

7 Other

8 Staged, individual not specified

9 Unknown if staged

Clarification of Codes:

Code	Definitions
0	Staging was not done
1	Staged by the managing physician only
2	Staged by the pathologist only
3	Staged by a physician other than the managing physician or pathologist
4	Staged by more than one of the individuals specified in codes 1–3
5	Staged by the cancer registrar only
6	Staged by the cancer registrar and one of the physicians specified in codes 1–3
7	Staged by someone other than a physician or the cancer registrar (resident, student, physician's assistant, etc.)
8	The case has been staged; the individual who did the staging is not identified
9	Unknown if case was staged

Other Staging System

Item Length: 15
Data Type: Free Text
Optional Data Set

Other Staging System allows institutions the opportunity to collect additional staging classifications.

Free text field allows entry of a staging system not included in the database.

Examples: Duke's B

FIGO II

Stage of Disease at Diagnosis

Type of Staging System (Pediatric)

Item Length: 2
Data Type: Numeric
Allowable Values: 00-15, 88, 97, 99
Required Data Set

The Commission requires staging of pediatric patients using the staging criteria of the pediatric intergroup studies and the pediatric cooperative groups.

Record the type of pediatric staging system used.

Codes:

00 None

01 American Joint Committee on Cancer (AJCC)

02 Ann Arbor

03 Children's Cancer Group (CCG)

04 Evans

05 General Summary

06 Intergroup Ewings

07 Intergroup Hepatoblastoma

08 Intergroup Rhabdomyosarcoma

09 International System

10 Murphy

11 National Cancer Institute (pediatric oncology)

12 National Wilms' Tumor Study

13 Pediatric Oncology Group (POG)

14 Reese-Ellsworth

15 SEER Extent of Disease

88 Not applicable

97 Other

99 Unknown

Record none (00) when a pediatric case is unstaged. Record not applicable (88) if the patient is an adult. Code other (97) when the case is staged using pediatric staging system other than those identified in codes 01–15. Code unknown (99) if the case is staged, but the staging system is unknown.

Stage of Disease at Diagnosis

Pediatric Stage

Item Length: 2
Data Type: Alphanumeric
Upper Case
Required Data Set
Left Justified
Blank Fill

Record the pediatric stage as specified in the pediatric staging system selected. If the pediatric stage is only one digit, then record to the left and leave the second space blank. Truncate the least significant subdivision of the category from the right as needed.

Code

Stage I		=	1
Stage IA	(rhabdomyosarcomas and related sarcomas only)	=	1A
Stage IB	(rhabdomyosarcomas and related sarcomas only)	=	1B
Stage II		=	2
Stage IIA	(rhabdomyosarcomas and related sarcomas only)	=	2A
Stage IIB	(rhabdomyosarcomas and related sarcomas only)	=	2B
Stage IIC	(rhabdomyosarcomas and related sarcomas only)	=	2C
Stage III		=	3
Stage IIIA	(liver, rhabdomyosarcomas and related sarcomas, Wilms' tumor only)	=	3A
Stage IIIB	(liver, rhabdomyosarcomas and related sarcomas, Wilms' tumor only)	=	3B
Stage IIIC	(Wilms' tumor only)	=	3C
Stage IIID	(Wilms' tumor only)	=	3D
Stage IIIE	(Wilms' tumor only)	=	3E
Stage IV		=	4
Stage IVA	(bone only)	=	4A
Stage IVB	(bone only)	=	4B
Stage IVS	(neuroblastoma only)	=	4S
Stage V	(Wilms' tumor, retinoblastoma only)	=	5
Stage A	(neuroblastoma only)	=	A
Stage B	(neuroblastoma only)	=	B
Stage C	(neuroblastoma only)	=	C
Stage D	(neuroblastoma only)	=	D
Stage DS	(neuroblastoma only)	=	DS
Not applicable (not pediatric case)		=	88
Unstaged, unknown		=	99

Staged By (Pediatric Stage)

Item Length: 1
Data Type: Numeric
Allowable Values: 0-9
Required Data Set

Staged By (Pediatric Stage) identifies the person who documented the pediatric staging system and the stage. The Commission requires analytic cases to be staged by the managing physician. The institution can confirm compliance with the Commission's approved program requirements by using this data item.

Code

0 Not staged

1 Managing physician

2 Pathologist

3 Other physician

4 Any combination of 1, 2, or 3

5 Registrar

6 Any combination of 5 with 1, 2, or 3

7 Other

8 Staged, individual not specified

9 Unknown if staged

Clarification of Codes:

Code	Definitions
0	Staging was not done
1	Staged by the managing physician only
2	Staged by the pathologist only
3	Staged by a physician other than the managing physician or pathologist
4	Staged by more than one of the individuals specified in codes 1–3
5	Staged by the cancer registrar only
6	Staged by the cancer registrar and one of the physicians specified in codes 1–3
7	Staged by someone other than a physician or the cancer registrar (resident, student, physician's assistant, etc.)
8	The case has been staged; the individual who did the staging is not identified.
9	Unknown if case was staged

Stage of Disease at Diagnosis

TNM Edition Number

Item Length: 1
Data Type: Numeric
Allowable Values: 0-5, 8, 9
Required Data Set
Position

TNM Edition Number identifies the edition of the *AJCC Cancer Staging Manual* used to stage the case. This will allow analysis of cases grouped by edition number.

Code

0 Not staged (cases that have AJCC staging scheme and staging was not done)

1 First edition

2 Second edition

3 Third edition

4 Fourth edition

5 Fifth edition

8 Not applicable (cases that do not have an AJCC staging scheme)

9 Unknown edition

Note: All Commission on Cancer Approved programs were required to use the *AJCC Cancer Staging Manual*, Fifth Edition for cases diagnosed and/or treated on or after January 1, 1998. The Fifth edition was published in 1997.

Date of First Positive Biopsy

Item Length: 8
Data Type: Numeric
Optional Data Set

Record the date of the first positive incisional or excisional biopsy. The biopsy may be taken from the primary or a secondary site. This data item refers to a tissue biopsy/positive histology only. The first positive biopsy may be at any time during the disease course. It may be non cancer-directed or cancer-directed surgery.

The first two digits record the month, the third and fourth digits record the day, and the last four digits record the year.

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			

Example: Record June 30, 1993 as 06301993.

Code 9 for unknowns:

- Code 99 for unknown month.
- Code 99 for unknown day.
- Code 9999 for unknown year.

If a positive biopsy was never obtained, code 00000000.

If information is limited to a description, use the following:

Descriptive Term Used	Date Code
"Spring"	April
"The middle of the year"	July
"The fall of the year"	October
"The winter of"	Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

Diagnostic and Staging Procedures

Combined Items Length: 4
Data Type: Numeric
Allowable Values: Site Specific
Required Data Set

First digit: **Item Name: Biopsy Procedure**
Item Length: (1)

Second digit: **Item Name: Guidance**
Item Length: (1)

Third digit: **Breast: Palpability of Primary**
Prostate: Approach for Biopsy of Primary (1)
Item Length: (1)

Fourth digit: **Breast: First Detected By**
Prostate: Biopsy of Other Than Primary
Item Length: (1)

Diagnostic and Staging Procedures are biopsies that do not grossly remove the primary tumor and/or surgical margins were macroscopically involved. Diagnostic and staging procedures are collected on two sites, breast and prostate.

If the primary tumor was grossly removed during the biopsy procedure, code all of the diagnostic and staging items 0 (not done, not a separate procedure). The biopsy would be coded as cancer-directed surgery.

If the primary site is other than breast or prostate, code all data items 0.

Breast

Biopsy Procedure (Breast Only)

0 Not done, not a separate procedure

1 Biopsy, NOS
- 2 Fine needle aspiration (cytology)
- 3 Core biopsy (histology)
- 5 Excision of major duct (if procedure removes all gross primary tumor, code as cancer-directed surgery)

9 Unknown if biopsy performed; death certificate only

Code	Definition (Biopsy Procedure)
0	No diagnostic or staging procedures were done. Diagnostic or staging procedures were done, but were a part of a cancer-directed surgery (i.e., excisional biopsy). Not a breast or prostate primary.
1	A biopsy was done, but the type is unknown.
2	A fine needle aspiration was done and the results were interpreted by cytology.
3	A core needle biopsy was done and the results were interpreted by histology (tissue).
5	A major duct was excised, but this excision did not remove all gross primary tumor.
9	It is unknown if the patient had a biopsy; death certificate only cases.

Diagnostic and Staging Procedures (Continued)

Guidance (Breast Only)

0 Not guided; no biopsy of primary site

1 Guided, NOS

- 2 Radiographic NOS (no dye or dye unknown)
- 3 Mammographic; wire/needle localization
- 4 Stereotactic
- 5 Dye only
- 6 Dye plus (1–3)
- 7 Ultrasound

9 Unknown if guided; biopsy performed; death certificate only

Code	Definition (Guidance)
0	No biopsy of primary site was done, or the biopsy was part of a cancer-directed surgery (i.e., excisional biopsy). A biopsy of the primary site was done, none of the guidance techniques listed in codes 1–7 were used. Not a breast or prostate primary.
1	A biopsy was done, it is known that guidance was used, but the type of guidance is not documented/known.
2	A biopsy was done guided by any radiographic technology. No dye was used to localize the tumor or it is unknown if dye was used to localize the tumor.
3	The tumor was localized by needles or wire placed with mammograpic guidance.
4	Stereotactic biopsy was performed using a fine needle (cytology), or a core needle (histology).
5	Tumor was localized using dye only.
6	Tumor was localized using dye and guided by one of the techniques described in codes 1–3.
7	Biopsy was guided by ultrasound.
9	It is unknown if a biopsy was done. A biopsy was done, it is unknown if a guidance technique was used. Death certificate only case.

Diagnostic and Staging Procedures **(Continued)**

Palpability of Primary (Breast Only)

0 Not palpable

1 Palpable

9 Palpability not stated; death certificate only

First Detected By (Breast Only)

Record the method by which the breast mass or abnormality was first recognized.

0 Not a breast or prostate primary

1 Patient first felt lump or noted nipple discharge

2 Physician first felt lump

3 Mammography—routine (screening)

4 Occult; incidental finding during other procedure

9 Unknown how first detected

Diagnostic and Staging Procedures **(Continued)**

Prostate

Biopsy Procedure (Prostate Only)

0 Not done, not a separate procedure

1 Incisional biopsy, NOS

2 Fine needle aspiration (cytology)

3 Needle core biopsy; biopsy gun (histology)

4 Sextant biopsy

9 Unknown if biopsy of primary was done; death certificate only

Code	Definition (Biopsy Procedure)
0	No diagnostic or staging procedures were done. Diagnostic or staging procedures were done, but were coded as cancer-directed surgery (i.e., TURP). Not a breast or prostate primary.
1	A biopsy was done, but the tumor was not grossly removed during this procedure and/or surgical margins were macroscopically involved, or it is unknown whether it was incisional or a core needle biopsy.
2	A fine needle aspiration was done and the results were interpreted by cytology.
3	A core needle biopsy was done and the results were interpreted by histology (tissue). A biopsy gun was used to get a tissue sample that was interpreted by histology.
4	A biopsy was done using a sextant.
9	It is unknown if the patient had a biopsy; death certificate only cases.

Diagnostic and Staging Procedures **(Continued)**

Guidance (Prostate Only)

0 Not guided; no biopsy of primary

1 Guided, NOS

2 Radiographic

3 Ultrasound

9 Unknown if guided, biopsy performed; death certificate only

Code	Definition (Guidance)
0	No biopsy of primary site was done, or the biopsy was part of a cancer-directed surgery (TURP). A biopsy of the primary site was done, none of the guidance techniques listed in codes 1–7 were used. Not a breast or prostate primary.
1	A biopsy was done, it is known that guidance was used, but the type of guidance was not documented/known.
2	A biopsy was guided by any radiographic technology. No dye was used to localize the tumor or it is unknown if dye was used to localize the tumor.
3	Biopsy was guided by ultrasound.
9	It is unknown if a biopsy was done. A biopsy was done, it is unknown if a guidance technique was used. Death certificate only case.

Diagnostic and Staging Procedures **(Continued)**

Approach for Biopsy of Primary (Prostate Only)

0 No biopsy

1 Transrectal

2 Transperineal

3 Transurethral

4 Laparoscopic

5 Open (laparotomy)

9 Unknown approach, but biopsy performed; death certificate only

Biopsy of Other Than Primary (Prostate Only)

0 No biopsy of other than primary

1 Biopsy of seminal vesicle(s), NOS

- 2 Unilateral
- 3 Bilateral

4 Other than seminal vesicle

5 4 + 1

6 4 + 2

7 4 + 3

9 Unknown if biopsy of other than primary; death certificate only

First Course of Treatment

Date of First Course Treatment
(Date Started)

Item Length: 8
Data Type: Numeric
Required Data Set

Date of first course treatment is the month, day, and year (MMDDCCYY) of the first cancer-directed therapy. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year.

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			

Examples: Record June as 06.

Record December 15, 1996 as 12151996.

If the physician decides not to treat the patient, record the date of this decision as the date of initial treatment. The physician may decide not to treat the patient because of co-morbid conditions, advanced disease, or because the accepted management of the cancer is to observe until the disease progresses or until the patient becomes symptomatic.

Example: On February 12, 1996 the physician says that a low-stage prostate cancer patient will be observed until the Prostatic Specific Antigen (PSA) starts to rise. Enter 02121996 as the Date of First Course Treatment.

If the patient refuses treatment, record the date of this decision as the date of initial treatment. Record the date of death for autopsy-only cases. If the patient is diagnosed at the reporting facility and no further information is available (patient is lost to follow-up), then record the date the patient was last seen at the reporting institution.

Code 99999999 when it is unknown if any treatment was given, or the date is not known, or the case was identified by death certificate only.

If the exact date of the beginning of treatment is not available, then recording an approximate date is preferred.

First Course of Treatment

Date of Non Cancer-Directed Surgery

Item Length: 8
Data Type: Numeric
Required Data Set

Collecting dates for each treatment modality allows sequencing of multiple treatments and aids evaluation of time intervals (from diagnosis to treatment and treatment to recurrence).

Date of non cancer-directed surgery is the month, day, and year (MMDDCCYY) that non cancer-directed surgery was performed at any facility. The first two digits are the month, the third and fourth digits are the day and the last four digits are the year.

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: Record June as 06.

Record December 15, 1996 as 12151996.

Code 00000000 when no non cancer-directed surgery is performed; as well as for autopsy-only cases.

Code 99999999 when it is unknown if any non cancer-directed surgery was performed or the date is not known, or the case was identified by death certificate only.

If the exact date of non cancer-directed surgery is not available, then recording an approximate date is preferred.

Non Cancer-Directed Surgery

Item Length: 2
Data Type: Numeric
Required Data Set

Surgical procedures performed to diagnose/stage disease (exploratory) or for relief of symptoms (palliative) are non cancer-directed surgery. Valid codes are 00–07, 09.

Examples of exploratory surgery are:

- Celiotomy
- Laparotomy
- Cystotomy
- Nephrotomy
- Gastrotomy
- Thoracotomy

Examples of palliative bypass surgery are:

- Colostomy
- Nephrostomy
- Esophagostomy
- Tracheostomy
- Gastrostomy
- Urethrostomy

Brushings, washings, aspiration of cells, and hematologic findings (peripheral blood smears) are not surgical procedures.

Record the type of non cancer-directed surgery performed as part of the initial diagnosis and workup, whether performed at your institution or at other institutions.

Non Cancer-Directed Surgery **(Continued)**

Code

00 No surgical procedure

01 Incisional biopsy of other than primary site
Needle biopsy of other than primary site
Aspiration biopsy of other than primary site

02 Incisional biopsy of primary site
Needle biopsy of primary site
Aspiration biopsy of primary site

03 Exploratory **only** (no biopsy)

04 Bypass surgery (no biopsy); –ostomy **only** (no biopsy)

05 Exploratory **only** and incisional or needle biopsy of primary site or other sites

06 Bypass surgery and incisional or needle biopsy of primary site or other sites
–ostomy **only** and incisional or needle biopsy of primary site or other sites

07 Non cancer-directed surgery, NOS

09 Unknown if non cancer-directed surgery done

Priority of Codes

In the site-specific surgery code schemes, except where otherwise noted, the following priorities hold:

- Codes 01–07 have priority over code 09.
- In the range 01–06, the higher code has priority.
- Codes 01–06 have priority over code 07.

First Course of Treatment

Non Cancer-Directed Surgery at this Facility

Item Length: 2
Data Type: Numeric
Supplementary Data Set

Record the type of non cancer-directed surgery performed at this facility. Do not include procedures done at other institutions.

Code

00 No surgical procedure

01 Incisional biopsy of other than primary site

Needle biopsy of other than primary site

Aspiration biopsy of other than primary site

02 Incisional biopsy of primary site

Needle biopsy of primary site

Aspiration biopsy of primary site

03 Exploratory **only** (no biopsy)

04 Bypass surgery (no biopsy); –ostomy **only** (no biopsy)

05 Exploratory **only** and incisional or needle biopsy of primary site or other sites

06 Bypass surgery and incisional or needle biopsy of primary site or other sites

–ostomy **only** and incisional or needle biopsy of primary site or other sites

07 Non cancer-directed surgery, NOS

09 Unknown if non cancer-directed surgery done

Priority of Codes

In the site-specific surgery code schemes, except where otherwise noted, the following priorities hold:

- Codes 01–07 have priority over code 09.
- In the range 01–06, the higher code has priority.
- Codes 01–06 have priority over code 07.

First Course of Treatment

Date of Cancer-Directed Surgery

Item Length: 8
Data Type: Numeric
Required Data Set

Date of cancer-directed surgery is the month, day, and year (MMDDCCYY) that cancer-directed surgery was performed. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year.

Collecting the dates for each treatment modality allows sequencing of multiple treatments and aids evaluation of time intervals (from diagnosis to treatment and from treatment to recurrence).

If your software allows the collection of only one date, record the first date on which the patient had cancer-directed surgery.

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			

Example: Record December 15, 1996 as 12151996.

Code 00000000 when no cancer-directed surgery is performed and for autopsy-only cases.

Code 99999999 when it is unknown if any cancer-directed surgery was performed and the date is unknown, or if the case was identified by death certificate only.

If the exact date of cancer-directed surgery is not available, then record an approximate date.

Date of Cancer-Directed Surgery **(Continued)**

If information is limited to a description, use the following:

Descriptive Term Used	Date Code
"Spring"	April
"The middle of the year"	July
"The fall of the year"	October
"The winter of"	Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

First Course of Treatment

Surgical Approach

Item Length: 1
Data Type: Numeric
Allowable Values: Site Specific
Required Data Set

Surgical Approach describes the method used to approach the organ of origin and/or primary tumor. Code the approach for cancer-directed surgery of the primary site only. If no primary site surgical procedure was done (Surgery of Primary Site 00), Surgical Approach must be 0. If the field Surgery of Primary Site is 99 (Unknown if cancer-directed surgery performed; death certificate **only**), then code Surgical Approach 9 (Unknown; not stated; death certificate **only**).

"Endoscopy, image guided" is a generic term for guidance provided by any imaging technique which include, but are not limited to, CT, MRI, ultrasound, or radiographic imaging.

"Open" is a generic term describing all nonscope approaches. Procedures for which Surgical Approach would be coded "open" include, but are not limited to, mastectomy, excision of a melanoma of the skin, glossectomy.

"Open, assisted by endoscopy" means that the scope is being used (present in the body) at the same time the primary tumor is resected. **Do not code** a procedure as assisted by endoscopy when the scope is used and removed prior to the resection or when it is inserted and used after the resection of the primary tumor.

Example: Patient with lung cancer is taken to the surgical suite. A bronchoscopy and mediastinoscopy are done to evaluate whether the lesion is resectable. The scopes are removed before the surgeon performs a wedge resection. Code "Surgical Approach "open, **not** assisted by endoscopy".

There are differences in how software providers present the surgery codes. Some programs allow only one surgical event to be recorded. Other programs will allow the user to record multiple, consecutive surgical events.

If only one field is available for the data item Surgical Approach or if a summary treatment field is provided, use the following guidelines.

If the patient has multiple cancer-directed surgeries of the primary site, then code Surgical Approach as the most invasive, definitive surgery (numerically highest code).

Example: Patient has a colonoscopy with removal of a polyp in the sigmoid colon. The pathology report identifies carcinoma extending into the stalk (Surgery of Primary Site 27). A week later, the patient has a hemicolectomy (Surgery of Primary Site 40). Since the hemicolectomy is the most invasive, definitive surgery and has the numerically higher code (40), the Surgical Approach is coded "open, not assisted by endoscopy" (5).

First Course of Treatment

Surgery of Primary Site

Item Length: 2
Data Type: Numeric
Allowable Values: Site Specific
Required Data Set

Only record surgeries of the primary site. Surgery to remove regional tissue or organs is coded in this field only if the tissue/organs are removed with the primary site in an **en bloc** resection. An en bloc resection is the removal of organs in one piece at one time.

Example: When a patient has a modified radical mastectomy, since the breast and axillary contents are removed in one piece (en bloc), surgery of primary site is coded as a modified radical mastectomy (50) even if the pathology finds no nodes in the specimen.

The range of codes from 00–89 is hierarchical. If more than one code describes the procedure, use the numerically higher code.

Record a non en bloc resection of a secondary or metastatic site in the data field Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s).

There are differences in how software providers present the surgery codes. Some programs allow only one surgical event to be recorded. Other programs will allow the user to record multiple, consecutive surgical events.

If a single field is available for the data item Surgery of Primary Site or if a summary treatment field is provided, then use the following guidelines:

- If the patient has multiple cancer-directed surgeries of the primary site, then code the most invasive, definitive surgery (numerically highest code).

  Example: Patient has a colonoscopy with removal of a polyp in the sigmoid colon. The pathology report identifies carcinoma extending into the stalk (Surgery of Primary Site 27). A week later, the patient has a hemicolectomy (Surgery of Primary Site 40). Code the hemicolectomy since it is the most invasive, definitive surgery and has the numerically higher code.

- If no primary site surgical procedure was done, then code 00.

Surgery of Primary Site **(Continued)**

If multiple fields are provided to record consecutive surgical events, use the following guidelines.

- Code each consecutive surgery of the primary site.
- If no primary site surgical procedure was done, then code 00.

Site-Specific Surgery Codes

ICD-O-2 Code	Site
C00.0–C06.9	Lip and oral cavity
C07.9–C.8.9	Parotid and other unspecified glands
C09.0–C14.0	Pharynx
C15.0–C15.9	Esophagus
C16.0–C16.9	Stomach
C18.0–C18.9	Colon
C19.9	Rectosigmoid
C20.9	Rectum
C21.0–C21.9	Anus
C22.0–C22.1	Liver and intrahepatic bile ducts
C25.0–C25.9	Pancreas
C32.0–C32.9	Larynx
C34.0–C34.9	Lung
C40.0–C 41.9, C47.0–C47.9, C49.0–C49.9	Bones, joints, and articular cartilage; peripheral nerves and autonomic nervous system; connective, subcutaneous, and other soft tissues
C42.0, C77.0–C77.9	Spleen and lymph nodes
C44.0–C44.9	Skin
C50.0–C50.9	Breast

Surgery of Primary Site **(Continued)**

ICD-O-2 Code	Site
C53.0–C53.9	Cervix uteri
C54.0–C55.9	Corpus uteri
C56.9	Ovary
C61.9	Prostate
C62.0–C62.9	Testis
C64.9–C66.9	Kidney, renal pelvis, and ureter
C67.0–C67.9	Bladder
C70.0–C72.9	Brain and other parts of central nervous system
C73.9	Thyroid
C14.1–C14.8, C17.0–C17.9, C23.9, C24.0–C24.8, C26.0–C26.9, C30.0–C30.1, C31.0–C31.9, C33.9, C37.9, C38.0–C38.8, C39.0–C39.9, C42.0–C42.1, C42.3–C42.4, C48.0–C48.8, C51.0–C51.9, C52.9, C57.0–C57.9, C58.9, C60.0–C 60.9, C63.0–C 63.9, C68.0, C68.9, C69.0, C69.9, C74.0–C76.8, C80.9	All other sites

Priority of Codes

In the surgery of primary site codes, the following priorities hold:

- Codes 10–90 have priority over code 99.
- Codes 10–80 have priority over codes 90 and 99.
- Codes 10–79 have priority over codes 80, 90, and 99.

First Course of Treatment

Cancer-Directed Surgery at this Facility

Combined Items Length: 9
Surgical Approach: 1
Surgery of Primary Site at this Facility: 2
Surgical Margins: 1
Scope of Regional Lymph Node Surgery at This Facility: 1
Number of Regional Lymph Nodes Removed at This Facility: 2
Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s) at This Facility: 1
Reconstruction/Restoration: 1

Record only surgery of the primary site done at the reporting facility. See data items Surgical Approach; Surgery of Primary Site; Surgical Margins; Scope of Regional Lymph Node Surgery; Number of Regional Lymph Nodes Removed; Surgery of Other Regional Site(s), Distant site(s), or Distant Lymph Node(s); and Reconstruction/Restoration—First Course for coding instructions.

First Course of Treatment

Surgical Margins
(Residual Primary Tumor following Cancer-Directed Surgery)

Item Length: 1
Data Type: Numeric
Allowable Values: Site Specific
Required Data Set

This field describes the status of the surgical margins after resection of the primary tumor. Do not code margin status from regional lymph node surgery or secondary or metastatic site surgery.

Microscopic involvement cannot be seen by the naked eye. The pathology report usually documents microscopic involvement in the final diagnosis or the microscopic portion of the report.

Macroscopic involvement is gross tumor which is visible to the naked eye. It may be documented in the operative report or in the gross portion of the pathology report.

The code is hierarchical, if two codes describe the margin status, use the numerically higher code.

Example: The pathology report from a colon resection describes the proximal margin as grossly involved with tumor (5) and the distal margin as microscopically involved (code 2). Code macroscopic involvement (5).

There are differences in how software providers present the surgery codes. Some programs will allow one surgical event to be recorded. Other programs will allow the user to record multiple, consecutive surgical events.

If a single field is available for the data item Surgical Margins or if a summary treatment field is provided, use the following guidelines.

- If the patient has multiple cancer-directed surgeries of the primary site (at least two fields Surgery of Primary Site are coded in the range 10-89), then code the status of the surgical margins after the final or last surgery.

  Example: Patient has an excisional biopsy of a breast lesion. The pathology report describes an infiltrating ductal carcinoma. The margins are microscopically involved. A few weeks later, the patient has a modified radical mastectomy. The pathology report says all margins are free. Code the margin status after the mastectomy, all margins grossly and microscopically negative (0).

- If no cancer-directed surgery of the primary site was done (Surgery of Primary Site 00), then Surgical Margins must be 8.

If multiple fields are provided to record surgical margins for consecutive surgical events, use the following guidelines.

- Code the margin status for each individual surgical event.
- For each surgical event, if no primary site surgical procedure was done (Surgery of Primary Site 00), surgical margins must be 8 (no cancer-directed surgery of primary site).

First Course of Treatment

Scope of Regional Lymph Node Surgery

Item Length: 1
Data Type: Numeric
Allowable Values: Site Specific
Required Data Set

For the majority of sites, Scope of Regional Lymph Node Surgery defines the removal of regional lymph node(s). There is no minimum number of nodes that must be removed. If at least one regional lymph node was removed, the code for this field must be in the range of 1–5. If a regional lymph node was aspirated, code regional lymph node(s) removed, NOS (1).

For head and neck sites, this field describes neck dissections. Codes 2–5 indicate only that a neck dissection procedure was done, they do not imply that nodes were found during the pathologic examination of the surgical specimen. Code the neck dissection even if no nodes were found in the specimen.

The codes are hierarchical. If only one procedure can be recorded, code the procedure that is numerically higher.

Example: A patient with a head and neck primary has a lymph node biopsy (1) followed by a limited neck dissection (3). Code the limited neck dissection (3).

If a patient has a modified radical neck dissection, then record 4 (modified radical neck dissection) rather than the generic code neck dissection, NOS (2).

A list identifies the regional lymph nodes for each site in Appendix D. Any other nodes are distant, code in the data field Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s).

If no cancer-directed surgical procedure was performed, then code 0.

Number of Regional Lymph Nodes Removed

Item Length: 2
Data Type: Numeric
Allowable Values: Site Specific
Required Data Set

Record the number of regional lymph nodes identified in the pathology report during this surgical procedure only. Do not add numbers of nodes removed at different surgical events.

If no regional lymph nodes are identified in the pathology report, then code 00 even if the surgical procedure includes a lymph node dissection (i.e., modified radical mastectomy) or if the operative report documents removal of nodes.

Because this field is not cumulative and not affected by timing issues, it does not replace or duplicate the field Regional Lymph Nodes Removed. Do not copy the values from one field to the other.

Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)

Item Length: 1
Data Type: Numeric
Allowable Values: Site Specific
Required Data Set

Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s) describes the removal of tissue(s) or organ(s) other than the primary tumor or organ of origin. The tissue or organ is not removed in continuity with the primary tumor (not en bloc).

Example: A patient has an excisional biopsy of a hard palate lesion which is removed from the floor of the mouth and a resection of a metastatic lung nodule during the same surgical event. Code the resection of the lung nodule as 6 (distant site).

Code the removal of non-primary tissue which was removed because the surgeon suspected it was involved with malignancy even if the pathology is negative.

Do not code the incidental removal of tissue. Incidental is defined as tissue removed for reasons other than the malignancy. For example, during a colon resection, the surgeon noted that the patient had cholelithiasis and removed the gall bladder. Do not code removal of the gall bladder.

Reconstruction/Restoration–First Course

Item Length: 1
Data Type: Numeric
Allowable Values: Site Specific
Required Data Set

Reconstruction/Restoration–First Course is a surgical procedure that improves the shape and appearance or function of body structures that are missing, defective, damaged, or misshapen by cancer or cancer-directed therapies.

Reconstruction/Restoration–First Course is limited to procedures started during the first course of cancer-directed therapy. Some reconstructive/restorative procedures involve several surgical events. Code as Reconstruction/Restoration–First Course if the first event occurred during the first course of treatment.

Each site-specific surgery code scheme in Appendix D has either a list of reconstructive/restorative procedures or codes that define specific procedures. Code only those procedures listed under each site.

Reconstructive/restorative procedures may be performed after first course of therapy is complete. Code these procedures in the field Reconstruction/Restoration–Delayed.

First Course of Treatment

Reason for No Surgery

Item Length: 1
Data Type: Numeric
Allowable Values: 0-2, 6-9
Supplementary Data Set

Record the reason no cancer-directed surgery was done. Codes 1–2 or 6–9 are valid only when the field Cancer-Directed Surgery is 00.

Code

0 Cancer-directed surgery performed

1 Cancer-directed surgery not recommended

2 Contraindicated because of other conditions, autopsy-only cases

6 Reason unknown for no cancer-directed surgery

7 Patient or patient's guardian refused surgery

8 Surgery recommended, unknown if done

9 Unknown if cancer-directed surgery recommended or performed, death certificate only cases

First Course of Treatment

Reason for No Surgery **(Continued)**

Clarification of code definitions:

Code	Definition	Example
0	Cancer-directed surgery was performed. The field "Surgery is coded in the range 10–90.	
1–2 6–9	No cancer-directed surgery known to have been performed. The field Cancer-Directed Surgery must be 00.	
1	Cancer-directed surgery is not recommended for this stage of disease, histologic type, or site.	Small cell carcinoma of the lung; widely metastatic colon cancer; leukemia
2	Cases in which cancer-directed surgery would have been the treatment of choice, but could not be performed because of comorbid conditions. Cases in which surgery was recommended, but the patient expired before it could be performed. Autopsy-only cases (Class of Case 5).	Stage I adenocarcinoma of the lung. Patient has severe COPD. Cannot remove any part of the lung because pulmonary function is not adequate.
6	Cancer-directed surgery would have been the treatment of choice; surgery was not performed, but the reason is not given.	
7	Cancer-directed surgery was the treatment of choice and was recommended by the physician. The patient, a family member, or guardian refused surgical treatment.	
8	Cancer-directed surgery was recommended by a physician; no follow-up information available to confirm if surgery was performed.	
9	No cancer-directed surgery known to have been performed. No confirmation if surgery was recommended or performed (frequently non-analytic cases). Death certificate-only cases.	

Date Radiation Started

Item Length: 8
Data Type: Numeric
Required Data Set

Date Radiation Started is the month, day, and year (MMDDCCYY) first course of radiation therapy was started. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year.

Collecting dates for each treatment modality will allow sequencing of multiple treatments and evaluation of time intervals (from diagnosis to treatment and from treatment to recurrence).

Record the date on which radiation therapy was initiated.

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			

Example: Record December 15, 1996 as 12151996.

Code 00000000 when no radiation therapy is administered, or a case is identified only at autopsy.

Code 99999999 when it is unknown if any radiation therapy was administered, the date is unknown, or the case was identified only from death certificate information.

If the exact date radiation started is not available, then record an approximate date.

If information is limited to a description, use the following:

Descriptive Term Used	Date Code
“Spring”	April
“The middle of the year”	July
“The fall of the year”	October
“The winter of”	Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

First Course of Treatment

Radiation
(Radiation Therapy)

Item Length: 1
Data Type: Numeric
Allowable Values: 0-5, 9
Required Data Set

Record the type of radiation administered to the primary site or any metastatic site. Include all procedures that are a part of the first course of treatment, whether delivered at the reporting institution or at other institutions.

Code

0 None

1 Beam radiation

2 Radioactive implants

3 Radioisotopes

4 Combinations of beam radiation, with radioactive implants, or radioisotopes (combination of 1 with 2 and/or 3)

5 Radiation therapy, NOS (method or source not specified)

9 Unknown if radiation therapy recommended or administered; death certificate-only cases

Clarification of code definitions:

Code	Definition
0	No radiation therapy was administered.
1	X-ray, cobalt, linear accelerator, neutron beam, betatron, spray radiation, intraoperative radiation and stereotactic radiosurgery (gamma knife and proton beam).
2	Brachytherapy, interstitial implants, molds, seeds, needles, or intracavitary applicators of radioactive materials (cesium, radium, radon, and radioactive gold).
3	Internal use of radioactive isotopes (iodine-131, phosphorus-32, strontium 89 and 90). Can be administered orally, intracavitary, or by intravenous injection.
4	The patient was treated with a combination of beam radiation and at least one of the two methods described by codes 2 and 3.
5	Radiation was administered, but the method or source is not documented (radiation therapy, NOS).
9	No confirmation if radiation therapy was recommended or performed (frequently non-analytic cases); unknown if radiation therapy administered. Death certificate-only cases.

First Course of Treatment

Radiation at this Facility

Item Length: 1
Data Type: Numeric
Allowable Values: 0-5, 9
Supplementary Data Set

Code the type of radiation the patient received at the reporting facility. Record radiation administered to the primary site or any metastatic site as a part of the first course of treatment.

Do not record procedures done at other institutions. Data analysis of this item will provide marketing and referral information. It will also allow administrative evaluation of the oncology product line and aid program planning.

Code

0 None

1 Beam radiation

2 Radioactive implants

3 Radioisotopes

4 Combinations of beam radiation, with radioactive implants, or radioisotopes (combination of 1 with 2 and/or 3)

5 Radiation therapy, NOS (method or source not specified)

9 Unknown if radiation therapy administered

Clarification of code definitions:

Code	Definition
0	No radiation therapy was administered.
1	X-ray, cobalt, linear accelerator, neutron beam, betatron, spray radiation, intraoperative radiation and stereotactic radiosurgery (gamma knife and proton beam).
2	Brachytherapy, interstitial implants, molds, seeds, needles, or intracavitary applicators of radioactive materials (cesium, radium, radon, and radioactive gold).
3	Internal use of radioactive isotopes (iodine-131, phosphorus-32, strontium 89 and 90). Can be administered orally, intracavitary, or by intravenous injection.
4	The patient was treated with a combination of beam radiation and at least one of the two methods described by codes 2 and 3.
5	Radiation was administered, but the method or source is not documented (radiation therapy, NOS).
9	No confirmation if radiation therapy was recommended or performed (frequently non-analytic cases); unknown if radiation therapy administered.

Regional Dose: cGy

Item Length: 5
Data Type: Numeric
Optional Data Set
Right Justified

Regional Dose: cGy is used to code the dominant or most clinically significant dose delivered. This may be highly subjective and require assistance from the radiation oncologist for consistent coding. The International Council for Radiation Protection (ICRP) recommends recording doses at the axis point where applicable (opposed fields, four field box, wedged pairs, and so on). For maximum consistency in this field, the ICRP recommendations should be followed whenever possible. Where there is no clear axis point, record the dose as indicated in the summary in the chart.

Do not include boost doses.

This data item is used by radiation oncology departments to evaluate patterns of care and may be helpful in comparing the practices of different institutions.

Record the actual dose delivered.

Examples: A patient with stage III prostate carcinoma receives pelvic irradiation to 5,000 cGy followed by a prostate boost to 7,000 cGy. Record the regional dose as 5,000 cGy.

A patient with stage II breast carcinoma is treated with the breast intact. Tangent fields are utilized to bring the access dose of the breast to 5,000 cGy. The supraclavicular lymph nodes are treated to 4,500 cGy, calculated at a depth of 3 cm, and interstitial boost in the primary tumor bed delivers an additional 2,500 cGy to a small volume within the breast. The breast is the primary target. Record the regional dose as 5,000 cGy.

A patient with a left supraclavicular metastasis from a gastric carcinoma receives 6,000 cGy to the left supraclavicular region. The dose is calculated at a prescribed depth of 3 cm. A secondary calculation shows a D-Max dose of 6,450 cGy. Record the regional dose as 6,000 cGy.

Code 00000 if no radiation therapy was administered.

Code 99999 if radiation therapy was administered, but dose is unknown.

Number of Treatments to This Volume

Item Length: 2
Data Type: Numeric
Optional Data Set
Right Justified

Record the actual number of treatment sessions.

A treatment session may include several treatment portals, but they are delivered within a relatively confined interval of time, usually a few minutes, and should be counted as one session.

This item is used primarily to evaluate patterns of care and the appropriateness of treatment schedules.

Examples: A patient with stage IIIB bronchogenic carcinoma receives 25 treatments to the left hilum and mediastinum, given in 25 daily treatments over five weeks. A left hilar boost is then given in 10 additional treatments. Record 35 treatments.

A patient with breast carcinoma has treatment sessions in which treatment is delivered to the chest wall and separately to the ipsilateral supraclavicular region for a total of three treatment portals. Twenty-five treatment sessions are given. Record 25 total treatments to the volume.

A patient with advanced head and neck cancer is treated using "hyperfractionation." Three fields are delivered in each session, two sessions are given each day, six hours apart, with each session delivering a total dose of 150 cGy. Treatment is given for a total of 25 days. Record 50 treatments to the volume.

Code 00 if no radiation therapy was administered.

Code 99 if radiation therapy was administered, but the number of treatments is unknown.

Radiation Elapsed Treatment Time (Days)

Item Length: 3
Data Type: Numeric
Optional Data Set
Right Justified

Radiation Elapsed Treatment Time (Days) is the actual number of treatment days, including weekend days and intervals of rest.

Count the first day of treatment as day zero (0). If a patient receives only two treatments and they are given on successive days, then the elapsed treatment time would be one day.

Many radiation oncologists believe this is an important factor in tumor control and treatment morbidity. It is potentially useful in quality assurance for evaluating success of patient support programs designed to maintain continuity of treatment.

Example: A patient begins treatment on Monday, January 3rd, and completes treatment on Thursday, January 27th. The elapsed treatment time is 27 – 3 = 24 days. Record 24 days.

Code 000 if no radiation therapy was administered.

Code 999 if radiation therapy was administered, but the number of treatment days is unknown.

Radiation Treatment Volume

Item Length: 2
Data Type: Numeric
Allowable Values: 00-39, 98, 99
Optional Data Set

This field is intended primarily to provide a simple expression of the most common radiation volumes treated.

This item may be used as a quality assurance monitor to evaluate the overall pattern of care within a facility. It is potentially useful as a monitor of appropriateness and efficacy of treatment and in selecting patients for outcome reporting.

In many cases, radiation treatment volume will be most appropriately coded by the radiation oncologist.

Code

00 Consult only, no radiation therapy, not applicable
01 Eye/orbit
02 Pituitary
03 Brain (NOS)
04 Brain (limited)
05 Head and neck (NOS)
06 Head and neck (limited)
07 Glottis
08 Sinuses
09 Parotid
10 Chest/lung (NOS)
11 Lung (limited)
12 Esophagus
13 Stomach
14 Liver
15 Pancreas
16 Kidney
17 Abdomen (NOS)
18 Breast
19 Breast/lymph nodes
20 Chest wall
21 Chest wall/ lymph nodes
22 Mantle
23 Lower extended field
24 Spine

Radiation Treatment Volume **(Continued)**

Code

25 Skull
26 Ribs
27 Hip
28 Pelvic bones
29 Pelvis (NOS)
30 Skin
31 Soft tissue
32 Hemibody
33 Whole body
34 Bladder and pelvis
35 Prostate and pelvis
36 Uterus
37 Shoulder
38 Extremities
39 Inverted Y
98 Other volume
99 Unknown volume

Clarification of code definitions:

Code	Definition	Example
00	Patient did not receive radiation therapy.	
01	The radiation therapy target volume is limited to the eye and/or orbit.	Lymphoma of the orbit treated with 4-cm x 4-cm portals.
02	The target volume is restricted to the pituitary gland and all adjacent volumes are irradiated incidentally.	Pituitary adenomas receiving small opposed field or rotational treatment.
03	Treatment is directed at tumors lying within the substance of the brain.	The entire brain is treated for metastatic disease.
04	The treatment volume encompasses less than the total brain.	Limited field irradiation of an oligodendroglioma.

Radiation Treatment Volume **(Continued)**

Clarification of code definitions:

Code	Definition	Example
05	The treatment volume is directed at a primary tumor of the oropharyngeal complex, usually encompassing regional lymph nodes.	Carcinoma of the left tonsil treated with opposed lateral fields to the neck and an anterior supraclavicular field.
06	Limited volume treatment of a head and neck primary.	Interstitial implant utilized to treat a small carcinoma of the lateral tongue.
07	Treatment is limited to a volume in the immediate neighborhood of the vocal cords.	Small lateral fields utilized to treat a T1 or T2 glottic tumor.
08	The primary target is one or both of the maxillary sinuses or the ethmoidal frontal sinuses. In some cases, the adjacent lymph node regions may be irradiated.	
09	The primary target is one of the parotid glands. There may be secondary regional lymph node irradiation as well.	
10	Radiation treatment is directed to some combination of hilar mediastinal supraclavicular or peripheral lung structures.	
11	Radiation treatment is directed at just one region of the lung.	Small portal treatment is delivered to the right hilar region to stop hemoptysis.
12	The primary target is some portion of the esophagus. Regional lymph nodes may or may not be included in the treatment. Include tumors of the gastroesophageal junction.	
13	The primary malignancy is in the stomach. Radiation is directed to the stomach and possibly adjacent lymph nodes.	
14	The primary target is all or a portion of the liver, for either primary or metastatic disease.	
15	The primary tumor is in the pancreas. The treatment field encompasses the pancreas and possibly adjacent lymph node regions.	

Radiation Treatment Volume **(Continued)**

Clarification of code definitions:

Code	Definition	Example
16	The target is primary or metastatic disease in the kidney or the kidney bed after resection of a primary kidney tumor. Adjacent lymph node regions may be included in the field.	
17	Include all cases of treatment of abdominal contents that do not fit codes 12–16.	Irradiation for hypersplenism due to lymphoma.
18	The primary target is the intact breast and no attempt has been made to irradiate the regional lymph nodes.	
19	A deliberate attempt has been made to include regional lymph nodes in the treatment of an intact breast.	The radiation therapy record shows that tangent fields have been arranged in a manner that will encompass internal mammary lymph nodes in a patient with a medial primary.
20	The target includes soft-tissue structures of the chest wall (the patient is not being irradiated for rib metastases).	Following mastectomy, a patient has prophylactic chest wall irradiation to prevent local recurrence; a thoracotomy scar is irradiated because of known contamination with tumor.
21	Treatment encompasses the chest wall (after mastectomy) plus fields directed at regional lymph nodes.	
22	Use this code exclusively for patients with Hodgkin's or non-Hodgkin's lymphoma in which a large radiation field has been designed to encompass all the regional lymph nodes above the diaphragm, including cervical, supraclavicular, axillary, mediastinal, and hilar.	
23	The target zone includes lymph nodes below the diaphragm along the periaortic axis. It may include extension to one side of the pelvis. This coding includes the "hockey stick" field utilized to treat seminomas.	

Radiation Treatment Volume **(Continued)**

Clarification of code definitions:

Code	Definition	Example
24	The primary target relates to the bony structures of the spine, including the sacrum. Note that primary spinal chord malignancies would be coded 98.	An inverted "T" field is utilized to treat painful metastases in the lumbar vertebra and sacrum in a patient with prostate carcinoma.
25	Treatment is directed at the bony structures within the skull. Any brain irradiation is a secondary consequence.	Patient with myeloma receives total skull irradiation for numerous "punched out" lesions that are causing discomfort.
26	Treatment is directed toward metastatic disease in one or more ribs. Fields may be tangential or direct. If soft-tissue disease is present in the region, it is not the primary target of the treatment.	
27	This term is not used very precisely in some radiation therapy practices. It generally refers to treatment of the proximal femur for metastatic disease. In many cases, there may be acetabular disease as well.	
28	The target includes structures of the bony pelvis other than the hip and sacrum.	
29	Irradiation is directed at soft tissues within the pelvic region, and codes 34–36 do not apply.	
30	The primary malignancy originates in the skin and the skin is the primary target. Note that so-called skin metastases are usually subcutaneous and should be coded 31.	
31	All cases of primary or metastatic soft-tissue malignancies not fitting other categories.	
32	A single treatment volume encompasses all structures above the diaphragm (or all structures below the diaphragm). This is almost always administered for palliation of wide-spread bony metastases in patients with prostate or breast cancer.	

Radiation Treatment Volume **(Continued)**

Clarification of code definitions:

Code	Definition	Example
33	Entire body included in a single treatment.	Patient with chronic lymphocytic leukemia receives five treatments of 10 cGy each to reduce adenopathy to lymphocyte count.
34	The primary malignancy originated in the bladder, all or most of the pelvis is treated as part of the plan, with a boost to the bladder.	
35	The primary malignancy originated in the prostate, all or most of the pelvis is treated as part of the plan, usually with a boost to the prostate.	
36	Treatment is confined to the uterus. If the entire pelvis is included in a portion of the treatment, then code to 29.	Patient receives intracavitary therapy alone for a high-grade stage IA carcinoma of the endometrium.
37	Treatment is directed to the proximal humerus, lateral clavicle, or other components of the shoulder complex, usually for control of symptoms for metastases.	
38	Bony structures of the arms (excluding proximal humerus) or legs (excluding proximal femur).	The distal forearm is treated for a metastatic lesion involving the radius.
39	Treatment has been given to a field that encompasses the periaortic and bilateral inguinal or inguinal-femoral lymph nodes in a single portal.	Stage IA Hodgkin's disease presenting in an inguinal lymph node.
98	Include all categories that do not fit the above definitions.	Anterior neck is treated for a primary thyroid lymphoma.
99	Radiation has been administered, but the records available do not clearly define the volume.	

Location of Radiation Treatment

Item Length: 1
Data Type: Numeric
Allowable Values: 0-4, 8, 9
Optional Data Set

Record the location where radiation treatment was administered.

This field provides information useful for assessing the quality and outcome of radiation treatment by delivery site and monitoring the referral pattern for these services.

Code

0 No radiation treatment

1 All radiation treatment at this facility

2 Regional treatment at this facility, boost elsewhere

3 Boost radiation at this facility, regional elsewhere

4 All radiation treatment elsewhere

8 Other, NOS

9 Unknown

Clarification of code definitions:

Code	Definition	Example
0	No radiation treatment.	
1	The record shows that all radiation treatment was administered at this institution.	
2	Most of the patient's treatment was delivered at this institution. The patient was sent to another institution specifically for a boost treatment, where the boost volume is generally smaller than the regional volume.	Patient with carcinoma of the nasopharynx receives treatment to the entire head and neck region at this institution, but is sent to another institution for a high-dose-rate (HDR) intracavitary boost.

Location of Radiation Treatment **(Continued)**

Code	Definition	Example
3	Only the boost treatment is administered at this institution. Other treatment to the region was administered elsewhere.	The reporting institution has HDR treatments available. A patient with carcinoma of the nasopharynx is diagnosed at another institution and receives regional external beam radiation therapy there and then is referred to the reporting institution for intracavitary HDR treatment.
4	All radiation treatment was administered at another institution. The data in adjacent radiation treatment fields identify the treatment given elsewhere.	
8	The patient's treatment pattern does not fit the above categories.	Regional treatment is initiated at another institution and mid-way through treatment, the patient is transferred to the reporting institution for completion of therapy while he or she resides with a nearby relative.
9	Patient is known to have received radiation treatment, but the records do not define the location.	

Intent of Treatment (Radiation)

Item Length: 1
Data Type: Numeric
Allowable Values: 0-2, 4-6, 8,9
Optional Data Set

Code the intent of radiation treatment.

This item is useful in assessing the appropriateness of treatment and correlating outcome with original intent of the treatment. The choice in this data field is subjective.

The radiation oncologist managing the patient is the best person to provide this information.

Code

0 No radiation treatment

1 Curative (primary)

2 Curative (adjuvant)

4 Palliative (pain control)

5 Palliative (other, cosmetic)

6 Prophylactic (no symptoms, preventive)

8 Other, NOS

9 Unknown

Clarification of code definitions:

Code	Definition	Example
0	Patient did not receive radiation therapy as part of the first course of treatment.	
1	Radiation treatment, which is administered as part of the primary plan for control of the disease, is believed to be a major factor in the control of the disease. That is, recurrence would be very likely without the radiation therapy.	The breast is irradiated following local excision for nfiltrating ductal carcinoma; mediastinal and hilar structures are irradiated with curative intent in a patient with inoperable stage IIIA bronchogenic carcinoma.
2	Radiation treatment is administered as a supplement to some other therapy that is generally recognized as the primary modality for control of the disease. The radiation is intended to “improve the odds” of local/regional control.	Pelvic irradiation following anterior resection for carcinoma of the sigmoid colon, stage III.

Intent of Treatment (Radiation) **(Continued)**

Code	Definition	Example
4	Radiation treatment is directed to a site primarily for the purpose of pain control. Other benefits of the radiation are considered secondary contributions to the patient's quality of life.	Painful hip metastasis from prostate carcinoma with no evidence of impending hip fracture.
5	This classification encompasses most other non-curative applications of radiation treatment, in which pain is not a major factor.	A lymphoma patient with a large axillary mass that is painless, but interferes with movement and activ-ity, undergoes radiation therapy di-rected to reduce the size of the mass. HIV patient with Kaposi's sarcoma nodules on the face that are asymptom-atic, but cause distressing disfigurement.
6	Prophylactic radiation therapy is administered for the purpose of preventing the development of symptoms in a setting in which clinical evidence indicates that problems are likely to develop if treatment is not administered.	Patient with lung cancer has a pelvic X-ray with the incidental finding of a large, but painless, lytic lesion of the left hip, and radiation treatment is administered to stop the destruction that might lead to fracture. An as-ymptomatic supraclavicular mass is irradiated to prevent the develop-ment of a brachial plexus injury.
8	Record this value for those special circumstances not fitting any of the earlier categories.	
9	The patient received radiation treatment, but informa-tion on the record does not clearly indicate the pur-pose.	

Regional Treatment Modality

Item Length: 2
Data Type: Numeric
Allowable Values: 00-16, 98, 99
Optional Data Set

Regional Treatment Modality is intended to identify the dominant modality of therapy delivered to the primary volume of interest. In some cases, it may be appropriate to choose a code for its academic or economic interest, even though it may not reflect the majority of the patient's therapy. For example, a patient with carcinoma of the nasopharynx may receive original treatment using a linear accelerator and then have a boost with high-dose-rate (HDR) brachytherapy. In a department with a special interest in brachytherapy, the code 15 would be chosen.

This field can be useful in assessing resource utilization, planning for expansion, or monitoring quality. It should be used at the discretion of the radiation oncologist.

Code

00 No radiation therapy

01 Orthovoltage

02 Cobalt 60, cesium 137

03 X-Rays (2–-5 MV)

04 X-Rays (6–10 MV)

05 X-Rays (11–19 MV)

06 X-Rays (>19 MV)

07 X-Rays (mixed energies)

08 Electrons

09 X-Rays and electrons (mixed)

10 Neutrons (with or without X-Ray/electrons)

11 Megavoltage (NOS)

12 Protons

13 Stereotactic radiosurgery

14 Brachytherapy (standard)

15 Brachytherapy, high-dose-rate (HDR)

16 Intraoperative radiation therapy (IORT)

98 Other, NOS

99 Unknown

Regional Treatment Modality **(Continued)**

Clarification of code definitions:

Code	Definition	Example
00	Treatment not administered.	
01	External beam treatment administered using equipment with a maximum voltage of less than one (1) MV.	
02	External beam therapy using a machine containing either a cobalt 60 or cesium 137 source. Intracavitary use of these sources would be coded 14.	
03-06	All or most of the patient's treatment was delivered by external beam using an X-ray producing machine, such as a linear accelerator or Van de Graf accelerator. The breakdown here follows the rules used for CPT coding.	
07	All or most of the treatment was delivered by external beam X-ray, but more than one energy was utilized in the course of treatment.	
08	All of the treatment was delivered by electron beam.	
09	Treatment was administered with some combination of X-rays and electrons.	Patient with carcinoma of the parotid receives daily treatments of which 60% are delivered by 15-MV photons and 40% of the dose is delivered by 16-MeV electrons.
10	Any part of the patient's radiation treatment was delivered using neutron beam.	In an experimental program, a patient with stage III carcinoma of the prostate receives 4,500 cGy to the pelvis using 15-MV photons and then the prostate receives a 600-cGy boost with neutrons.
11	The patient is known to have received external beam therapy, but the specific energies are unknown.	A patient with a head and neck cancer is referred from another institution for an HDR brachytherapy boost. Detailed treatment records from the other institution are not available.

Regional Treatment Modality **(Continued)**

Code	Definition	Example
12	Any portion of the patient's treatment was delivered by proton therapy.	A patient with prostate carcinoma receives pelvic irradiation at his home institution and is then referred to a major medical center for experimental proton therapy boost.
13	Any portion of the patient's treatment has included stereotactic radiosurgery.	
14	Use this to code all cases of interstitial or intracavitary therapy with radioisotopes.	Patient receives external pelvic treatment to 4,500 cGy for cervical carcinoma then receives two Fletcher intracavitary implants. A patient treated with breast conservation has an interstitial boost at the time of the excisional biopsy. The implant uses Ir-192 and is left in place for three days.
15	The patient receives primary or boost therapy using HDR brachytherapy equipment. Typically, the treatment application takes just a few minutes and the patient is rarely, if ever, admitted to the hospital.	
16	Part or all of the treatment was administered using external beam (X-ray) equipment in an operating room environment.	Patient with a suspected carcinoma of the pancreas has exploratory surgery in the radiation therapy department, and during the operation, external beam radiation is administered to the tumor.
98	Code all treatments that do not fit one of the above categories.	
99	It is known that the patient received radiation treatment, but the records do not provide enough information to code the modality.	

First Course of Treatment

Radiation Therapy to CNS

(Radiation Therapy to the Central Nervous System)

Item Length: 1
Data Type: Numeric
Allowable Values: 0-1, 7-9
Optional Data Set

These data are being kept for historical purposes. Do not code for cases diagnosed as of January 1, 1996. Cases diagnosed on or after January 1, 1996, should be coded in the field Radiation.

Radiation Treatment to the Central Nervous System (CNS) codes 0–8 are valid only for patients with lung or leukemia primaries. Code 9 (not applicable) for all other cases.

Code

0 No radiation therapy to the brain or central nervous system

1 Radiation therapy

7 Patient or patient's guardian refused radiation therapy

8 Radiation therapy recommended, unknown if administered

9 Unknown

Clarification of code definitions:

Code	Definition
0	Lung or leukemia primary, no radiation treatment to CNS. Autopsy only (lung or leukemia primary).
1	Lung or leukemia primary, radiation was administered to the brain or CNS. (This is coded if radiation is prophylactic or if there are CNS metastases present. The code states only that radiation was administered. It does not confirm the absence or presence of CNS metastases.)
7	Lung or leukemia primary, radiation to CNS was recommended, but the patient, the patient's family, or guardian refused the treatment.
8	Lung or leukemia primary, radiation treatment to CNS was recommended by a physician or patient was referred for a radiation consult with the intent of delivering radiation to CNS. Follow up does not confirm that treatment was received.
9	All other sites and histologic types (NOT lung or leukemia). Death certificate only (lung and leukemia cases).

Radiation/Surgery Sequence
(Radiation Therapy Sequence with Surgery)

Item Length: 1
Data Type: Numeric
Acceptable Values: 0, 2-6, 9
Optional Data Set

Radiation treatment sequence with surgery defines the order in which radiation therapy and cancer-directed surgery were delivered during first course of treatment. Code in the range of 2–6 **only** if the patient had both cancer-directed surgery **and** radiation therapy as first course of treatment. Surgery is limited to cancer-directed only. Non cancer-directed surgery (biopsy, bypass, exploratory) does not qualify.

For patients who had both surgery and radiation, code the sequence of events.

Code

0 No radiation therapy and/or cancer-directed surgery

2 Radiation therapy before surgery

3 Radiation therapy after surgery

4 Radiation therapy both before and after surgery

5 Intraoperative radiation therapy

6 Intraoperative radiation therapy with other radiation therapy administered before or after surgery

9 Sequence unknown, but both surgery and radiation therapy were administered

First Course of Treatment

Radiation Treatment Completion Status

Item Length: 1
Data Type: Numeric
Optional Data Set
Allowable Values: 0-9

Radiation Treatment Completion Status is useful in evaluating treatment outcomes and the appropriateness of the initial decision to treat.

This field indicates whether the patient's radiation therapy was completed as outlined in the initial treatment plan. This information is generally available only in the radiation treatment chart.

Code

0 No radiation treatment

1 Treatment completed

2 Radiation not complete, patient health

3 Radiation not complete, patient expired

4 Radiation not complete, patient choice

5 Radiation not complete, family choice

6 Radiation not complete, complications

7 Radiation not complete, cytopenia

8 Radiation not complete, other reason

9 Radiation not complete, reason unknown

Clarification of code definitions:

Code	Definition	Example
0	Patient did not receive radiation treatment.	
1	Radiation therapy was completed to the point outlined in the original treatment prescription.	
2	Treatment was discontinued because of concurrent medical problems that were not related to the radiation treatment.	Patient receiving primary treatment for bronchogenic carcinoma has a severe myocardial infarction. The patient is judged to have a very poor prognosis because of the heart disease, and the radiation treatment is discontinued.
3	The patient expired while receiving therapy, but before completing treatment.	

Radiation Treatment Completion Status **(Continued)**

Code	Definition	Example
4	The patient elected to discontinue treatment.	An alcoholic patient receiving treatment for a tonsillar carcinoma develops severe oral mucositis. The patient is last seen in a local tavern, and does not return for therapy.
5	Treatment is discontinued at the request of one or more family members. The patient is unable to participate in this decision-making process.	
6	Treatment is discontinued because of the unplanned effects of acute radiation treatment complications.	An elderly patient with rheumatoid arthritis had been receiving low-dose methotrexate for control of joint symptoms before pelvic treatment was initiated for rectal carcinoma. At 3,000 cGy, the patient develops severe proctitis and bleeding, and treatment is stopped.
7	Treatment is discontinued because of low peripheral blood counts. This classification should be reserved for those circumstances in which the cytopenia is considered directly due the radiation therapy and not some other cause, such as concurrent chemotherapy.	The patient is scheduled to have sequential hemibody irradiation. The second phase of treatment is never administered because the patient develops cytopenia after upper hemibody irradiation and the blood counts never return to normal.
8	Use this classification when a reason for discontinuance of treatment is known, but it does not fit the above categories.	
9	Patient did not complete the planned treatment and the reason is not specified on the record.	

First Course of Treatment

Radiation Therapy Local Control Status
(Irradiated Volume)

Item Length: 1
Data Type: Numeric
Optional Data Set
Allowable Values: 0-4, 8, 9

Radiation Therapy Local Control Status records the radiation treatment results in terms of disease control within the irradiated volume. The data may be used in quality assurance studies to assess the effectiveness of treatment. This is a dynamic data item. To be clinically useful, these data must be evaluated at each follow up.

Code

0 No radiation treatment

1 Tumor control status not evaluable

2 Tumor/symptoms controlled

3 Tumor/symptoms have returned

4 Tumor/symptoms never adequately controlled

8 Other, NOS

9 Unknown

Clarification of code definitions:

Code	Definition	Example
0	Patient did not receive radiation treatment.	
1	A volume has been treated, but there are no objective criteria for assessing tumor control.	An asymptomatic patient with known carcinoma of the pancreas receives pancreatic irradiation. There are no follow-up CT studies on the record. The patient never becomes symptomatic and dies of heart disease.
2	Available objective and subjective evidence indicates that there is no sign of active disease in the irradiated volume.	Irradiation is given to the breast following local excision. At the time of last follow up, there was no evidence of local recurrence. A patient with stage III carcinoma of the prostate receives definitive treatment, and at the last follow up, the PSA is normal and the prostate is palpably normal. The patient with stage III prostate carcinoma is treated definitively, the gland returns to normal, and PSA returns to normal. The gland remains normal at last follow up, but the PSA is 20–local control appears to have been maintained. The PSA may be a reflection of metastatic disease.

Radiation Therapy Local Control Status **(Continued)**

Code	Definition	Example
3	Initially there is evidence of local tumor control, but at last follow up the symptoms had recurred.	Patient with stage III prostate carcinoma received definitive irradiation, the PSA dropped into the normal range, and the prostate became palpably normal. Now the PSA remains normal, but a new nodule is palpable in the prostate.
4	There was measurable disease within the treatment volume that never achieved a complete response after irradiation.	Patient with stage III prostate carcinoma presented with elevated PSA. After irradiation, the gland remains abnormal to palpation and the PSA never returned to the normal range.
8	Use this code for any patient that does not fit one of the above categories; this code should rarely be used.	
9	The local tumor control status remains unknown.	

First Course of Treatment

Reason for No Radiation

Item Length: 1
Data Type: Numeric
Allowable Values: 0-2, 6-9
Supplementary Data Set

Record the reason the patient did not receive radiation treatment.

Code

0 Radiation treatment performed

1 Radiation treatment not recommended

2 Radiation contraindicated because of other conditions; autopsy only cases

6 Reason unknown for no radiation therapy

7 Patient or patient's guardian refused radiation

8 Radiation treatment recommended, unknown if administered

9 Unknown if radiation recommended or performed; death certificate-only cases

Clarification of code definitions:

Code	Definition	Example
0	Radiation therapy was performed as part of the first course of treatment.	
1	Radiation therapy was considered, but not recommended as appropriate for this stage of disease, for this histologic type, or for this site.	Stage I colon carcinoma after wide local resection with clear margins.
2	Cases in which radiation therapy would have been recommended as part of the treatment plan, but could not be performed because of comorbid conditions. Cases in which radiation therapy was recommended, but the patient expired before radiation was given. Autopsy only cases (class 5)	Stage I adverse infiltrating ductal carcinoma of the breast, completely locally excised in a patient with severe and poorly compensated heart disease who is not expected to live more than a year.
6	Radiation therapy was part of the treatment plan, but it was not done and the reason is not given.	Breast conservation surgery performed in a young, healthy woman. Radiation therapy is not given and the records do not state why.

Reason for No Radiation **(Continued)**

Code	Definition	Example
7	Radiation therapy was the treatment of choice and was recommended by the physician. The patient, a family member, or guardian refused radiation treatment.	
8	Radiation therapy was recommended. There is no information on whether the patient received radiation.	
9	Available medical records do not state whether radiation therapy was considered, consultation performed, treatment recommended, or treatment performed. Death certificate-only cases.	

First Course of Treatment

Date Chemotherapy Started

Item Length: 8
Data Type: Numeric
Required Data Set

Record the month, day, and year (MMDDCCYY) first course of chemotherapy was started. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year.

Collecting dates for each treatment modality allows sequencing of multiple treatments and aids evaluation of time intervals (from diagnosis to treatment and from treatment to recurrence).

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			

Example: Record December 15, 1996 as 12151996.

Code 00000000 when no chemotherapy is administered and for cases diagnosed at autopsy.

Code 99999999 when it is unknown if any chemotherapy was administered, the date is unknown, or the case was identified from death certificate information.

If the exact date chemotherapy started is not available, then record an approximate date.

If information is limited to a description, then use the following:

Descriptive Term Used	Date Code
"Spring"	April
"The middle of the year"	July
"The fall of the year"	October
"The winter of"	Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

Chemotherapy

Item Length: 1
Data Type: Numeric
Allowable Values: 0-3, 9
Required Data Set

Record the type of chemotherapy administered as first course of treatment at your institution and at all other institutions. Chemotherapy consists of a group of anticancer drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis.

Code

0 None

1 Chemotherapy, NOS

2 Chemotherapy, single agent

3 Chemotherapy, multiple agents (combination regimen)

9 Unknown if chemotherapy recommended or administered; death certificate only cases

Chemotherapeutic agents may be administered by intravenous infusion or given orally.

Other methods of administration include:

Intrathecal	Administered directly into the cerebrospinal fluid through a lumbar puncture needle into an implanted access device (Ommaya reservoir).
Pleural/pericardial	Injected directly into pleural or pericardial space to control malignant effusions.
Intraperitoneal	Injected into the peritoneal cavity.
Hepatic artery	Injected into a catheter inserted into the artery that supplies blood to the liver.

Chemotherapy agents are administered in treatment cycles, either singly or in a combination regimen of two or more chemotherapy drugs. The interval of a treatment cycle varies and chemotherapy may be administered for several weeks or several years.

Refer to the *Self-Instructional Manual for Tumor Registrars: Book 8—Antineoplastic Drugs*, Third Edition, for drug categories.

First Course of Treatment

Chemotherapy **(Continued)**

Clarification of terms:

Term	Definitions
Adjuvant chemotherapy	Chemotherapy is given after other methods have destroyed the clinically detectable cancer cells. Chemotherapy is given to destroy micrometastases (undetectable cancer cells). The intent is to prevent or delay a recurrence. *Example:* The patient has breast cancer with positive nodes. The patient is clinically free of disease after a modified radical mastectomy. The patient is treated with adjuvant chemotherapy to prevent or delay disease recurrence.
Multimodality therapy Combined modality therapy Concurrent therapy	Chemotherapy given before, during, or after other treatment modalities (surgery, radiation) as a part of the treatment plan.
Neo-adjuvant therapy	Given prior to surgical resection or radiation therapy to reduce the bulk of a locally advanced primary cancer. *Example*: A patient with locally advanced breast cancer receives chemotherapy to reduce tumor size. Chemotherapy is followed by a modified radical mastectomy.

Chemotherapy **(Continued)**

Chemotherapy group classifications:

Group	Subgroup(s)	Examples
Alkylating agents	Nitrogen mustard	Mechlorethamine (Mustargen), phenylalanine mustard (Melphalan), chlorambucil (Leukeran), cyclophosphamide (Cytoxan)
	Ethylenimine derivatives	Triethylene-thiophosphoramide (Thio-TEPA)
	Alkyl sulfonates	Busulfan (Myleran)
	Nitrosoureas	Carmustine (Lomustine)
	Triazines	DTIC (Dacarbazine)
Antimetabolites	Folic acid analogues	Methotrexate (Amethopterin, MTX)
	Pyrimidine analogues	5-fluorouracil (5-FU)
	Purine analogues	6-mercaptopurine (6-MP)
Natural products	Anti-tumor	Dactinomycin (Actinomycin D), doxorubicin (Adriamycin), daunorubicin (Daunomycin), bleomycin (Blenoxane), mitomycin C (Mutamycin)
	Plant alkaloids	Vinblastine (Velban, VBL), vincristine (Oncovin, VCR)
	Enzymes	L-asparaginase (Elspar)
Miscellaneous		Cis-diammine dichloroplatinum II (Cisplatin), hydroxyurea (Hydrea), procarbazine (Matulane)

If the patient has an adverse reaction, the physician may change one of the drugs in a combination regimen. If the replacement drug belongs to the same **group** as the original drug, there is no change in the regimen. If the replacement drug is in a different **group** than the original drug, code the new regimen as subsequent therapy.

Example: The physician documents a multimodality treatment plan that includes a combination regimen of chemotherapy. Velban is one of the drugs in the chemotherapy regimen. After two cycles of chemotherapy, the physician says the Velban will be replaced with Oncovin, and the chemotherapy will continue as planned. This is a continuation of the planned first course of therapy.

Refer to the *Self-Instructional Manual for Tumor Registrars: Book 8—Antineoplastic Drugs*, Third Edition, for drug categories.

First Course of Treatment

Chemotherapy at This Facility

Item Length: 1
Data Type: Numeric
Allowable Values: 0-3, 9
Supplementary Data Set

Record the type of chemotherapy administered at the reporting facility as first course of treatment. Chemotherapy consists of a group of anticancer drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis. See data item Chemotherapy for a detailed description of chemotherapeutic terms and agents.

Record only chemotherapy administered at or by the reporting facility. Do not record chemotherapy delivered by other institutions. Data analysis of this item will provide marketing and referral information. It will also allow administrative evaluation of the oncology product line and aid program planning.

Code

0 None

1 Chemotherapy, NOS

2 Chemotherapy, single agent

3 Chemotherapy, multiple agents (combination regimen)

9 Unknown if chemotherapy administered

Chemotherapy Field #1

Item Length:
Data Type:
Optional Data Set

In development.

Chemotherapy Field #2

Item Length:
Data Type:
Optional Data Set

In development.

Chemotherapy Field #3

Item Length:
Data Type:
Optional Data Set

In development.

Chemotherapy Field #4

Item Length:
Data Type:
Optional Data Set

In development.

Reason for No Chemotherapy

Item Length: 1
Data Type: Numeric
Allowable Values: 0-2, 6-9
Supplementary Data Set

Record the reason the patient did not receive chemotherapy. Reason for No Chemotherapy is useful in survival analysis. It is a quality assurance monitor of appropriateness of treatment.

Code

0 Chemotherapy administered

1 Chemotherapy not recommended

2 Chemotherapy contraindicated because of other conditions; autopsy only cases

6 Reason unknown for no chemotherapy

7 Patient or patient's guardian refused chemotherapy

8 Chemotherapy recommended, unknown if administered

9 Unknown if chemotherapy recommended or administered; death certificate only cases

Code	Definition
0	Chemotherapy was administered. The field Chemotherapy is coded in the range 1–3.
1-9	No chemotherapy. The field Chemotherapy must be 0 or 9.
1	Chemotherapy is not the method recommended for this stage of disease, this histologic type, or this site.
2	Cases in which chemotherapy would have been the treatment of choice, but could not be performed because of comorbid conditions. Cases in which chemotherapy was recommended, but patient expired before the treatment was started. Autopsy only cases (Class of Case 5).
6	Chemotherapy would have been the treatment of choice, but it was not administered; the reason is not given.
7	Chemotherapy was the treatment of choice and was recommended by the physician. The patient, a family member, or guardian refused chemotherapy.
8	Chemotherapy was recommended by a physician; no follow-up information is available to confirm if chemotherapy was administered.
9	No confirmation if chemotherapy was recommended or administered (frequently nonanalytic cases) Death certificate-only cases.

Date Hormone Therapy Started

Item Length: 8
Data Type: Numeric
Required Data Set

Record the month, day, and year (MMDDCCYY) first course of hormone therapy was started. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year.

Collecting dates for each treatment modality will allow sequencing of multiple therapies and aid evaluation of time intervals (from diagnosis to treatment and from treatment to recurrence).

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			

Example: Record December 15, 1996 as 12151996.

Code 00000000 when no hormone treatment is administered and for cases diagnosed at autopsy.

Code 99999999 when it is unknown if any hormone treatment was administered, the date is unknown, or the case was identified from death certificate information.

If the exact date hormone treatment started is not available, then record an approximate date.

If information is limited to a description, then use the following:

Descriptive Term Used	Date Code
"Spring"	April
"The middle of the year"	July
"The fall of the year"	October
"The winter of"	Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

First Course of Treatment

Hormone Therapy
(Hormone/Steroid [Endocrine] Therapy)

Item Length: 1
Data Type: Numeric
Allowable Values: 0-3, 9
Required Data Set

Record the type of hormone therapy the patient received as a part of first course of treatment at your institution and all other institutions.

Code

0 None

1 Hormone (including NOS and antihormones)

2 Endocrine surgery and/or endocrine radiation therapy (if cancer is of another site)

3 Combination of 1 and 2

9 Unknown if hormonal therapy recommended or administered; death certificate only cases

Hormones can be used to alter the growth of cancer. Some tissues, such as prostate or breast, depend on hormones to develop. When a malignancy arises in these tissues, it is usually hormone responsive. Other primaries and histologic types may be hormone responsive, such as melanoma and hypernephroma. Hormonal therapy may effect a long-term control of the cancer growth. It is not usually used to "cure" the cancer.

Record prednisone as hormonal therapy when administered in combination with chemotherapy, such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone) or COPP (cyclophosphamide, vincristine, procarbazine, prednisone).

Exception: When prednisone is administered for other reasons, do not code as hormone therapy.

Examples: A patient has advanced lung cancer with multiple metastases to the brain. The physician orders decadron to reduce the edema in the brain and relieve the neurological symptoms. Decadron is not coded as hormone therapy.

A patient with advanced disease is given prednisone to stimulate the appetite and improve nutritional status. Do not code the prednisone as hormone therapy.

Tumor involvement or cancer-directed treatment may destroy hormone-producing tissue. Hormone replacement therapy will be given if the hormone is necessary to maintain normal metabolism and body function. Do not code the replacement therapy as a cancer-directed hormone treatment.

Example: Patients with breast cancer may be treated with aminoglutethimide (Cytadren, Elipten), which suppresses the production of glucocorticoids and mineralocorticoids. These patients must take glucocorticoid (hydrocortisone) and may also need a mineralocorticoid (Florinef) as a replacement therapy.

Exception: Thyroid hormone replacement inhibits the pituitary production of thyroid-stimulating hormone (TSH). Because TSH could stimulate tumor growth, the thyroid hormone replacement is also a cancer-directed treatment.

Hormone Therapy **(Continued)**

Irradiation and/or surgery must be bilateral to qualify as endocrine surgery. If only one gland is intact, surgery and/or radiation to that remaining gland qualifies as endocrine surgery. Endocrine surgery and radiation are used for prostate cancer.

Refer to *Self-Instructional Manual for Tumor Registrars: Book 8—Antineoplastic Drugs*, Third Edition, for drug categories.

Hormone Therapy at This Facility

Item Length: 1
Data Type: Numeric
Allowable Values: 0-3, 9
Supplementary Data Set

Record the type of hormone therapy administered at the reporting facility as a part of first course of treatment. See data item Hormone Therapy for detailed description.

Record only hormone therapy received at the reporting facility. Do not record therapy administered at other institutions. Data analysis of this item will provide marketing and referral information. It will also allow administrative evaluation of the oncology product line and aid program planning.

Code

0 None

1 Hormone (including NOS and antihormones)

2 Endocrine surgery and/or endocrine radiation therapy (if cancer is of another site)

3 Combination of 1 and 2

9 Unknown if hormonal therapy recommended or administered; death certificate only cases

Irradiation and/or surgery must be bilateral to qualify as endocrine surgery. If only one gland is intact, surgery and/or radiation to that remaining gland qualifies as endocrine surgery. Endocrine surgery and radiation are used for prostate cancer.

Refer to *Self-Instructional Manual for Tumor Registrars: Book 8—Antineoplastic Drugs*, Third Edition, for drug categories.

First Course of Treatment

Reason for No Hormone Therapy

Item Length: 1
Data Type: Numeric
Allowable Values: 0-2, 6-9
Supplementary Data Set

Code the reason the patient did not receive hormone therapy.

Code

0 Hormone therapy administered

1 Hormone therapy not recommended

2 Hormone therapy contraindicated because of other conditions; autopsy only cases

6 Reason unknown for no hormone therapy

7 Patient or patient's guardian refused hormone therapy

8 Hormone therapy recommended, unknown if administered

9 Unknown if hormone therapy recommended or administered; death certificate only cases

Clarification of code definitions:

Code	Definition
0	Hormone therapy was given. The field Hormone Therapy is coded in the range 1–3.
1–9	No hormone therapy given. The field Hormone Therapy must be 0 or 9.
1	Hormone therapy is not the method recommended for this stage of disease, this histologic type, or this site.
2	Cases in which hormone therapy would have been the treatment of choice, but could not be administered because of comorbid conditions. Cases in which hormone therapy was recommended, but the patient expired before therapy was administered. Autopsy-only cases (Class of Case 5).
6	Hormone therapy would have been the treatment of choice, but was not administered; the reason is not given.
7	Hormone therapy was the treatment of choice and was recommended by the physician. The patient, a family member, or guardian refused hormone therapy.
8	Hormone therapy was recommended, but no information is available about whether the patient received hormones.
9	No confirmation if hormone therapy was recommended or administered (frequently nonanalytic cases). Death certificate-only cases.

Date Immunotherapy Started

Item Length: 8
Data Type: Numeric
Required Data Set

Record the month, day, and year (MMDDCCYY) first course of immunotherapy was started. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year.

Collecting dates for each treatment modality allows sequencing of multiple treatments and aids evaluation of time intervals (from diagnosis to treatment and from treatment to recurrence).

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			

Example: Record December 15, 1996 as 12151996.

Code 00000000 when no immunotherapy is administered and for cases diagnosed at autopsy.

Code 99999999 when it is unknown if any immunotherapy was administered, the date is unknown, or the case was identified from death certificate information.

If the exact date immunotherapy started is not available, then record an approximate date.

If information is limited to a description, then use the following:

Descriptive Term Used	Date Code
"Spring"	April
"The middle of the year"	July
"The fall of the year"	October
"The winter of"	Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

First Course of Treatment

Immunotherapy
(Biological Response Modifier Therapy)

Item Length: 1
Data Type: Numeric
Allowable Values: 0-6, 7-9
Required Data Set

Record the immunotherapy (biological response modifier) the patient received as a part of first course of treatment at the reporting institution and all other institutions. Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to the tumor cells.

Code

0 None

1 Biological response modifier

2 Bone marrow transplant—autologous

3 Bone marrow transplant—allogeneic

4 Bone marrow transplant, NOS

5 Stem cell transplant

6 Combination of 1 and any 2, 3, 4, or 5

7 Patient or patient's guardian refused

8 Biological response modifier therapy recommended, unknown if administered

9 Unknown if biological response modifier therapy recommended or administered

Immunotherapy includes:

- BCG vaccine
- C-Parvum
- Interferon
- Levamisole
- MVE-2
- Pyran copolymer
- Thymosin
- Vaccine therapy
- Virus therapy

Refer to *Self-Instructional Manual for Tumor Registrars: Book 8—Antineoplastic Drugs*, Third Edition, for drug categories.

First Course of Treatment

Immunotherapy at This Facility

Item Length: 1
Data Type: Numeric
Allowable Values: 0-6, 7-9
Supplementary Data Set

Record the immunotherapy (biological response modifier) the patient received at the reporting facility as a part of first course of treatment. Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to the tumor cells.

Record only immunotherapy received at the reporting facility. Do not record procedures done at other institutions. Data analysis of this item will provide marketing and referral information. It will also allow administrative evaluation of the oncology product line and aid program planning.

Code

0 None

1 Biological response modifier

2 Bone marrow transplant—autologous

3 Bone marrow transplant—allogeneic

4 Bone marrow transplant, NOS

5 Stem cell transplant

6 Combination of 1 and any 2, 3, 4, or 5

7 Patient or patient's guardian refused

8 Biological response modifier therapy recommended, unknown if administered

9 Unknown if biological response modifier therapy recommended or administered

Immunotherapy includes:

- BCG vaccine
- C-Parvum
- Interferon
- Levamisole
- MVE-2
- Pyran copolymer
- Thymosin
- Vaccine therapy
- Virus therapy

Refer to *Self-Instructional Manual for Tumor Registrars: Book 8—Antineoplastic Drugs*, Third Edition, for drug categories.

Date Other Treatment Started

Item Length: 8
Data Type: Numeric
Required Data Set

Record the month, day, and year (MMDDCCYY) first course of other treatment was started. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year.

Collecting dates for each treatment modality allows sequencing of multiple treatments and aids evaluation of time intervals (from diagnosis to treatment and from treatment to recurrence).

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			

Example: Record December 15, 1996 as 12151996.

Code 00000000 when no other treatment is administered and for cases diagnosed at autopsy.

Code 99999999 when it is unknown if any other treatment was administered, the date is unknown, or the case was identified from death certificate information.

If the exact date other treatment started is not available, then record an approximate date.

If information is limited to a description, then use the following:

Descriptive Term Used	Date Code
"Spring"	April
"The middle of the year"	July
"The fall of the year"	October
"The winter of"	Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

First Course of Treatment

Other Treatment
(Other Cancer-Directed Therapy)

Item Length: 1
Data Type: Numeric
Allowable Values: 0-3, 6-9
Required Data Set

Record other cancer-directed therapy received by the patient as part of the first course of treatment at the reporting institution and all other institutions.

Other Treatment includes therapies designed to modify or control the cancer cells that are not defined in the Surgery, Radiation, Chemotherapy, or Hormone Therapy fields.

Code

0 No other cancer-directed therapy, except as coded elsewhere

1 Other cancer-directed therapy

2 Other experimental cancer-directed therapy (not included elsewhere)

3 Double-blind clinical trial, code not yet broken

6 Unproven therapy (including laetrile, krebiozen, etc.)

7 Patient or patient's guardian refused therapy which would have been coded 1-3 above

8 Other cancer-directed therapy recommended, unknown if administered

9 Unknown if other cancer-directed therapy administered

Clarification of code definitions:

Code	Definition
0	All cancer-directed therapy was coded in other treatment fields. Patient received no cancer-directed therapy.
1	Cancer-directed therapy that cannot be appropriately assigned to other specific treatment codes. *Examples:* hyperbaric oxygen (as adjunct to cancer-directed treatment) or hyperthermia
2	This code is not defined. It may be used for institution-based clinical trials.
3	Patient is involved in a double-blind clinical trial. Code the treatment actually administered when the double-blind clinical trial code is broken.
6	Treatments given by nonmedical personnel.
7	The physician recommended cancer-directed therapy that could not be appropriately assigned to other specific treatment codes. The patient or the patient's family refused treatment.
8	The physician recommended cancer-directed therapy that could not be appropriately assigned to other specific treatment codes. No follow-up information is available to confirm whether the patient received the therapy.
9	There is reason to believe that other cancer-directed therapy was recommended or given, but there is no information to confirm the recommendation or administration of treatment.

Other Treatment **(Continued)**

Do not code ancillary drugs in this field. There is no coding scheme for ancillary drugs.

Examples: Ancillary drugs:

Allopurinol

G-CSF (growth stimulating factors)

Epogen

Nupogen

Note: This is a partial list. See the *Self-Instructional Manual for Tumor Registrars: Book 8—Antineoplastic Drugs*, Third Edition, for a more complete listing.

Other Treatment at This Facility

Item Length: 1
Data Type: Numeric
Allowable Values: 0-3, 6, 8, 9
Supplementary Data Set

Record other cancer-directed therapy received by the patient at the reporting facility as part of the first course of treatment.

Record only other cancer-directed treatment received at the reporting facility. Do not record procedures done at other institutions. Data analysis of this item will provide marketing and referral information. It will also allow administrative evaluation of the oncology product line and aid program planning.

Code

0 No other cancer-directed therapy, except as coded elsewhere

1 Other cancer-directed therapy

2 Other experimental cancer-directed therapy (not included elsewhere)

3 Double-blind clinical trial, code not yet broken

6 Unproven therapy (including laetrile, krebiozen, etc.)

7 Patient or guardian refused therapy, which would have been coded 1–3 above

8 Other cancer-directed therapy recommended, unknown if administered

9 Unknown if other cancer-directed therapy administered

Clarification of code definitions:

Code	Definition
0	All cancer-directed therapy was coded in other treatment fields. Patient received no cancer-directed treatment.
1	Cancer-directed therapy that cannot be appropriately assigned to other specific treatment codes. *Examples*: hyperbaric oxygen (as adjunct to cancer-directed treatment) or hyperthermia.
2	This code is not defined. It may be used for institution-based clinical trials.
3	Patient is involved in a double-blind clinical trial. Code the treatment actually administered when the double-blind clinical trial code is broken.
6	Treatments given by nonmedical personnel.
7	The physician recommended cancer-directed therapy that could not be appropriately assigned to other specific treatment codes. The patient or the patients' family refused treatment.
8	The physician recommended cancer-directed therapy that could not be appropriately assigned to other specific treatment codes. No follow-up information is available to confirm whether the patient received the therapy.
9	There is reason to believe that other cancer-directed therapy was recommended or given, but there is no information to confirm the recommendation or administration of treatment.

Other Treatment at this Facility **(Continued)**

Do not code ancillary drugs in this field. There is no coding scheme for ancillary drugs.

Examples: Ancillary drugs:

Allopurinol

G-CSF (growth stimulating factors)

Epogen

Nupogen

Note: This is a partial list. See the *Self-Instructional Manual for Tumor Registrars: Book 8—Antineoplastic Drugs*, Third Edition, for a more complete listing.

First Course of Treatment

Protocol Eligibility Status

Item Length: 1
Data Type: Numeric
Allowable Values: 0-4, 6-9
Supplementary Data Set

Record the eligibility status of the patient to be entered into a protocol. Analysis of protocol eligibility status assists program planning.

Code

0 Protocol not available

1 On protocol

2 Patient ineligible (age, stage, etc.)

3 Patient ineligible (comorbidity, preexisting condition)

4 Patient entered, but withdrawn from study

6 Patient eligible, not entered, reason not specified

7 Patient eligible, patient or patient's guardian refused

8 Protocol not recommended

9 Unknown if on protocol

Clarification of code definitions:

Code	Definition
0	No protocols available for this type of case (for example, site, histologic type).
1	The patient was enrolled in the protocol and started treatment.
2	Patient was not entered into protocol because he or she did not meet eligibility criteria (age, stage of disease).
3	Patient was not entered into protocol because he or she did not meet eligibility criteria (preexisting condition or comorbidity).
4	Patient met eligibility criteria, entered protocol, started treatment, and then stopped participating in the protocol. The decision to stop may be the patient's or physician's.
6	Patient met eligibility criteria, but did not start treatment, reason is not known.
7	Patient did meet eligibility criteria, but refused protocol enrollment.
8	The physician discussed the protocol with the patient and assessed the patient for protocol participation. The physician did not recommend entering the patient into the protocol.
9	Unknown if protocol was discussed with patient or if patient is participating in a protocol.

First Course of Treatment

Protocol Participation

Item Length: 2
Data Type: Numeric
Allowable Values: 00-11, 99
Supplementary Data Set

Record whether the patient was enrolled in and treated on a protocol. A physician may treat a patient following the guidelines of an established protocol; however, the patient is not enrolled into the protocol. For these patients, use code 00 (not on/not applicable).

Code

00 Not on/not applicable

01 NSABP

02 GOG

03 RTOG

04 SWOG

05 ECOG

06 POG

07 CCG

08 CALGB

09 NCI

10 ACS

11 National protocol, NOS

99 Unknown

Beginning with 1999 cases, “12” will designate enrollment in the American College of Surgeons-Oncology Group (ACOS-OG) trial.

Recurrence

Date of First Recurrence

Item Length: 8
Data Type: Numeric
Required Data Set

The term recurrence is defined by the return or reappearance of the cancer after a disease free intermission or remission. Date of First Recurrence is the date a medical practitioner diagnoses metastatic or recurrent cancer. Record the month, day and year (MMDDCCYY) of first recurrence, based on the best available information.

The first two digits record the month, the third and fourth digits record the day and the last four digits record the year of recurrence.

Month		Day		Year
01	January	1		Use four digit year
02	February	2		9999 Year unknown
03	March	3		
04	April	..		
05	May	..		
06	June	..		
07	July	30		
08	August	31		
09	September	99	Day unknown	
10	October			
11	November			
12	December			
99	Month unknown			

Examples: Record June as 06.

Record December 13, 1993 as 12131993.

Code 00000000 if the patient became disease-free after treatment, never had a recurrence, or if the patient was never disease-free.

Code 99999999 when it is unknown if the patient had a first recurrence.

If the exact date of first recurrence is not available, then recording an approximate date is preferred.

Recurrence

Type of First Recurrence

Item Length: 2
Data Type: Numeric
Allowable Values: 00, 01, 10, 11, 15, 20-22, 25, 30, 40, 70, 88, 99
Required Data Set

Record the Type of First Recurrence. The term recurrence refers to the return or reappearance of the cancer after a disease-free intermission or remission.

The cancer may recur in more than one site (i.e., both regional and distant metastases). Code regional in this data field and "distant" in Other Type of Recurrence.

If the patient has been disease-free since treatment, then code 00.

Code

00 None, disease-free

01 In situ

10 Local

11 Trocar site

15 Combination of 10 and 11

20 Regional, NOS

21 Regional tissue

22 Regional lymph nodes

25 Combination of 21 and 22

30 Any combination of 10, 11, and 20, 21, or 22

40 Distant

70 Never disease-free

88 Recurred, site unknown

99 Unknown if recurred

Recurrence

Type of First Recurrence **(Continued)**

Clarification of code definitions:

Code	Definition
00	Became disease-free after treatment, never had a recurrence.
01	Recurrence is in situ.
10	Recurrence is confined to the remnant of the organ of origin. Recurrence is confined to the site of the organ of origin (to the anastomosis, or to scar tissue where the organ previously existed).
11	Recurrence is in the trocar path or entrance site.
15	Recurrence is in both the site of the organ of origin and the trocar path or site.
20	Recurrence is regional, unknown if lymph nodes or tissue involved. Recurrence is in both regional nodes and scar tissue.
21	Recurrence is in tissues adjacent to the organ of origin.
22	Recurrence is in regional lymph nodes.
25	Recurrence is in both the regional tissue and lymph nodes.
30	Recurrence is in the site of the organ of origin **and** trocar path **and** in the regional nodes or tissue.
40	Recurrence is distant from the organ of origin.
70	Recurrence has never been disease-free since diagnosis. Cases with distant metastasis at diagnosis, systemic disease*, unknown primary, or minimal disease that is not treated.
88	The patient has recurred, the type or site of recurrence is unknown.
99	Cases in which it is unknown if the patient has recurred or was never disease-free.

****Exception:*** Code leukemias that are in remission 00. If the patient relapses, code recurrence status 10–40 as appropriate.

Other Type of First Recurrence

Item Length: 2
Data Type: Numeric
Allowable Values: 00, 01, 10, 11, 15, 20-22, 25, 30, 40, 70, 88, 99
Required Data Set

Record the Other Type of First Recurrence. The term recurrence refers to the return or reappearance of the cancer after a disease-free intermission or remission.

The patient may have more than one site of recurrence (i.e., both regional and distant metastases). Code "regional" in the data field Type of First Recurrence, and "distant" in this field.

If the patient has only one site of recurrence or has been disease-free since treatment, code 00.

Code

00 None, disease-free

- 01 In situ

10 Local

- 11 Trocar site
- 15 Combination of 10 and 11

20 Regional, NOS

- 21 Regional tissue
- 22 Regional lymph nodes
- 25 Combination of 21 and 22

30 Any combination of 10, 11, and 20, 21, or 22

40 Distant

70 Never disease-free

88 Recurred, site unknown

99 Unknown if recurred

Other Type of First Recurrence **(Continued)**

Clarification of code definitions:

Code	Definition
00	Became disease-free after treatment, never had a recurrence.
01	Recurrence is in situ.
10	Recurrence is confined to the remnant of the organ of origin. Recurrence is confined to the site of the organ of origin (to the anastomosis, or to scar tissue where the organ previously existed).
11	Recurrence is in the trocar path or entrance site.
15	Recurrence is in both the site of the organ of origin and the trocar path or site.
20	Recurrence is regional, unknown if lymph nodes or tissue involved. Recurrence is in both regional nodes and scar tissue.
21	Recurrence is in tissues adjacent to the organ of origin.
22	Recurrence is in regional lymph nodes.
25	Recurrence is in both the regional tissue and lymph nodes.
30	Recurrence is in the site of the organ of origin **and** trocar path **and** in the regional nodes or tissue.
40	Recurrence is distant from the organ of origin.
70	Recurrence has never been disease-free since diagnosis. Cases with distant metastasis at diagnosis, systemic disease*, unknown primary, or minimal disease that is not treated.
88	The patient has recurred, the type or site of recurrence is unknown.
99	Cases in which it is unknown if the patient has recurred or was never disease-free.

****Exception:*** Code leukemias that are in remission 00. If the patient relapses, code recurrence status 10–40 as appropriate.

Recurrence

Date(s) of Subsequent Treatment(s) for Recurrence or Progression
(Second Course of Therapy–Date Started)

Item Length: 8
Data Type: Numeric
Supplementary Data Set
(2nd Course)
(3rd Course)
(4th Course)
(5th Course)

Date of Subsequent Treatment(s) For Recurrence or Progression records the date(s) of treatment(s) administered for progression or recurrence of disease. Subsequent therapy starts after first course of therapy has been completed, stopped, or changed. The first two digits are the month, the third and fourth digits are the day, and the last four digits are the year. (MMDDCCYY).

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: Record June as 06.

Record December 13, 1996 as 12131996.

Enter dates in chronological order. Applies to each modality of treatment delivered over the lifetime of the patient.

00000000 No subsequent treatment was initiated.

99999999 Unknown if any subsequent treatment administered.

If the exact date(s) of treatment(s) are not available, THEN recording an approximate date is preferred.

Date of Subsquent Treatment(s) for Recurrence or Progression **(Continued)**

If information is limited to a description, use the following:

Descriptive Term Used	Date Code
"Spring"	April
"The middle of the year"	July
"The fall of the year"	October
"The winter of"	Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

Type(s) of Subsequent Treatment(s) for Recurrence or Progression

(Second Course of Therapy—Type of Treatment)
Second, Third, Fourth, and Fifth Course

Data Type: Numeric
Supplementary Data Set
(Combined Item Length for Each Course: 19)

Date (Item Length 8)
Surgery of Primary Site (Item Length 2)
Scope of Regional Lymph Node Surgery (Item Length 1)
Number of Regional Lymph Nodes Removed (Item Length 2)
Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s) (Item Length 1)
Radiation (Item Length 1)
Chemotherapy (Item Length 1)
Hormone Therapy (Item Length 1)
Immunotherapy (Item Length 1)
Other Therapy (Item Length 1)

Type of Subsequent Treatment(s) for Recurrence or Progression consists of all treatments administered for disease progression or recurrence. Subsequent treatment begins after the first course of therapy is completed, stopped, or changed.

Types of therapy:

- Surgery of primary site
- Scope of regional lymph node surgery
- Number of regional lymph nodes removed
- Surgery of other regional site(s), distant site(s), or distant lymph node(s)
- Radiation
- Chemotherapy
- Hormone
- Immunotherapy (biological response modifier)
- Other cancer-directed therapy.

Use the First Course of Treatment codes from Appendix D (cancer-directed surgery codes) and Section Four: Coding Instructions for Radiation, Chemotherapy, Hormone Therapy, Immunotherapy, and Other Treatment.

Recurrence

Recurrence Site(s)
(Distant Site[s] of First Recurrence)

Item Length: 3
Data Type: Numeric
Allowable Values: 0-9
Optional Data Set
Left Justified
Zero Fill

Recurrence Site(s) documents a maximum of three metastatic sites. When there are fewer than three sites, left justify and code remaining sites 0 (none). Record 000 if there are no distant sites or no known metastases. Use the *AJCC Cancer Staging Manual*, Fifth Edition, to identify distant sites. Do not code sites of regional or local metastases identified in the "T" field.

Code

0 None or none known

1 Peritoneum

2 Lung

3 Pleura

4 Liver

5 Bone

6 Central nervous system

7 Skin

8 Lymph nodes (distant)

9 Other, generalized, NOS, carcinomatosis

Recurrence Site(s) (Continued)

Clarification of code definitions:

Code	Definition
0	No distant metastases identified.
1	Peritoneum, including peritoneal surfaces of all structures within the abdominal cavity and/or positive ascitic fluid.
2	Lung, including the visceral pleura.
3	Pleura, including the pleural surface of all structures within the thoracic cavity and/or positive pleural fluid.
4	Liver only.
5	Bones other than the primary site.
6	Includes brain and spinal cord, but **not** the external eye.
7	Skin other than the primary site.
8	Lymph nodes not classified as regional. Refer to the staging scheme for a description of lymph nodes that are distant for a particular site. (Use the *AJCC Cancer Staging Manual*, Fifth Edition, to identify distant nodes.)
9	Bone marrow metastases, carcinomatosis, generalized disease.

A biopsy may distinguish the source of distant disease in a patient with multiple primaries. If there is no histologic or cytologic confirmation, consult the physician to help identify which primary has metastasized. If the physician is unable to decide which primary has metastasized, code both primaries as having metastatic disease. If at a later date, the primary is identified, update the codes as appropriate.

Code 999 if carcinomatosis is present.

Follow-Up

Date of Last Contact or Death

Item Length: 8
Data Type: Numeric
Required Data Set

Record the month, day, and year (MMDDCCYY) of the date of last contact or death. If the patient is deceased, record the date of death. The first two digits are the month, the third and fourth digits are the day, and the last four digits record the year.

Do not use the date information was received in the mail or the date information was requested from a patient, physician, or clinic. If a patient has multiple primaries, all records should have the same date of last contact.

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			

Example: Record December 13, 1996 as 12131996.

If the exact date of last contact or death is not available, then record an approximate date.

If information is limited to a description, then use the following:

Descriptive Term Used	Date Code
"Spring"	April
"The middle of the year"	July
"The fall of the year"	October
"The winter of"	Try to determine if this means the beginning or the end of the year. Code January or December as indicated.

Follow-Up

Vital Status

Item Length: 1
Data Type: Numeric
Allowable Values: 0, 1
Required Data Set

Code the patient's vital status as of the date recorded in the Date of Last Contact or Death. Use the most accurate information available. If a patient has multiple primaries, all records should have the same vital status.

Code

0 Dead

1 Alive

Follow-Up

Cancer Status

Item Length: 1
Data Type: Numeric
Allowable Values: 1, 2, 9
Required Data Set

Cancer Status is the presence or absence of clinical evidence of cancer as of the Date of Last Contact or Death. Cancer status changes if the patient has a recurrence or relapse. It is coded independently for each primary. If a patient has multiple primaries, each primary could have a different cancer status.

Code

1 No evidence of this cancer

2 Evidence of this cancer

9 Unknown, indeterminate whether this cancer is present

For patients with hematopoietic disease who are in remission, code 1, no evidence of this cancer.

Death certificates do not always record the presence of cancer. If the registry abstract indicates that the patient had cancer immediately before death, then code evidence of this cancer (2). Consult the registry physician when questions arise. Decisions on cancer status coding can be based on information such as:

- How much time elapsed between the last follow up and the patient's death?
- Was the last follow- up and cancer status information from a medical source (physician, hospital admission)?
- Are autopsy findings available to the registry?

Example: A patient with prostate cancer has a two-year history of metastatic disease. The patient had a bone scan at the reporting institution in April 1996. The urologist's diagnosis was progressive bony metastases and the bone scan confirmed extensive bone destruction. The registrar finds an obituary documenting the patient's death in a nursing home in June 1996. Record the cancer status as evidence of this cancer (2).

Quality of Survival

Item Length: 1
Data Type: Numeric
Allowable Values: 0-4, 8, 9
Optional Data Set

Record the patient's ability to carry on the activities of daily living at the date of last contact. Quality of Survival reflects the patient's overall status, not just cancer-related disabilities. This data item changes over time.

Code

0 Normal activity

1 Symptomatic and ambulatory

2 Ambulatory more than 50% of the time, occasionally needs assistance

3 Ambulatory less than 50% of the time, nursing care needed

4 Bedridden, may require hospitalization

8 Not applicable, dead

9 Unknown or unspecified

Do not consider transient health problems when assigning a quality of life code. Examples of transient problems:

- Broken leg
- Any side effects of treatment that are expected to improve after treatment is completed

These codes are taken from the AJCC's Host Performance Scale, which is adapted from the Karnofsky Scale and the Eastern Cooperative Oncology Group (ECOG) Scale.[14]

Record 8 when the patient has expired.

[14]*AJCC Manual for Staging of Cancer*, Third Edition (1988).

Reconstruction/Restoration–Delayed

Item Length: 1
Data Type: Numeric
Range of Allowable Values: Site Specific
Required Data Set

Reconstruction/Restoration–Delayed describes surgical procedures that improve the shape and appearance or function of body structures that are missing, defective, damaged, or misshapen by cancer or cancer-directed therapies. Reconstruction/Restoration–Delayed is limited to procedures started after the first course of cancer-directed therapy is completed or when it is unknown whether reconstruction was started during first or second course of therapy.

Each site-specific surgery code scheme (Appendix D) has either a list of reconstructive/restorative procedures or codes that define specific procedures. Code only those procedures listed under each site.

Following Registry

Item Length: 6
Data Type: Numeric
Optional Data Set

Record the six-digit institution identification number for the facility responsible for following the patient.

Record 999999, if the following registry's identification number is unknown.

This item is useful when multiple registries follow the same patient. A written agreement may be drawn up between two registries noting which hospital will be responsible for follow up.

Follow-Up

Follow-Up Source
(Follow-Up Method)

Item Length: 1
Data Type: Numeric
Allowable Values: 0-5, 7-9
Supplementary Data Set

Follow-up Source identifies the source of the latest follow-up information.

Code

0 Reported hospitalization

1 Readmission

2 Physician

3 Patient

4 Department of Motor Vehicles

5 Medicare/Medicaid file

7 Death certificate

8 Other

9 Unknown

Clarification of code definitions:

Code	Definition
0	Hospitalization at another institution/hospital or first admission to the reporting institution.
1	Hospitalization or outpatient visit at the reporting institution.
2	Information from a physician.
3	Direct contact with the patient.
4	The Department of Motor Vehicles confirmed that the patient has a current license.
5	The Medicare or Medicaid office confirmed that the patient is alive.
7	Information from death certificate-only.
8	Friends, relatives, employers, other registries, or any sources not covered by other codes.
9	Unknown/unspecified.

Next Follow-Up Source
(Next Follow-Up Method)

Item Length: 1
Data Type: Numeric
Allowable Values: 0-5, 8, 9
Supplementary Data Set

Next Follow-up Source identifies the method planned for the next follow up.

Code

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

Code 8: Foreign residents do not have to be followed. This is not a blanket policy recommending that registries not attempt follow up.

Code 9: Cases for which follow up is not required.

Example: Reportable-by-Agreement

Unusual Follow-Up Method

Item Length: 1
Data Type: Numeric
Optional Data Set
User Defined

This data item is used to flag a case that needs unusual follow-up methods.

The available codes are 0–9. There are no standards for this item. Each registry assigns codes as needed. Document code assignments in your procedure manual to assure data consistency.

Examples of code assignments:

Code 1: Patient unaware of diagnosis.

Code 2: Patient not mentally competent.

Follow-Up

Cause of Death
(Underlying Cause of Death [ICD Code])

Item Length: 4
Data Type: Alphanumeric
Optional Data Set
Left Justified

Record the cause of death listed on the death certificate. Central registries are the primary users of this data item. Use the underlying cause of death (ICD code) identified by the state health department.

Code

0000 Patient alive at last follow up

7777 State death certificate or listing not available

7797 State death certificate or listing available, but underlying cause of death not coded

All other cases: ICDA-8, ICD-9, or ICD-10 underlying cause of death code.

Some codes may have an optional fifth digit. The fifth digit is not used in coding cause of death.

If the fourth digit for the underlying cause of death is "X", "blank", or "–", fill with a 9.

Use code 7797 when the coded underlying cause of death is not available.

Examples:

Underlying Cause of Death	ICDA-8 or ICD-9	Code
Cancer of the thyroid	193	1939
Acute appendicitis with peritonitis	540.0	5400
Adenocarcinoma of stomach	151.9	1519

Beginning in the late 1990s, all deaths will be coded using the *International Statistical Classification of Diseases and Related Health Problems*, Tenth Revision (ICD-10). The ICD-10 codes consist of four characters—a letter followed by two or three digits.

Example:

Underlying Cause of Death	ICD-10	Code
Cancer of the thyroid	C73	C739
Acute appendicitis with peritonitis	K35.0	K350
Adenocarcinoma of stomach	C16.9	C169

ICD Revision Number

Item Length: 1
Data Type: Numeric
Allowable Values: 0, 1, 8, 9
Optional Data Set

ICD Revision Number identifies the ICD edition used to code cause of death.

Code

0 Patient alive at last follow up

1 ICD-10

8 ICDA-8

9 ICD-9

Follow-Up

Autopsy

Item Length: 1
Data Type: Numeric
Allowable Values: 0-2, 9
Optional Data Set

Record whether the patient had an autopsy. Codes 1, 2, and 9 are used only if the patient has expired.

Code

0 Patient alive

1 Autopsy performed

2 No autopsy performed

9 Patient expired, unknown if autopsy performed

Follow-Up

Commission on Cancer Coding System–Current

Item Length: 1
Data Type: Numeric
Required Data Set
Allowable Values: 0-7, 9

Commission on Cancer Coding System–Current identifies the coding scheme used for data collection.

Code

	No Commission on Cancer coding system used
1	Pre-1988 (Cancer Program Manual Supplement)
2	1988 Data Acquisition Manual
3	1989 Data Acquisition Manual Revisions
4	1990 Data Acquisition Manual Revisions
5	1994 Data Acquisition Manual (Interim/Revised)
6	Registry Operations and Data Standards (ROADS)
7	1998 Registry Operations and Data Standards (ROADS) Revisions
9	Unknown

Appendix A
ICD-O-2 Codes

These ICD–O–2 Codes are regarded as one primary site when determining multiple primaries.

Reprinted from *The SEER Program Code Manual*, Revised Edition, June 1992

ICD-O-2 Code	Site Groupings
C01	Base of tongue
C02	Other and unspecified parts of tongue
C05	Palate
C06	Other and unspecified parts of mouth
C07	Parotid gland
C08	Other and unspecified major salivary glands
C09	Tonsil
C10	Oropharynx
C12	Pyriform sinus
C13	Hypopharynx
C23	Gallbladder
C24	Other and unspecified parts of biliary tract
C30	Nasal cavity and middle ear
C31	Accessory sinuses
C33	Trachea
C34	Bronchus and lung
C37	Thymus
C38.0	Heart
C38.1–C38.3	Mediastinum
C38.8	Overlapping lesion of heart, mediastinum, and pleura
C38.4	Pleura
C51	Vulva
C52	Vagina
C57.7	Other specified female genital organs
C57.8–C57.9	Unspecified female genital organs
C56	Ovary
C57.0	Fallopian tube
C57.1	Broad ligament
C57.2	Round ligament
C57.3	Parametrium
C57.4	Uterine adnexa

ICD-O-2 Code	Site Groupings
C60	Penis
C63	Other and unspecified male genital organs
C64	Kidney
C65	Renal pelvis
C66	Ureter
C68	Other and unspecified urinary organs
C74	Adrenal gland
C75	Other endocrine glands and related structures

Appendix B

Determination of Subsequent Primaries for Lymphatic (Nodal and Extranodal) and Hematopoietic Diseases

Determination of Subsequent Primaries for Lymphatic (Nodal and Extranodal) and Hematopoietic Diseases

Reprinted from *The SEER Program Code Manual*, Revised Edition, June 1992

First Primary	Presumably a Second Primary	Presumably <u>not</u> a Subsequent Primary (Only (One Primary)
Hodgkin's disease (9650–9667)	Non-Hodgkin's lymphoma (9591–9595, 9670–9686, 9690–9698, 9702–9714)	Hodgkin's disease[1] (9650–9667)
	Burkitt's lymphoma (9687)	Malignant lymphoma, NOS (9590)
	Mycosis fungoides or Sezary's disease (9700–9701)	
	Malignant histiocytosis or Letterer-Siwe disease (9720, 9722)	
	True histiocytic lymphoma (9723)	
	Plasmacytoma or multiple myeloma (9731, 9732)	
	Mast cell tumor (9740–9741)	
	Waldenstrom's macroglobuline-mia (9761)	
	Any leukemia (9800–9941)	

[1]Code to the term with the higher histology code.

Determination of Subsequent Primaries for Lymphatic (Nodal and Extranodal) and Hematopoietic Diseases (Continued)

First Primary	Presumably a Second Primary	Presumably <u>not</u> a Subsequent Primary (Only One Primary)
Malignant lymphoma, NOS[2] (9590)	Burkitt's lymphoma (9687)	Non-Hodgkin's lymphoma[3] (9590–9595, 9670–9686, 9690–9698, 9702–9714)
	Mycosis fungoides or Sezary's disease (9700, 9701)	Hodgkin's disease[3] (9650–9667)
	Malignant histiocytosis or Letterer-Siwe disease (9720, 9722)	True histiocytic lymphoma (9723)
	Mast cell tumor (9740, 9741)	Plasmacytoma[3] or multiple myeloma (9731, 9732)
	Acute leukemia, NOS (9801)	Leukemia, NOS (9800)
	Nonlymphocytic leukemias (9840–9842, 9860–9910)	Chronic leukemia, NOS (9803)
	Myeloid sarcoma (9930)	Lymphoid or lymphocytic leukemia (9820–9827)
	Acute panmyelosis (9931)	Plasma cell leukemia (9830)
	Acute myelofibrosis (9932)	Lymphosarcoma cell leukemia (9850)
	Hairy cell leukemia (9940)	Waldenstrom's macroglobulinemia (9761)
	Leukemic reticuloendotheliosis (9941)	

[2]If the diagnosis includes "can't rule out leukemia" or "consistent with chronic lymphocytic leukemia," and a bone marrow or peripheral blood study within two months confirms the chronic lymphocytic leukemia diagnosis, then code only to chronic lymphocytic leukemia (9823/3). If not confirmed as chronic lymphocytic leukemia, then code as the lymphoma.

[3]Presumably this is the correct diagnosis. Code the case to this histologic type.

Determination of Subsequent Primaries for Lymphatic (Nodal and Extranodal) and Hematopoietic Diseases (Continued)

First Primary	Presumably a Second Primary	Presumably <u>not</u> a Subsequent Primary (Only One Primary)
Non-Hodgkin's[2] lymphoma (9591–9595, 9670–9686, 9690–9698, 9711–9714)	Hodgkin's disease (9650–9667)	Non-Hodgkin's lymphoma[1] (9590–9595, 9670–9686, 9690–9698, 9702–9714)
	Burkitt's lymphoma (9687)	Plasmacytoma[3] or multiple myeloma (9731, 9732)
	Mycosis fungoides or Sezary's disease (9700, 9701)	True histiocytic lymphoma (9723)
	Malignant histiocytosis or Letterer-Siwe disease (9720, 9722)	Leukemia, NOS (9800)
	Mast cell tumor (9740–9741)	Chronic leukemia, NOS (9803)
	Acute leukemia, NOS (9801)	Lymphoid or lymphocytic leukemia (9820-9827)
	Nonlymphocytic leukemias (9840–9842, 9860–9910)	Plasma cell leukemia (9830)
	Myeloid sarcoma (9930)	Lymphosarcoma cell leukemia (9850)
	Acute panmyelosis (9931)	Waldenstrom's macroglobuline-mia (9761)
	Acute myelofibrosis (9932)	
	Hairy cell leukemia (9940)	
	Leukemic reticuloendotheliosis (9941)	

Determination of Subsequent Primaries for Lymphatic (Nodal and Extranodal) and Hematopoietic Diseases (Continued)

First Primary	Presumably a Second Primary	Presumably not a Subsequent Primary (Only One Primary)
Burkitt's lymphoma (9687)	Specific non-Hodgkin's lymphoma (9593–9594, 9670–9686, 9690–9698, 9702–9714)	Malignant lymphoma, NOS (9590–9591, 9595)
	Hodgkin's disease (9650–9667)	Lymphosarcoma (9592)
	Mycosis fungoides or Sezary's disease (9700, 9701)	Burkitt's lymphoma (9687)
	Malignant histiocytosis or Letterer-Siwe disease (9720, 9722)	Burkitt's leukemia (9826)
	Plasmacytoma or multiple myeloma (9731, 9732)	Lymphoid or lymphocytic leukemia (9820–9822, 9824–9825, 9827)
	True histiocytic lymphoma (9723) Mast cell tumor (9740, 9741) Waldenstrom's macroglobulinemia (9761) Leukemia, NOS (9800) Acute leukemia, NOS (9801) Chronic leukemia, NOS (9803) Chronic lymphocytic leukemia (9823) Nonlymphocytic leukemias (9840–9842, 9860–9910) Plasma cell leukemia (9830) Lymphosarcoma cell leukemia (9850) Myeloid sarcoma (9930) Acute panmyelosis (9931) Acute myelofibrosis (9932) Hairy cell leukemia (9940) Leukemic reticuloendotheliosis (9941)	

Determination of Subsequent Primaries for Lymphatic (Nodal and Extranodal) and Hematopoietic Diseases (Continued)

First Primary	Presumably a Second Primary	Presumably not a Subsequent Primary (Only One Primary)
Cutaneous and peripheral T-cell lymphomas (9700–9709)	Specific non-Hodgkin's lymphoma (9593–9594, 9670–9687, 9690–9698, 9711–9714)	Malignant lymphoma, NOS (9590–9591, 9595)
	Hodgkin's disease (9650–9667)	Lymphosarcoma (9592)
	Malignant histiocytosis or Letterer-Siwe disease (9720–9722)	Cutaneous and peripheral T-cell lymphomas (9700–9709)
	True histiocytic lymphoma (9723)	Leukemia, NOS (9800)
	Plasmacytoma or multiple myeloma (9731, 9732)	Acute leukemia, NOS (9801)
	Mast cell tumor (9740, 9741)	Chronic leukemia, NOS (9803)
	Waldenstrom's macroglobulinemia (9761)	Lymphoid or lymphocytic leukemia unless specifically identified as B-cell (9820–9827)
	Lymphoid or lymphocytic leukemia specified as B-cell (9820–9827) Plasma cell leukemia (9830) Nonlymphocytic leukemia (9840–9842, 9860–9910) Lymphosarcoma cell leukemia (9850) Myeloid sarcoma (9930) Acute panmyelosis (9931) Acute myelofibrosis (9932) Hairy cell leukemia (9940) Leukemia reticuloendotheliosis (9941)	

Determination of Subsequent Primaries for Lymphatic (Nodal and Extranodal) and Hematopoietic Diseases (Continued)

First Primary	Presumably a Second Primary	Presumably not a Subsequent Primary (Only One Primary)
Malignant histiocytosis or Letterer-Siwe disease (9720, 9722, 9723)	Specific non-Hodgkin's lymphoma (9592–9594, 9670–9686, 9690–9698, 9702–9714)	Non-Hodgkin's lymphoma, NOS (9590–9591, 9595)
	Hodgkin's disease (9650-9667)	Malignant histiocytosis or Letterer-Siwe disease (9720, 9722, 9723)
	Burkitt's lymphoma (9687)	Hairy cell leukemia (9940)
	Mycosis fungoides or Sezary's disease (9700, 9701)	Leukemic reticuloendotheliosis (9941)
	Plasmacytoma or multiple myeloma (9731, 9732) Mast cell tumor (9740, 9741) Waldenstrom's macroglobulinemia (9761) Leukemia except hairy cell and leukemic reticuloendotheliosis (9800–9932)	

Determination of Subsequent Primaries for Lymphatic (Nodal and Extranodal) and Hematopoietic Diseases (Continued)

First Primary	Presumably a Second Primary	Presumably <u>not</u> a Subsequent Primary (Only One Primary)
Plasmacytoma or multiple myeloma (9731, 9732)	Non-Hodgkin's lymphoma except immunoblastic or large cell lymphoma (9592–9594, 9670, 9672–9677, 9683, 9685–9686, 9690–9697, 9702–9713)	Malignant lymphoma, NOS (9590, 9591, 9595)
	Hodgkin's disease (9650-9667)	Immunoblastic or large cell lymphoma[4] (9671, 9680–9682, 9684, 9698, 9714)
	Burkitt's lymphoma (9687)	Plasmacytoma or multiple myeloma (9731, 9732)
	Mycosis fungoides or Sezary's (9700, 9701)	Waldenstrom's macroglobulinemia disease (9761)
	Malignant histiocytosis or Letterer-Siwe disease (9720, 9722)	Plasma cell leukemia (9830)
	True histiocytic lymphoma (9723) Mast cell tumor (9740, 9741) Leukemia except plasma cell (9800–9827, 9840-9941)	

[4] Occasionally multiple myeloma develops an immunoblastic or large cell lymphoma phase. This is to be considered one primary, multiple myeloma. Consult your medical advisor or pathologist if questions remain.

Determination of Subsequent Primaries for Lymphatic (Nodal and Extranodal) and Hematopoietic Diseases (Continued)

First Primary	Presumably a Second Primary	Presumably <u>not</u> a Subsequent Primary (Only One Primary)
Mast cell tumor (9740, 9741)	Non-Hodgkin's lymphoma (9590–9595, 9670–9687, 9690–9698, 9702–9714)	Mast cell tumor (9740, 9741)
	Hodgkin's disease (9650–9667)	Leukemia, NOS (9800)
	Mycosis fungoides or Sezary's disease (9700, 9701)	Acute leukemia, NOS (9801)
	Malignant histiocytosis or Letterer-Siwe disease (9720, 9722)	Chronic leukemia, NOS (9803)
	True histiocytic lymphoma (9723)	Monocytic leukemia (9890-9894)
	Plasmacytoma or multiple myeloma (9731, 9732) Waldenstrom's macroglobuline-mia (9761) Chronic lymphocytic leukemia (9823) Plasma cell leukemia (9830) Nonlymphocytic leukemias (9840–9842, 9860–9880, 9910) Lymphosarcoma cell leukemia (9850) Myeloid sarcoma (9930) Acute panmyelosis (9931) Acute myelofibrosis (9932) Hairy cell leukemia (9940) Leukemic reticuloendotheliosis (9941)	Mast cell leukemia (9900)

Determination of Subsequent Primaries for Lymphatic (Nodal and Extranodal) and Hematopoietic Diseases (Continued)

First Primary	Presumably a Second Primary	Presumably <u>not</u> a Subsequent Primary (Only One Primary)
Waldenstrom's macroglobulinemia (9761)	Non-Hodgkin's lymphoma except immunoblastic or large cell lymphoma (9593–9594, 9673–9677, 9683, 9685–9686, 9690–9697, 9702–9713)	Malignant lymphoma, NOS 9590, 9591, 9595)
	Hodgkin's disease (9650–9667)	Lymphosarcoma (9592)
	Burkitt's lymphoma (9687)	Immunoblastic or large cell lymphoma (9671, 9680–9682, 9684, 9698, 9714)
	Mycosis fungoides or Sezary's disease (9700, 9701)	Malignant lymphoma, lymphocytic disease (9670, 9672)
	Malignant histiocytosis or Letterer-Siwe disease (9720, 9722)	Plasmacytoma or multiple myeloma (9731, 9732)
	True histiocytic lymphoma (9723)	Waldenstrom's macroglobulinemia (9761)
	Mast cell tumor (9740, 9741) Leukemia except plasma cell (9800–9827, 9840–9941)	Plasma cell leukemia (9830)

Determination of Subsequent Primaries for Lymphatic (Nodal and Extranodal) and Hematopoietic Diseases (Continued)

First Primary	Presumably a Second Primary	Presumably <u>not</u> a Subsequent Primary (Only One Primary)
Leukemia, NOS (9800)	Non-Hodgkin's lymphoma[2] (9590–9595, 9670–9687, 9690–9698, 9702–9714)	Any leukemia[5] (9800–9941)
	Hodgkin's disease (9650–9667)	Sezary's disease[3] (9701)
	Mycosis fungoides (9700) Malignant histiocytosis or Letterer-Siwe disease (9720, 9722) True histiocytic lymphoma (9723) Plasmacytoma or multiple myeloma (9731, 9732) Mast cell tumor (9740, 9741) Waldenstrom's macroglobulinemia (9761)	

[5] Note: Leukemia, NOS (9800) should be upgraded to a more specific leukemia diagnosis (higher number) when it is found but not considered a second primary.

Determination of Subsequent Primaries for Lymphatic (Nodal and Extranodal) and Hematopoietic Diseases (Continued)

First Primary	Presumably a Second Primary	Presumably <u>not</u> a Subsequent Primary (Only One Primary)
Acute leukemia, NOS (9801)	Non-Hodgkin's lymphoma (9590–9595, 9670–9687, 9690–9698, 9702–9714)	Any leukemia[6] (9800–9941)
	Hodgkin's disease (9650–9667)	Sezary's disease[3] (9701)
	Mycosis fungoides (9700) Malignant histiocytosis or Letterer-Siwe disease (9720, 9722) True histiocytic lymphoma (9723) Plasmacytoma or multiple myeloma (9731, 9732) Mast cell tumor (9740, 9741) Waldenstrom's macroglobuline-mia (9761)	

[6] Note: Acute leukemia, NOS (9801) should be upgraded to a more specific type of acute leukemia (higher number) when it is found, but not considered a second primary.

Determination of Subsequent Primaries for Lymphatic (Nodal and Extranodal) and Hematopoietic Diseases (Continued)

First Primary	Presumably a Second Primary	Presumably <u>not</u> a Subsequent Primary (Only One Primary)
Chronic leukemia, NOS (9803)	Hodgkin's disease (9650–9667)	Non-Hodgkin's lymphoma[2] (9590–9595, 9670–9686, 9690–9698, 9702–9714)
	Malignant histiocytosis or Letterer-Siwe disease (9720, 9722)	Burkitt's lymphoma (9687)
	Mast cell tumor (9740, 9741)	Mycosis fungoides or Sezary's disease (9700, 9701) True histiocytic lymphoma (9723) Plasmacytoma or multiple myeloma (9731, 9732) Waldenstrom's macroglobulinemia (9761) Any leukemia[7] (9800–9941)

[7] Note: Chronic leukemia, NOS (9803) should be upgraded to a more specific type of chronic leukemia (higher number) when it is found, but not considered a second primary.

Determination of Subsequent Primaries for Lymphatic (Nodal and Extranodal) and Hematopoietic Diseases (Continued)

First Primary	Presumably a Second Primary	Presumably <u>not</u> a Subsequent Primary (Only One Primary)
Lymphocytic leukemia (9820-9827)	Hodgkin's disease (9650–9667)	Non-Hodgkin's lymphoma[2] (9592–9595, 9670–9687, 9690–9698, 9702–9714)
	Malignant histiocytosis or Letterer-Siwe disease[8] (9720, 9722)	Malignant lymphoma, NOS[2] (9590–9591)
	Plasmacytoma or multiple myeloma (9731, 9732)	Mycosis fungoides or Sezary's disease[9] (9700, 9701)
	Mast cell tumor (9740, 9741)	True histiocytic lymphoma (9723)
	Waldenstrom's macroglobu-linemia (9761)	Leukemia, NOS (9800)
	Nonlymphocytic leukemias[8] (9840–9842, 9860–9910)	Acute leukemia, NOS (9801)
	Myeloid sarcoma[8] (9930)	Chronic leukemia, NOS (9803)
	Acute panmyelosis[8] (9931)	Lymphocytic leukemia[9] (9820–9827)
	Acute myelofibrosis[8] (9932)	Plasma cell leukemia[8] (9830) Lymphosarcoma cell leukemia[8] (9850) Hairy cell leukemia[8] (9940) Leukemic reticuloendotheliosis[8] (9941)

[8] If any of these diagnoses are made within four months of lymphocytic leukemia, NOS (9820) or acute lymphocytic leukemia (9821), one of the two diagnoses probably is wrong. The case should be reviewed.

[9] Note: Lymphocytic leukemia, NOS (9820) should be upgraded to a more specific diagnosis that is not considered a second primary.

Determination of Subsequent Primaries for Lymphatic (Nodal and Extranodal) and Hematopoietic Diseases (Continued)

First Primary	Presumably a Second Primary	Presumably <u>not</u> a Subsequent Primary (Only One Primary)
Plasma cell leukemia (9830)	Non-Hodgkin's lymphoma (9590–9595, 9670–9686, 9690–9698, 9702–9714)	Plasmacytoma or multiple myeloma (9731, 9732)
	Hodgkin's disease (9650–9667)	Waldenstrom's macroglobulinemia (9761)
	Burkitt's lymphoma (9687)	Leukemia, NOS (9800)
	Mycosis fungoides or Sezary's disease (9700, 9701)	Acute leukemia, NOS (9801)
	Malignant histiocytosis or Letterer-Siwe disease (9720, 9722)	Chronic leukemia, NOS (9803)
	True histiocytic lymphoma (9723)	Lymphocytic leukemia (9820–9827)
	Mast cell tumor (9740, 9741)	Plasma cell leukemia (9830)
	Nonlymphocytic leukemia (9840–9842, 9860–9910)	Lymphosarcoma cell leukemia (9850)
	Myeloid sarcoma (9930)	Hairy cell leukemia (9940)
	Acute panmyelosis (9931)	Leukemic reticuloendotheliosis (9941)
	Acute myelofibrosis (9932)	

Determination of Subsequent Primaries for Lymphatic (Nodal and Extranodal) and Hematopoietic Diseases (Continued)

First Primary	Presumably a Second Primary	Presumably not a Subsequent Primary (Only One Primary)
Lymphosarcoma cell leukemia (9850)	Hodgkin's disease (9650–9667)	Non-Hodgkin's lymphoma (9590–9595, 9670–9687, 9690–9698, 9702–9714)
	Mycosis fungoides or Sezary's disease (9700, 9701)	True histiocytic lymphoma (9723)
	Malignant histiocytosis or Letterer-Siwe disease (9720, 9722)	Plasmacytoma or multiple myeloma (9731–9732)
	Mast cell tumor (9740, 9741)	Waldenstrom's macroglobulinemia (9761)
	Nonlymphocytic leukemia (9840–9842, 9860–9941)	Leukemia, NOS (9800)
		Acute leukemia, NOS (9801) Chronic leukemia, NOS (9803) Lymphocytic leukemia (9820-9827) Plasma cell leukemia (9830) Lymphosarcoma cell leukemia (9850)

Determination of Subsequent Primaries for Lymphatic (Nodal and Extranodal) and Hematopoietic Diseases (Continued)

First Primary	Presumably a Second Primary	Presumably not a Subsequent Primary (Only One Primary)
Nonlymphocytic leukemias (9840-9842, 9860-9894, 9910-9932)	Non-Hodgkin's lymphoma (9590–9595, 9670–9686, 9690–9698, 9702–9714)	Leukemia, NOS (9800)
	Hodgkin's disease (9650–9667)	Acute leukemia, NOS (9801)
	Burkitt's lymphoma (9687)	Chronic leukemia, NOS (9803)
	Mycosis fungoides or Sezary's disease (9700, 9701)	Nonlymphocytic leukemias[1] (9840–9842, 9860–9894, 9910–9932)
	Malignant histiocytosis or Letterer-Siwe disease (9720, 9722) True histiocytic lymphoma (9723) Plasmacytoma or multiple myeloma (9731, 9732) Mast cell tumor (9740, 9741) Waldenstrom's macroglobulinemia (9761) Lymphocytic leukemia (9820–9827) Plasma cell leukemia (9830) Lymphosarcoma cell leukemia (9850) Mast cell leukemia (9900) Hairy cell leukemia (9940) Leukemic reticuloendotheliosis (9941)	

Determination of Subsequent Primaries for Lymphatic (Nodal and Extranodal) and Hematopoietic Diseases (Continued)

First Primary	Presumably a Second Primary	Presumably not a Subsequent Primary (Only One Primary)
Mast cell leukemia (9900)	Non-Hodgkin's lymphoma (9590–9595, 9670–9686, 9690–9698, 9702–9714)	Mast cell tumor (9740, 9741)
	Hodgkin's disease (9650–9667)	Leukemia, NOS (9800)
	Burkitt's lymphoma (9687)	Acute leukemia, NOS (9801)
	Mycosis fungoides or Sezary's disease (9700, 9701)	Chronic leukemia, NOS (9803)
	Malignant histiocytosis or Letterer-Siwe disease (9720, 9722) True histiocytic lymphoma (9723) Plasmacytoma or multiple myeloma (9731, 9732) Waldenstrom's macroglobulinemia (9761) Any other leukemia (9820–9894, 9910–9941)	Mast cell leukemia (9900)

Determination of Subsequent Primaries for Lymphatic (Nodal and Extranodal) and Hematopoietic Diseases (Continued)

First Primary	Presumably a Second Primary	Presumably not a Subsequent Primary (Only One Primary)
Hairy cell leukemia or leukemic reticuloendotheliosis (9940, 9941)	Non-Hodgkin's lymphoma (9590–9595, 9670–9686, 9690–9698, 9702–9714)	Malignant histiocytosis or Letterer-Siwe disease (9720, 9722)
	Hodgkin's disease (9650–9667)	Lymphocytic leukemia, NOS (9820)
	Burkitt's lymphoma (9687)	Hairy cell leukemia or leukemic reticuloendotheliosis (9940, 9941)
	Mycosis fungoides or Sezary's disease (9700, 9701) True histiocytic lymphoma (9723) Plasmacytoma or multiple myeloma (9731, 9732) Mast cell tumor (9740, 9741) Waldenstrom's macroglobulinemia (9761) Any nonlymphocytic leukemia (9800–9804, 9830–9932) Lymphocytic leukemia (9821–9827)	

Appendix C
Geocodes

Geocodes

Numerical List

Codes for the United States are by section of the country. The second digit represents the first digit of the **zip** code.

Continental United States and Hawaii

000 United States

- 001 New England and New Jersey
  - 002 Maine
  - 003 New Hampshire
  - 004 Vermont
  - 005 Massachusetts
  - 006 Rhode Island
  - 007 Connecticut
  - 008 New Jersey
- 010 North Mid-Atlantic States
  - 011 New York
  - 014 Pennsylvania
  - 017 Delaware
- 020 South Mid-Atlantic States
  - 021 Maryland
  - 022 District of Columbia
  - 023 Virginia
  - 024 West Virginia
  - 025 North Carolina
  - 026 South Carolina
- 030 Southeast States
  - 031 Tennessee
  - 033 Georgia
  - 035 Florida
  - 037 Alabama
  - 039 Mississippi
- 040 North Central States
  - 041 Michigan
  - 043 Ohio
  - 045 Indiana
  - 047 Kentucky
- 050 Northern Midwest States
  - 051 Wisconsin
  - 052 Minnesota
  - 053 Iowa
  - 054 North Dakota
  - 055 South Dakota
  - 056 Montana
- 060 Central Midwest States
  - 061 Illinois
  - 063 Missouri
  - 065 Kansas
  - 067 Nebraska
- 070 Southern Midwest States
  - 071 Arkansas
  - 073 Louisiana
  - 075 Oklahoma
  - 077 Texas
- 080 Mountain States
  - 081 Idaho
  - 082 Wyoming
  - 083 Colorado
  - 084 Utah
  - 085 Nevada
  - 086 New Mexico
  - 087 Arizona
- 090 Pacific Coast States
  - 091 Alaska
  - 093 Washington
  - 095 Oregon
  - 097 California
  - 099 Hawaii

United States Possessions

When these codes were originally assigned during the 1970s, the United States owned or governed islands in the Pacific. Many of these islands have been either granted independence or control has been given to another country. To be consistent, these islands are still coded to the original codes. The names have been annotated to indicate the new political designation.

100 Atlantic/Caribbean area
- 101 Puerto Rico
- 102 U.S. Virgin Islands
- 109 Other Atlantic/Caribbean area

110 Canal Zone

120 Pacific area
- 121 American Samoa
- 122 Canton and Enderbury Islands (Kiribati)
- 123 Caroline Islands (Trust Territory of Pacific Islands)
- 124 Cook Islands (New Zealand)
- 125 Gilbert (Kiribati) and Ellice (Tuvalu) Islands
- 126 Guam
- 127 Johnston Atoll
- 128 Line Islands, Southern (Kiribati)
- 129 Mariana Islands (Trust Territory of Pacific Islands)
- 131 Marshall Islands (Trust Territory of Pacific Islands)
- 132 Midway Islands
- 133 Nampo-Shoto, Southern
- 134 Ryukyu Islands (Japan)
- 135 Swan Islands
- 136 Tokelau Islands (New Zealand)
- 137 Wake Island

North and South America, Exclusive of the United States and Its Possessions

210 Greenland

220 Canada
- 221 Maritime Provinces (Newfoundland, Nova Scotia, Prince Edward Island, New Brunswick)
- 222 Quebec
- 223 Ontario
- 224 Prairie Provinces (Manitoba, Saskatchewan, Alberta)
- 225 Yukon Territory, Northwest Territories
- 226 British Columbia

230 Mexico

240 North American Islands
- 241 Cuba
- 242 Haiti
- 243 Dominican Republic
- 244 Jamaica
- 245 Other Caribbean Islands
- 246 Bermuda
- 247 Bahamas

250 Central America
- 251 Guatemala
- 252 Belize (British Honduras)
- 253 Honduras
- 254 El Salvador
- 255 Nicaragua
- 256 Costa Rica
- 257 Panama

300 South America
- 311 Colombia
- 321 Venezuela
- 331 Guyana (British Guiana)
- 332 Suriname (Dutch Guiana)
- 333 French Guiana
- 341 Brazil
- 345 Ecuador
- 351 Peru
- 355 Bolivia
- 361 Chile
- 365 Argentina
- 371 Paraguay
- 375 Uruguay

Europe

Europe, NOS (see code 499)

400 United Kingdom
- 401 England, Channel Islands
- 402 Wales
- 403 Scotland
- 404 Northern Ireland (Ulster)

410 Ireland (Eire)

420 Scandinavia
- 421 Iceland
- 423 Norway
- 425 Denmark
- 427 Sweden
- 429 Finland

430 Germanic Countries
- 431 Germany (East and West)
- 432 Netherlands
- 433 Belgium
- 434 Luxembourg
- 435 Switzerland
- 436 Austria
- 437 Liechtenstein

440 Romance-language Countries
- 441 France, (Corsica), Monaco
- 443 Spain, (Canary Islands, Balearic Islands), Andorra
- 445 Portugal (Madeira Islands, Azores, Cape Verde Islands)
- 447 Italy, (Sardinia, Sicily), San Marino
- 449 Romania

450 Slavic Countries
- 451 Poland
- 452 Czechoslovakia (Bohemia, Moravia, Slovakia)
- 453 Yugoslavia (Serbia, Croatia, Dalmatia, Montenegro, Macedonia, Slavonia, Slovenia)
- 454 Bulgaria
- 455 Russian S.F.S.R. (Russia)
- 456 Ukrainian S.S.R. (The Ukraine) and Moldavian S.S.R. (Bessarabia)
- 457 Byelorussian S.S.R. (White Russia)
- 458 Estonian S.S.R. (Estonia)
- 459 Latvian S.S.R. (Latvia)
- 461 Lithuanian S.S.R. (Lithuania)

470 Other Mainland Europe
- 471 Greece
- 475 Hungary
- 481 Albania
- 485 Gibraltar

490 Other Mediterranean Islands
- 491 Malta
- 495 Cyprus

499 Europe, NOS

Africa

500 Africa

- 510 North Africa
  - 511 Morocco
  - 513 Algeria
  - 515 Tunisia
  - 517 Libya (Tripoli, Tripolitania, Cyrenaica)
  - 519 Egypt (United Arab Republic)
- 520 Sudanese Countries (Western [Spanish] Sahara, Mauritania, Mall, Niger, Chad, Sudan, Upper Volta)
- 530 West Africa
  - 531 Nigeria
  - 539 Senegal, Gambia, Portuguese Guinea, Guinea, Sierra Leone, Liberia, Ivory Coast, Ghana, Togo, Benin (Dahomey), Cameroon (Kameroon), Equatorial Guinea, (Fernando Poo, Bioko, Rio Muni), Gabon, Congo-Brazzaville (French Congo), Central African Republic
- 540 South Africa
  - 541 Congo-Leopoldville(Zaire, Belgian Congo)
  - 543 Angola, Sao Tome, Principe, Cabinda
  - 545 Republic of South Africa (Cape Colony, Orange Free State, Natal, Transvaal), Namibia (South West Africa), Lesotho (Basutoland), Botswana (Bechuanaland), Ciskel, Swaziland, Transkei, Bophuthatswana, Venda
  - 547 Zimbabwe (Rhodesia, Southern Rhodesia)
  - 549 Zambia (Northern Rhodesia)
  - 551 Malawi (Nyasaland)
  - 553 Mozambique
  - 555 Madagascar (Malagasy Republic)
- 570 East Africa
  - 571 Tanzania (Tanganyika, Tanzanyika, Zanzibar)
  - 573 Uganda
  - 575 Kenya
  - 577 Rwanda (Ruanda)
  - 579 Burundi (Urundi)
  - 581 Somalia (Somali Republic, Somaliland)
  - 583 Afars and Issas (Djibouti, French Somaliland)
  - 585 Ethiopia (Abyssinia, Eritrea)

Asia

600 Asia, NOS

- 610 Near-East
  - 611 Turkey
- 620 Asian Arab countries
  - 621 Syria
  - 623 Lebanon
  - 625 Jordan (Transjordan) and former Arab Palestine
  - 627 Iraq
  - 629 Arabian Peninsula (Saudi Arabia, Yemen, People's Democratic Republic of Yemen, (Southern Yemen), United Arab Emirates (Trucial States), Aden, Bahrain, Kuwait, Oman and Muscat, Qatar)
  - 631 Israel and former Jewish Palestine
  - 633 Caucasian Republics of the U.S.S.R. (Georgia, Armenia, Azerbaijan)

- 634 Other Asian Republics of the U.S.S.R. (Kazakh S.S.R., Kirghiz S.S.R., Tadzhik S.S.R., Turkmen S.S.R., Uzbek, S.S.R.)
- 637 Iran (Persia)
- 638 Afghanistan
- 639 Pakistan (West Pakistan)

640 Mid-East

- 641 India
- 643 Nepal, Bhutan, Sikkim
- 645 Bangladesh (East Pakistan)
- 647 Ceylon (Sri Lanka)
- 649 Burma

650 Southeast Asia

- 651 Thailand (Siam)

660 Indochina

- 661 Laos
- 663 Cambodia
- 665 Vietnam (Tonkin, Annam, Cochin China)
- 671 Malaysia, Singapore, Brunei
- 673 Indonesia (Dutch East Indies)
- 675 Philippines (Philippine Islands)

680 East Asia

- 681 China (not otherwise specified)
- 682 China (People's Republic of China)
- 683 Hong Kong
- 684 Taiwan (Formosa) (Republic of China)
- 685 Tibet
- 686 Macao (Macau)

691 Mongolia

693 Japan

695 Korea (North and South)

Australia and Oceania

711 Australia and Australian New Guinea

715 New Zealand

720 Pacific Islands

- 721 Melanesian Islands*
- 723 Micronesian Islands*
- 725 Polynesian Islands*

Place of Birth Unknown

998 Place of birth stated not to be in the United States, but no other information available

999 Place of birth unknown

*Except possessions of the United States.

Geocodes

Alphabetical List

A

585 Abyssinia
629 Aden
583 Afars and Issas
638 Afghanistan
500 Africa
570 Africa, East
510 Africa, North
540 Africa, South
545 Africa, South West
530 Africa, West
037 Alabama
091 Alaska
481 Albania
224 Alberta
513 Algeria
250 America, Central
___ America, North (use more specific term)
300 America, South
121 American Samoa
641 Andaman Islands
443 Andorra
543 Angola
245 Anguilla
665 Annam
245 Antigua
245 Antilles, Netherlands
625 Arab Palestine
629 Arabia, Saudi
629 Arabian Peninsula
365 Argentina
087 Arizona
071 Arkansas
633 Armenia (U.S.S.R.)
611 Armenia (Turkey)
245 Aruba
600 Asia, NOS
680 Asia, East
640 Asia, Mid-East
610 Asia, Near-East
650 Asia, Southeast
620 Asian-Arab countries
634 Asian Republics of the U.S.S.R., other
109 Atlantic/Caribbean area, other U.S. possessions
100 Atlantic/Caribbean area, U.S. possessions
711 Australia
711 Australian New Guinea
436 Austria
633 Azerbaidzhan S.S.R.
445 Azores

B

247 Bahamas
629 Bahrain
443 Balearic Islands
645 Bangladesh
245 Barbados
245 Barbuda
545 Basutoland
431 Bavaria
545 Bechuanaland
541 Belgian Congo
433 Belgium
252 Belize
539 Benin
246 Bermuda
456 Bessarabia
643 Bhutan
452 Bohemia
355 Bolivia

545 Bophuthatswana
673 Borneo
545 Botswana
341 Brazil
226 British Columbia
331 British Guiana
252 British Honduras
245 British Virgin Islands
671 Brunei
454 Bulgaria
649 Burma
579 Burundi
457 Byelorussian S.S.R.

C

543 Cabinda
245 Caicos Islands
097 California
663 Cambodia
539 Cameroon
220 Canada
110 Canal Zone
443 Canary Islands
122 Canton Islands
545 Cape Colony
445 Cape Verde Islands
245 Caribbean Islands, other
123 Caroline Islands
711 Cartier Islands
633 Caucasian Republics of the U.S.S.R.
245 Cayman Islands
539 Central African Republic
250 Central America
060 Central Midwest States
647 Ceylon
520 Chad
401 Channel Islands (British)
361 Chile
681 China (not otherwise specified)
665 China, Cochin
682 China, People's Republic of
684 China, Republic of
723 Christmas Island
545 Ciskel
665 Cochin China
711 Cocos (Keeling) Islands
311 Colombia
083 Colorado
540 Comoros
226 Columbia, British
022 Columbia, District of
539 Congo-Brazzaville
541 Congo-Leopoldville
541 Congo, Belgian
539 Congo, French
007 Connecticut
124 Cook Islands
441 Corsica
256 Costa Rica
471 Crete
453 Croatia
241 Cuba
245 Curaco
495 Cyprus
517 Cyrenaica
452 Czechoslovakia

D

539 Dahomey
453 Dalmatia
017 Delaware
425 Denmark
022 District of Columbia
583 Djibouti
449 Dobruja
245 Dominica
243 Dominican Republic
673 Dutch East Indies
332 Dutch Guiana

E

570 East Africa
680 East Asia
431 East Germany
673 East Indies, Dutch
645 East Pakistan
345 Ecuador
519 Egypt
410 Eire
254 El Salvador
125 Ellice Islands
122 Enderbury Islands
401 England
539 Equatorial Guinea
585 Eritrea
458 Estonian S.S.R. (Estonia)
585 Ethiopia
499 Europe, NOS
470 Europe, other mainland

F

420 Faeroe Islands
300 Falkland Islands
431 Federal Republic of Germany
539 Fernando Poo
721 Fiji
429 Finland
035 Florida
684 Formosa
721 Fortuna
441 France
539 French Congo
333 French Guiana
725 French Polynesia
583 French Somaliland
245 French West Indies

G

539 Gabon
345 Galapagos Islands
539 Gambia
033 Georgia (U.S.A.)
633 Georgia (U.S.S.R.)
430 Germanic Countries
431 German Democratic Republic
431 Germany
431 Germany, East
431 Germany, Federal Republic of
431 Germany, West
539 Ghana
485 Gibraltar
125 Gilbert Islands
471 Greece
210 Greenland
245 Grenada
245 Grenadines, The
245 Guadeloupe
126 Guam
251 Guatemala
401 Guernsey
331 Guiana, British
332 Guiana, Dutch
333 Guiana, French
539 Guinea
539 Guinea-Bissau
539 Guinea, Equatorial
___ Guinea, New (See New Guinea)
539 Guinea, Portuguese
331 Guyana

H

242 Haiti
099 Hawaii
432 Holland
253 Honduras

252 Honduras, British
683 Hong Kong
475 Hungary

I

421 Iceland
081 Idaho
061 Illinois
641 India
045 Indiana
673 Indies, Dutch East
660 Indochina
673 Indonesia
053 Iowa
637 Iran
627 Iraq
410 Ireland
404 Ireland, Northern
400 Isle of Man
631 Israel
583 Issas
447 Italy
539 Ivory Coast

J

244 Jamaica
423 Jan Mayen
693 Japan
673 Java
401 Jersey
631 Jewish Palestine
127 Johnston Atoll
625 Jordan
453 Jugoslavia

K

539 Kameroon
663 Kampuchea
065 Kansas
634 Kazakh S.S.R.
047 Kentucky
575 Kenya
634 Kirghiz S.S.R.
___ Kiribati (code to specific island group)
695 Korea
695 Korea, North
695 Korea, South
629 Kuwait

L

221 Labrador
661 Laos
459 Latvian S.S.R. (Latvia)
623 Lebanon
545 Lesotho
539 Liberia
517 Libya
437 Liechtenstein
128 Line Islands, Southern
461 Lithuanian S.S.R. (Lithuania)
073 Louisiana
434 Luxembourg

M

686 Macao
686 Macau
453 Macedonia
555 Madagascar
445 Madeira Islands
002 Maine
555 Malagasy Republic
551 Malawi
671 Malay Peninsula
671 Malaysia
640 Maldives
520 Mali

491 Malta
224 Manitoba
129 Mariana Islands
221 Maritime Provinces, Canada
131 Marshall Islands
245 Martinique
021 Maryland
005 Massachusetts
520 Mauritania
540 Mauritius
540 Mayotte
490 Mediterranean Islands, other
721 Melanesian Islands
230 Mexico
041 Michigan
723 Micronesian Islands
640 Mid-East Asia
132 Midway Islands
052 Minnesota
240 Miquelon
039 Mississippi
063 Missouri
449 Moldavia (Romania)
456 Moldavian S.S.R. (U.S.S.R)
441 Monaco
691 Mongolia
056 Montana
453 Montenegro
245 Montserrat
452 Moravia
511 Morocco
080 Mountain States
553 Mozambique
629 Muscat

N

545 Namibia
133 Nampo-shoto, Southern
545 Natal
723 Nauru
610 Near-East Asia
067 Nebraska
643 Nepal
432 Netherlands
245 Netherlands Antilles
332 Netherlands Guiana
085 Nevada
221 New Brunswick
725 New Caledonia
001 New England
673 New Guinea, except Australian and North East
711 New Guinea, Australian
711 New Guinea, North East
003 New Hampshire
721 New Hebrides
008 New Jersey
086 New Mexico
011 New York
715 New Zealand
221 Newfoundland
255 Nicaragua
520 Niger
531 Nigeria
715 Niue
711 Norfolk Island
510 North Africa
___ North America (use more specific term)
240 North American islands
671 North Borneo (Malaysia)
025 North Carolina
040 North Central States
054 North Dakota
711 North East New Guinea
695 North Korea
010 North Mid-Atlantic States
404 Northern Ireland
129 Northern Mariana Islands

050 Northern Midwest States
549 Northern Rhodesia
225 Northwest Territories (Canada)
423 Norway
998 Not United States, NOS
221 Nova Scotia
551 Nyasaland

O

043 Ohio
075 Oklahoma
629 Oman
223 Ontario
545 Orange Free State
095 Oregon
403 Orkney Islands

P

120 Pacific area, U.S. Possessions
090 Pacific Coast States
720 Pacific Islands
___ Pacific Islands, Trust Territory of the (code to specific islands)
639 Pakistan
645 Pakistan, East
639 Pakistan, West
625 Palestine, Arab
631 Palestine, Jewish
257 Panama
711 Papua New Guinea
371 Paraguay
014 Pennsylvania
629 People's Democratic Republic of Yemen
682 People's Republic of China
637 Persia
351 Peru
675 Philippine Islands
675 Philippines
725 Pitcairn
451 Poland
725 Polynesian Islands
445 Portugal
539 Portuguese Guinea
224 Prarie Provinces, Canada
221 Prince Edward Island
543 Principe
101 Puerto Rico

Q

629 Qatar
222 Quebec

R

684 Republic of China
545 Republic of South Africa
540 Reunion
006 Rhode Island
547 Rhodesia
549 Rhodesia, Northern
547 Rhodesia, Southern
539 Rio Muni
440 Romance-language Countries
449 Romania
449 Roumania
577 Ruanda
449 Rumania
455 Russia
455 Russia S.F.S.R.
457 Russian, White
577 Rwanda
134 Ryukyu Islands

S

520 Sahara, Western
121 Samoa, American
725 Samoa, Western

245 St. Christopher-Nevis
540 St. Helena
245 St. Lucia
240 St. Pierre
245 St. Vincent
447 San Marino
543 Sao Tome
447 Sardinia
224 Saskatchewan
629 Saudi Arabia
420 Scandinavia
403 Scotland
539 Senegal
453 Serbia
540 Seychelles
403 Shetland Islands
651 Siam
447 Sicily
539 Sierra Leone
643 Sikkim
671 Singapore
450 Slavic countries
453 Slavonia
452 Slovakia
453 Slovenia
721 Solomon Islands
581 Somali Republic
581 Somalia
581 Somaliland
583 Somaliland, French
540 South Africa
545 South Africa, Republic of
545 South Africa, Union of
300 South America
026 South Carolina
055 South Dakota
020 South Mid-Atlantic States
545 South West Africa
650 Southeast Asia
030 Southeastern States
128 Southern Line Islands
070 Southern Midwest States
133 Southern Nampo-shoto
547 Southern Rhodesia
629 Southern Yemen
___ Soviet Union (see individual republics)
443 Spain
520 Spanish Sahara
647 Sri Lanka
520 Sudan
520 Sudanese Countries
673 Sumatra
332 Surinam
423 Svalbard
135 Swan Islands
545 Swaziland
427 Sweden
435 Switzerland
621 Syria

T

634 Tadzhik S.S.R.
684 Taiwan
571 Tanzania
571 Tanzanyika
571 Tanganyika
031 Tennessee
077 Texas
651 Thailand
685 Tibet
245 Tobago
539 Togo
136 Tokelau Islands
725 Tonga
665 Tonkin
625 Trans-Jordan
545 Transkei
545 Transvaal

449 Transylvania
245 Trinidad
517 Tripoli
517 Tripolitania
629 Trucial States
515 Tunisia
611 Turkey
634 Turkmen S.S.R.
245 Turks Islands
125 Tuvalu

U

573 Uganda
456 Ukraine
456 Ukrainian S.S.R.
404 Ulster
545 Union of South Africa
___ Union of Soviet Socialist Republics (U.S.S.R.) (see individual republics)
629 United Arab Emirates
519 United Arab Republic
400 United Kingdom
000 United States
102 U.S. Virgin Islands
999 Unknown
520 Upper Volta
375 Uruguay
579 Urundi
084 Utah
634 Uzbek S.S.R.

V

721 Vanuatu
440 Vatican City
545 Venda
321 Venezuela
004 Vermont
665 Vietnam
245 Virgin Islands (British)
102 Virgin Islands (U.S.)
023 Virginia

W

137 Wake Island
402 Wales
449 Wallachia
721 Wallis
093 Washington (state)
022 Washington, D.C.
530 West Africa
431 West Germany
___ West Indies (see individual islands)
639 West Pakistan
024 West Virginia
520 Western Sahara
725 Western Samoa
457 White Russia
051 Wisconsin
082 Wyoming

Y

629 Yemen
629 Yemen, People’s Democratic Republic of
453 Yugoslavia
225 Yukon Territory

Z

541 Zaire
549 Zambia
571 Zanzibar
547 Zimbabwe

Appendix D
Cancer-Directed Surgical Codes

Oral Cavity

Lip C00.0–C00.9, Base of Tongue C01.9, Other Parts of Tongue C02.0–C02.9, Gum C03.0–C03.9, Floor of Mouth C04.0–C04.9, Palate C05.0–C05.9, Other Parts of Mouth C06.0–C06.9

Surgical Approach

Code

0 None; no cancer-directed surgery of primary site

1 Endoscopy, NOS
- 2 Not image guided
- 3 Image guided

4 Open, NOS
- 5 Not assisted by endoscopy
- 6 Assisted by endoscopy

9 Unknown; not stated; death certificate **only**

Surgery of Primary Site

Code

00 None; no cancer-directed surgery of primary site

10 Local tumor destruction, NOS (**without pathology specimen**)
- 11 Photodynamic therapy (PDT)*
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery

14 Laser

No specimen sent to pathology from this surgical event.

Procedures in codes 20-27 include, but are not limited to:
- Shave
- Wedge resection

20 Local tumor excision, NOS (**with pathology specimen**)
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision
- 26 Polypectomy
- 27 Excisional biopsy

*PDT: Exposing photo-sensitive drugs to specific wave lengths of light in the presence of oxygen causing drug to become cytotoxic.

Oral Cavity (Continued)

Specimen sent to pathology from this surgical event.

Procedures in code 30 include, but are not limited to:
Hemiglossectomy
Partial glossectomy

30 Wide excision, NOS

Procedures in codes 40-43 include, but are not limited to:
Radical glossectomy

40 Radical excision of tumor, NOS
- 41 Radical excision of tumor **only**
- 42 Combination of 41 **with** en bloc mandibulectomy (marginal, segmental, hemi-, or total)
- 43 Combination of 41 **with** en bloc maxillectomy (partial, subtotal, total)

90 Surgery, NOS

99 Unknown if cancer-directed surgery performed; death certificate **only**

Surgical Margins

Code

0 All margins grossly and microscopically negative

1 Margins involved, NOS
- 2 Microscopic involvement
- 5 Macroscopic involvement

7 Margins not documented

8 No cancer-directed surgery of primary site

9 Unknown whether margins were involved or negative; death certificate **only**

Scope of Regional Lymph Node Surgery

Regional cervical lymph nodes are:

Caudal jugular (deep cervical)
Cranial jugular (deep cervical)
Dorsal cervical (superficial cervical)
Medial jugular (deep cervical)
Occipital
Paratracheal (anterior cervical)
Prelaryngeal (anterior cervical)
Retroauricular (mastoid, posterior auricular)
Submandibular (submaxillary)
Submental
Supraclavicular

Oral Cavity (Continued)

Code

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS

2 Neck dissection, NOS
- 3 Selective, limited; nodal sampling; "berry picking"
- 4 Modified/modified radical
- 5 Radical

9 Unknown; not stated; death certificate **only**

Terminology of neck dissection (Robbins et al. 1991):

A radical neck dissection includes the removal of all ipsilateral cervical lymph node groups, i.e., lymph nodes from levels I through V (submental, submandibular, cranial jugular, medial jugular, caudal jugular, dorsal cervical nodes along the accessory nerve, and supraclavicular), and removal of the spinal accessory nerve, internal jugular vein and sternocleidomastoid muscle.

In a modified radical neck dissection the same lymph nodes are removed as in a radical neck dissection; however, one or more non lymphatic structures are preserved.

A selective neck dissection preserves one or more lymph node groups routinely removed in radical neck dissection.

Number of Regional Lymph Nodes Removed

Code

00 No regional lymph nodes removed
01 One regional lymph node removed
02 Two regional lymph nodes removed
..
90 Ninety or more regional lymph nodes removed
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate **only**

Oral Cavity (Continued)

Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)

Code

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
- 2 Other regional site(s)
  - 3 Mandibulectomy (marginal, segmental, hemi-, or total)
  - 4 Maxillectomy (partial, subtotal, or total)

Code a mandibulectomy or a maxillectomy in this field only if the procedure is **not** a part of an en bloc resection of the primary tumor. If the mandibulectomy or maxillectomy **is** a part of an en bloc resection of the primary tumor, code under Surgery of Primary Site.

- 5 Distant lymph node(s)
- 6 Distant site(s)
- 7 Combination of 6 **with** 2, 3, 4, or 5

9 Unknown; not stated; death certificate **only**

Reconstruction/Restoration–First Course

Code

0 No reconstruction/restoration

1 Flaps, grafts, or any type of "plasty," NOS
- 2 **without** implant/prosthesis
- 3 **with** implant/prosthesis

8 Reconstruction/restoration recommended, unknown if performed

9 Unknown; not stated; death certificate **only**

Parotid and Other Unspecified Glands

Parotid Gland C07.9, Major Salivary Glands C08.0–C08.9

Surgical Approach

Code

0 None; no cancer-directed surgery of primary site

4 Open

9 Death certificate **only**

Surgery of Primary Site

Code

00 None; no cancer-directed surgery of primary site

10 Local tumor destruction, NOS (**without pathology specimen**)
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from this surgical event.

20 Local tumor excision, NOS (**with pathology specimen**)
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision
- 26 Polypectomy
- 27 Excisional biopsy

Specimen sent to pathology from this surgical event.

30 Less than total parotidectomy, NOS
- 31 Facial nerve spared
- 32 Facial nerve sacrificed
- 33 Superficial lobe **only**
  - 34 Facial nerve spared
  - 35 Facial nerve sacrificed
- 36 Deep lobe (**with** or **without** superficial lobe)
  - 37 Facial nerve spared
  - 38 Facial nerve sacrificed

40 Total parotidectomy, NOS
- 41 Facial nerve spared
- 42 Facial nerve sacrificed

Parotid and Other Unspecified Glands (Continued)

50 Radical parotidectomy, NOS
- 51 **without** removal of temporal bone
- 52 **with** removal of temporal bone

80 Parotidectomy, NOS

90 Surgery, NOS

99 Unknown if cancer-directed surgery performed; death certificate **only**

Surgical Margins

Code

0 All margins grossly and microscopically negative

1 Margins involved, NOS
- 2 Microscopic involvement
- 5 Macroscopic involvement

7 Margins not documented

8 No cancer-directed surgery of primary site

9 Unknown whether margins were involved or negative; death certificate **only**

Scope of Regional Lymph Node Surgery

Regional cervical lymph nodes are:

Buccal (facial)
Caudal jugular (deep cervical)
Cranial jugular (deep cervical)
Dorsal cervical (superficial cervical)
Medial jugular (deep cervical)
Occipital
Paratracheal (anterior cervical)
Parotid
Prelaryngeal (anterior cervical)
Retroauricular (mastoid, posterior auricular)
Retropharyngeal
Submandibular (submaxillary)
Submental
Supraclavicular

Parotid and Other Unspecified Glands (Continued)

Code

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS

2 Neck dissection, NOS
- 3 Selective, limited; nodal sampling; "berry picking"
- 4 Modified/modified radical
- 5 Radical

9 Unknown; not stated; death certificate **only**

Terminology of neck dissection (Robbins et al. 1991):

A radical neck dissection includes the removal of all ipsilateral cervical lymph node groups, i.e., lymph nodes from levels I through V (submental, submandibular, cranial jugular, medial jugular, caudal jugular, dorsal cervical nodes along the accessory nerve, and supraclavicular), and removal of the spinal accessory nerve, internal jugular vein and sternocleidomastoid muscle.

In a modified radical neck dissection, the same lymph nodes are removed as in a radical neck dissection; however, one or more nonlymphatic structures are preserved.

A selective neck dissection preserves one or more lymph node groups routinely removed in radical neck dissection.

Number of Regional Lymph Nodes Removed

Code

00 No regional lymph nodes removed
01 One regional lymph node removed
02 Two regional lymph nodes removed
..
90 Ninety or more regional lymph nodes removed
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate **only**

Parotid and Other Unspecified Glands (Continued)

Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)

Code

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
- 2 Other regional sites
- 3 Distant lymph node(s)
- 4 Distant site(s)
- 5 Combination of 4 **with** 2 or 3

9 Unknown; not stated; death certificate **only**

Reconstruction/Restoration–First Course

Code

0 No reconstruction/restoration

1 Flaps, grafts, or any type of "plasty," NOS
- 2 **without** implant/prosthesis
- 3 **with** implant/prosthesis

8 Reconstruction/restoration recommended, unknown if performed

9 Unknown; not stated; death certificate **only**

Pharynx

Tonsil C09.0–C09.9, Oropharynx C10.0–C10.9, Nasopharynx C11.0–C11.9, Pyriform Sinus C12.9, Hypopharynx C13.0–C13.9, Pharynx C14.0

Surgical Approach

Code

0 None; no cancer-directed surgery of primary site

1 Endoscopy, NOS
- 2 Not image guided
- 3 Image guided

4 Open, NOS
- 5 Not assisted by endoscopy
- 6 Assisted by endoscopy

9 Unknown; not stated; death certificate **only**

Surgery of Primary Site

Code

00 None; no cancer-directed surgery of primary site

10 Local tumor destruction, NOS (**without pathology specimen**)
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Stripping

No specimen sent to pathology from this surgical event.

20 Local tumor excision, NOS (**with pathology specimen**)
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision
- 26 Polypectomy
- 27 Excisional biopsy

Specimen sent to pathology from this surgical event.

30 Pharyngectomy, NOS
- 31 Limited/partial pharyngectomy
- 32 Total pharyngectomy

Pharynx (Continued)

40 Pharyngectomy **with** mandibulectomy (marginal, segmental, hemi-) and/or **with** laryngectomy, NOS
- 41 **with** laryngectomy (laryngopharyngectomy)
- 42 **with** mandibulectomy
- 43 **with** both 41 and 42

50 Radical pharyngectomy (includes total mandibular resection), NOS
- 51 **without** laryngectomy
- 52 **with** laryngectomy

90 Surgery, NOS

99 Unknown if cancer-directed surgery performed; death certificate **only**

Surgical Margins

Code

0 All margins grossly and microscopically negative

1 Margins involved, NOS
- 2 Microscopic involvement
- 5 Macroscopic involvement

7 Margins not documented

8 No cancer-directed surgery of primary site

9 Unknown whether margins were involved or negative; death certificate **only**

Scope of Regional Lymph Node Surgery

Regional cervical lymph nodes are:

Buccal (facial)
Caudal jugular (deep cervical)
Cranial jugular (deep cervical)
Dorsal cervical (superficial cervical)
Medial jugular (deep cervical)
Occipital
Paratracheal (anterior cervical)
Parotid
Prelaryngeal (anterior cervical)
Retroauricular (mastoid, posterior auricular)
Retropharyngeal
Submandibular (submaxillary)
Submental
Supraclavicular

Pharynx (Continued)

Code

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS
- 2 Neck dissection, NOS
  - 3 Selective, limited; nodal sampling; "berry picking"
  - 4 Modified/modified radical
  - 5 Radical

9 Unknown; not stated; death certificate **only**

Number of Regional Lymph Nodes Removed

Code

00 No regional lymph nodes removed
01 One regional lymph node removed
02 Two regional lymph nodes removed
..
90 Ninety or more regional lymph nodes removed
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate **only**

Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)

Code

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
- 2 Laryngectomy **only**
- 3 Mandibulectomy **only** (marginal, segmental, or hemi-)
- 4 Combination of 2 and 3
- 5 Removal of other regional sites
- 6 Combination of 5 with 2-4
- 7 Removal of other distant sites(s) or distant lymph node(s)
- 8 Combination of 7 **with** any of 2-6

9 Unknown; not stated; death certificate **only**

Pharynx (Continued)

Reconstruction/Restoration–First Course

Code only the following reconstructive procedures:

Myocutaneous flaps (pectoralis major, trapezius)
Reconstruction of mandible
Regional flaps

Code

0 No reconstruction/restoration

1 Reconstruction/restoration, NOS
- 2 **without** implant/prosthesis
- 3 **with** implant/prosthesis

8 Reconstruction/restoration recommended, unknown if performed

9 Unknown; not stated; death certificate **only**

Esophagus

C15.0–C15.9

Surgical Approach

Code

0 None; no cancer-directed surgery of primary site

Endoscopy procedures include:
Esophagoscopy
Mediastinoscopy
Thoracoscopy

1 Endoscopy, NOS
- 2 Not image guided
- 3 Image guided

4 Open, NOS
- 5 Trans-hiatal
- 6 Thoracotomy (includes split sternum)
- 7 Laparotomy

9 Unknown; not stated; death certificate **only**

Surgery of Primary Site

Code

00 None; no cancer-directed surgery of primary site

10 Local tumor destruction, NOS (**without pathology specimen**)
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from this surgical event.

20 Local tumor excision, NOS (**with pathology specimen**)
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision
- 26 Polypectomy
- 27 Excisional biopsy

Specimen sent to pathology from this surgical event.

30 Partial esophagectomy

Esophagus (Continued)

40 Total esophagectomy

50 Partial esophagectomy **with** laryngectomy and/or gastrectomy, NOS
- 51 **with** laryngectomy
- 52 **with** gastrectomy, NOS
  - 53 Partial gastrectomy
  - 54 Total gastrectomy
- 55 Combination of 51 **with** any of 52-54

60 Total esophagectomy, NOS **with** laryngectomy and/or gastrectomy, NOS
- 61 **with** laryngectomy
- 62 **with** gastrectomy, NOS
  - 63 Partial gastrectomy
  - 64 Total gastrectomy
- 65 Combination of 61 **with** any of 62-64

70 Esophagectomy, NOS **with** pharyngectomy and laryngectomy

80 Esophagectomy, NOS

90 Surgery, NOS

99 Unknown if cancer-directed surgery performed; death certificate **only**

Surgical Margins

Code

0 All margins grossly and microscopically negative

1 Margins involved, NOS
- 2 Microscopic involvement
- 5 Macroscopic involvement

7 Margins not documented

8 No cancer-directed surgery of primary site

9 Unknown whether margins were involved or negative; death certificate **only**

Esophagus (Continued)

Scope of Regional Lymph Node Surgery

Regional lymph nodes are different for each anatomical subsite. The following list identifies nodes classified as regional for each subsite.

Cervical esophagus

Cervical, NOS
Internal jugular
Periesophageal
Scalene
Supraclavicular
Upper cervical

Intrathoracic esophagus (upper, middle, lower)

Carinal
Hilar (pulmonary roots)
Internal jugular
Mediastinal, NOS
Paracardial
Periesophageal
Perigastric
Peritracheal
Superior mediastinal
Tracheobronchial

Code

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS

9 Unknown; not stated; death certificate **only**

Celiac nodes are distant for intrathoracic esophagus. Code removal of celiac nodes in the data item Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s).

Number of Regional Lymph Nodes Removed

Code

00 No regional lymph nodes removed
01 One regional lymph node removed
02 Two regional lymph nodes removed
..
90 Ninety or more regional lymph nodes removed
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate **only**

Esophagus (Continued)

Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)

Code

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
- 2 Other regional sites
- 3 Distant lymph node(s)
- 4 Distant site(s)
- 5 Combination of 4 **with** 2 or 3

9 Unknown; not stated; death certificate **only**

Reconstruction/Restoration–First Course

Code only the following procedures as reconstructive:

Endoluminal stents
Endoprosthesis
Esophageal stents
Esophagogastric fundoplasty
Esophagogastrostomy (cardioplasty)
Esophagojejunostomy
Esophagomyotomy
Esophagoplasty (plastic repair or reconstruction)
Esophagoplasty/**with**/**without** repair of a tracheoesophageal fistula
Esophagostomy
Gastropharyngostomy
Interposition of remaining esophagus with stomach using large or small bowel
Self expanding metal vynal
Stent placement in conjunction with cancer-directed surgery

Code

0 No reconstruction/restoration

1 Reconstruction/restoration, NOS
- 2 **without** implant/prosthesis
- 3 **with** implant/prosthesis

8 Reconstruction/restoration recommended, unknown if performed

9 Unknown; not stated; death certificate **only**

Stomach

C16.0–C16.9

Surgical Approach

Code

0 None; no cancer-directed surgery of primary site

Endoscopy procedures include:
Esophago-/gastro-/duodeno-/jejuno-scopy
Gastroscopy
Laparoscopy

1 Endoscopy, NOS
- 2 Not image guided
- 3 Image guided

4 Open, NOS
- 5 Not assisted by endoscopy
- 6 Assisted by endoscopy

9 Unknown; not stated; death certificate **only**

Surgery of Primary Site

Code

00 None; no cancer-directed surgery of primary site

10 Local tumor destruction, NOS (**without pathology specimen**)
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from this surgical event.

20 Local tumor excision, NOS (**with pathology specimen**)
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision
- 26 Polypectomy
- 27 Excisional biopsy

Specimen sent to pathology from this surgical event.

Stomach (Continued)

Code 30, partial gastrectomy, includes a sleeve resection of the stomach.
Billroth I: anastomosis to duodenum (duodenostomy)
Billroth II: anastomosis to jejunum (jejunostomy)

30 Gastrectomy, NOS (partial, subtotal, hemi-)
31 Antrectomy, lower (distal)

Resection of less than 40% of stomach

32 Lower (distal) gastrectomy (partial, subtotal, hemi-)
33 Upper (proximal) gastrectomy (partial, subtotal, hemi-)

40 Near-total or total gastrectomy

A total gastrectomy may follow a previous partial resection of the stomach.

50 Gastrectomy, NOS **with** removal of a portion of esophagus
51 Partial or subtotal gastrectomy
52 Near total or total gastrectomy

60 Gastrectomy **with** en bloc resection of other organs, NOS
61 Partial or subtotal gastrectomy **with** en bloc resection
62 Near total or total gastrectomy **with** en bloc resection (near total = 80% resection)
63 Radical gastrectomy **with** en bloc resection

En bloc resection is the removal of organs in one piece at one time and may include an omentectomy.

80 Gastrectomy, NOS

90 Surgery, NOS

99 Unknown if cancer-directed surgery performed; death certificate **only**

Surgical Margins

Code

0 All margins grossly and microscopically negative

1 Margins involved, NOS
2 Microscopic involvement
5 Macroscopic involvement

7 Margins not documented

8 No cancer-directed surgery of primary site

9 Unknown whether margins were involved or negative; death certificate **only**

Stomach (Continued)

Scope of Regional Lymph Node Surgery

The regional lymph nodes are:

Greater Curvature of Stomach
- Gastroduodenal
- Gastroepiploic, left
- Gastroepiploic, right or NOS
- Greater omental
- Greater curvature
- Pancreaticoduodenal (anteriorly along the first part of duodenum)
- Pyloric, including subpyloric and infrapyloric

Pancreatic and Splenic Area
- Pancreaticolienal
- Peripancreatic
- Splenic hilum

Lesser Curvature of Stomach
- Cardioesophageal
- Celiac
- Common hepatic
- Hepatoduodenal
- Left gastric
- Lesser omental
- Lesser curvature
- Paracardial; cardial
- Perigastric, NOS

Code

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS

9 Unknown; not stated; death certificate **only**

Number of Regional Lymph Nodes Removed

Code

00 No regional lymph nodes removed
01 One regional lymph node removed
02 Two regional lymph nodes removed
..
90 Ninety or more regional lymph nodes removed
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate **only**

Stomach (Continued)

Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)

Do not code the incidental removal of gallbladder, bile ducts, appendix, or vagus nerve. Incidental removal is when an organ is removed for a reason unrelated to the malignancy (gallbladder removed for obvious cholelithiasis).

Code

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
- 2 Removal of other regional sites, **only**
- 3 Removal of distant node(s)
- 4 Removal of distant site
- 5 Combination of 2 **with** 3 and/or 4

9 Unknown; not stated; death certificate **only**

Reconstruction/Restoration–First Course

Code

0 No reconstruction/restoration

1 Gastrostomy
- 2 **without** reservoir/pouch
- 3 **with** reservoir/pouch (abdominal)

9 Unknown; not stated; death certificate **only**

Colon

C18.0–C18.9

Surgical Approach

Code

0 None; no cancer-directed surgery of primary site

Endoscopy procedures include:
Colonoscopy
Laparoscopy
Sigmoidoscopy

1 Endoscopy, NOS
- 2 Not image guided
- 3 Image guided

4 Open, NOS
- 5 Not assisted by endoscopy
- 6 Assisted by endoscopy

9 Unknown; not stated; death certificate **only**

Surgery of Primary Site

Code removal/surgical ablation of single or multiple liver metastases under the data item Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s).

Code

00 None; no cancer-directed surgery of primary site

10 Local tumor destruction, NOS (**without pathology specimen**)
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from this surgical event.

20 Local tumor excision, NOS (**with pathology specimen**)
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision
- 26 Polypectomy
- 27 Excisional biopsy

Specimen sent to pathology from this surgical event.

Colon (Continued)

Procedures coded 30-31 include, but are not limited to:
Appendectomy (for an appendix primary only)
Enterocolectomy
Ileocolectomy
Partial colectomy, NOS
Partial resection of transverse colon and flexures
Segmental resection, e.g., cecectomy
Sigmoidectomy

30 Partial colectomy, but less than hemicolectomy
31 Partial colectomy **with** permanent colostomy (Hartmann's operation)

Also code colostomy in the data item Reconstruction/Restoration.

40 Hemicolectomy or greater (but less than total); right or left colectomy

A hemicolectomy is the removal of total right or left colon and a portion of transverse colon.

50 Total colectomy

Removal of colon from cecum to the rectosigmoid or a portion of the rectum.

60 Total proctocolectomy

Commonly used for familial polyposis or polyposis coli.

70 Colectomy or coloproctectomy **with** an en bloc resection of other organs; pelvic exenteration

Code 70 includes any colectomy (partial, hemicolectomy, or total) **with** an en bloc resection of any other organs. The other organs may be partially or totally removed. Procedures that may be a **part of an en bloc resection** include, but are not limited to: oophorectomy, partial proctectomy, rectal mucosectomy

En bloc resection is the removal of organs in one piece at one time.

The creation of ileal reservoir which is a part of a pelvic exenteration **must also be coded** in the data item Reconstruction/Restoration.

80 Colectomy, NOS

90 Surgery, NOS

99 Unknown if cancer-directed surgery performed; death certificate **only**

Colon (Continued)

Surgical Margins

Code

0 All margins grossly and microscopically negative

1 Margins involved, NOS
- 2 Microscopic involvement
- 5 Macroscopic involvement

7 Margins not documented

8 No cancer-directed surgery of primary site

9 Unknown whether margins were involved or negative; death certificate **only**

Scope of Regional Lymph Node Surgery

The pathology report often describes regional lymph nodes by their anatomic location: colic nodes; mesenteric nodes; peri-\epi-\para-\ colic. Regional lymph nodes differ for each anatomical subsite. The following list identifies the regional lymph nodes for each subsite of the colon.

Cecum and appendix

Anterior cecal
Ileocolic
Posterior cecal
Right colic

Ascending colon

Ileocolic
Middle colic
Right colic

Hepatic flexure

Middle colic
Right colic

Transverse colon

Middle colic

Splenic flexure

Inferior mesenteric
Middle colic
Left colic

Descending colon

Inferior mesenteric
Left colic
Sigmoid

Sigmoid colon

Inferior mesenteric
Sigmoid mesenteric
Sigmoidal
Superior rectal (hemorrhoidal)

Colon (Continued)

Superior mesenteric, external iliac and common iliac nodes are distant lymph nodes. Code the removal of any of these nodes in the data item Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s).

Code

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS

9 Unknown; not stated; death certificate **only**

Number of Regional Lymph Nodes Removed

Code

00 No regional lymph nodes removed
01 One regional lymph node removed
02 Two regional lymph nodes removed
..
90 Ninety or more regional lymph nodes removed
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate **only**

Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)

Do not code the incidental removal of appendix, gallbladder, bile ducts, or spleen. Incidental removal is when an organ is removed for a reason unrelated to the malignancy (gallbladder removed for obvious cholelithiasis).

Code

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
- 2 Removal of other regional site(s), **only**
- 3 Removal/surgical ablation of single liver metastasis
- 4 Removal/surgical ablation of multiple liver metastases
- 5 Combination of codes 2 and 3 or 2 and 4
- 6 Removal of other distant site(s) or distant lymph node(s), **only**
- 7 Combination of code 6 **with** 3 or 5
- 8 Combination of code 6 **with** 4

9 Unknown; not stated; death certificate **only**

Colon (Continued)

Reconstruction/Restoration–First Course

Do not code anastomosis as reconstruction.

Code

0 No reconstruction/restoration

1 Colostomy (permanent)

2 Ileostomy, NOS
- 3 **without** a reservoir or pouch
- 4 **with** an abdominal reservoir or pouch
- 5 **with** an anal reservoir or pouch; artificial sphincter

9 Unknown; not stated; death certificate **only**

Rectosigmoid

C19.9

Surgical Approach

Code

0 None; no cancer-directed surgery of primary site

1 Endoscopy, NOS (includes laparoscopic)

4 Open, NOS
- 5 Transanal
- 6 Posterior; coccygeal; trans-sacral; abdominosacral
- 7 Low anterior (LAR)
- 8 Abdominal perineal (AP)

9 Unknown; not stated; death certificate **only**

Surgery of Primary Site

Code removal/surgical ablation of single or multiple liver metastases under the data item Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s).

Code

00 None; no cancer-directed surgery of primary site

10 Local tumor destruction, NOS (**without pathology specimen**)
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser ablation

No specimen sent to pathology from this surgical event.

20 Local tumor excision, NOS (**with pathology specimen**)
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision
- 26 Polypectomy
- 27 Excisional biopsy

Specimen sent to pathology from this surgical event.

Rectosigmoid (Continued)

Procedures coded 30 include, but are not limited to:
- Anterior resection
- Hartmann's operation
- Low anterior resection
- Partial colectomy, NOS
- Rectosigmoidectomy, NOS
- Sigmoidectomy

30 Wedge or segmental resection; partial proctosigmoidectomy, NOS

Also code the colostomy the in the data item Reconstruction/Restoration.

Procedures coded 40 include but are not limited to:
- Altemeier's operation
- Duhamel's operation
- Soave's submucosal resection
- Swenson's operation
- Turnbull's operation

40 Pull through **with** sphincter preservation (colo-anal anastomosis)

Procedures coded 50 include but are not limited to:
- Abdominoperineal resection (A & P resection)
- Anterior/posterior resection (A/P resection)/Miles' operation
- Rankin's operation

50 Total proctectomy
51 Total colectomy

Removal of the colon from cecum to the rectosigmoid or a portion of the rectum

60 Combination of 50 and 51

70 Colectomy or proctocolectomy **with** an en bloc resection of other organs; pelvic exenteration

En bloc resection is the removal of organs in one piece at one time. Procedures that may be a part of an en bloc resection include, but are not limited to: an oophorectomy and a rectal mucosectomy.

Code 70 includes any colectomy (partial, hemicolectomy, or total) **with** an en bloc resection of any other organs. The other organs may be partially or totally removed.

An **ileal reservoir** which is part of a pelvic exenteration should be coded in the data item Reconstruction/Restoration.

80 Colectomy, NOS; Proctectomy, NOS

90 Surgery, NOS

99 Unknown if cancer-directed surgery performed; death certificate **only**

Rectosigmoid (Continued)

Surgical Margins

Code

0 All margins grossly and microscopically negative

1 Margins involved, NOS
- 2 Microscopic involvement
- 5 Macroscopic involvement

7 Margins not documented

8 No cancer-directed surgery of primary site

9 Unknown whether margins were involved or negative; death certificate **only**

Scope of Regional Lymph Node Surgery

The pathology report often identifies regional lymph nodes by their anatomic location: colic; mesenteric; peri-/para-/ colic; perirectal; rectal.

The specific regional lymph nodes are:

Inferior mesenteric
Left colic
Middle rectal (hemorrhoidal)
Perirectal
Sigmoid mesenteric
Sigmoidal
Superior rectal (superior hemorrhoidal)

Superior mesenteric, external iliac and common iliac nodes are distant nodes. Code removal of these nodes under the data item Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s).

Code

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS

9 Unknown; not stated; death certificate **only**

Rectosigmoid (Continued)

Number of Regional Lymph Nodes Removed

Code

00 No regional lymph nodes removed
01 One regional lymph node removed
02 Two regional lymph nodes removed
..
90 Ninety or more regional lymph nodes removed
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate **only**

Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)

Do not code the incidental removal of appendix, gallbladder, or bile ducts. Incidental removal is when an organ is removed for a reason unrelated to the malignancy (gallbladder removed for obvious cholelithiasis).

Code

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
- 2 Removal of other regional site(s), **only**
- 3 Removal/surgical ablation of single liver metastasis
- 4 Removal/surgical ablation of multiple liver metastases
- 5 Combination of codes 2 and 3 or 2 and 4
- 6 Removal of other distant site(s) or distant lymph node(s), **only**
- 7 Combination of code 6 **with** 3, 4 or 5
- 8 Combination of code 6 **with** 3 or 5

9 Unknown; death certificate **only**

Reconstruction/Restoration–First Course

Code

0 No reconstruction/restoration

1 Colostomy (permanent)

2 Ileostomy, NOS
- 3 **without** a reservoir or pouch
- 4 **with** an abdominal reservoir or pouch
- 5 **with** an anal reservoir or pouch; artificial sphincter

9 Unknown; not stated; death certificate **only**

Rectum

C20.9

Surgical Approach

Code

0 None; no cancer-directed surgery of primary site

1 Endoscopy, NOS (includes laparoscopy)

4 Open, NOS
- 5 Transanal (Kraske, York-Mason)
- 6 Posterior; coccygeal; trans-sacral; abdominosacral
- 7 Low anterior (LAR)
- 8 Abdominal perineal (AP)

9 Unknown; not stated; death certificate **only**

Surgery of Primary Site

Code removal/surgical ablation of single or multiple liver metastases under the data item Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s).

Code

00 None; no cancer-directed surgery of primary site

10 Local tumor destruction, NOS (**without pathology specimen**)
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from this surgical event.

20 Local tumor excision, NOS (**with pathology specimen**)
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision
- 26 Polypectomy
- 27 Excisional biopsy
- 28 Curette and fulguration

Specimen sent to pathology from this surgical event.

Rectum (Continued)

Procedures coded 30 include, but are not limited to:
- Anterior resection
- Hartmann's operation
- Low anterior resection (LAR)
- Trans-sacral rectosigmoidectomy

30 Wedge or segmental resection; partial proctectomy, NOS

Procedures coded 40 include but are not limited to:
- Altemeier's operation
- Duhamel's operation
- Soave's submucosal resection
- Swenson's operation
- Turnbull's operation

40 Pull through **with** sphincter preservation (colo-anal anastomosis)

Procedures coded 50 include but are not limited to:
- Abdominoperineal resection (A & P resection)
- Anterior/Posterior (A/P) resection/Miles' operation
- Rankin's operation

50 Total proctectomy

60 Total proctocolectomy, NOS

70 Proctectomy or proctocolectomy **with** an en bloc resection of other organs; pelvic exenteration

En bloc resection is the removal of organs in one piece at one time.

The creation of an ileal reservoir, which is a part of a pelvic exenteration, should be coded in the data item Reconstruction/Restoration.

80 Proctectomy, NOS

90 Surgery, NOS

99 Unknown if cancer-directed surgery performed; death certificate **only**

Rectum (Continued)

Surgical Margins

Code

0 All margins grossly and microscopically negative

1 Margins involved, NOS
- 2 Microscopic involvement
- 5 Macroscopic involvement

7 Margins not documented

8 No cancer-directed surgery of primary site

9 Unknown whether margins were involved or negative; death certificate **only**

Scope of Regional Lymph Node Surgery

The pathology report often identifies regional lymph nodes by their anatomic location: mesenteric nodes; perirectal nodes; rectal nodes.

The specific regional lymph nodes are:

Inferior rectal (hemorrhoidal)
Inferior mesenteric
Internal iliac
Lateral sacral
Middle rectal (hemorrhoidal)
Perirectal
Presacral
Sacral promontory (Gerota's)
Sigmoid mesenteric
Superior rectal (hemorrhoidal)

Superior mesenteric, external iliac and common iliac nodes are classified as distant lymph nodes. Code removal of these nodes under the data item Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s).

Code

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS

9 Unknown; not stated; death certificate **only**

Rectum (Continued)

Number of Regional Lymph Nodes Removed

Code

00 No regional lymph nodes removed
01 One regional lymph node removed
02 Two regional lymph nodes removed
..
90 Ninety or more regional lymph nodes removed
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate **only**

Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)

Do not code the incidental removal of appendix, gallbladder, bile ducts, or spleen. Incidental removal is when an organ is removed for a reason unrelated to the malignancy (gallbladder removed for obvious cholelithiasis).

Code

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
- 2 Removal of other regional site(s), **only**
- 3 Removal/surgical ablation of single liver metastasis
- 4 Removal/surgical ablation of multiple liver metastases
- 5 Combination of codes 2 with 3 or 2 with 4
- 6 Removal of other distant site(s) or distant lymph node(s), **only**
- 7 Combination of code 6 **with** 3, 4 or 5
- 8 Combination of code 6 **with** 3 or 5

9 Unknown; death certificate **only**

Reconstruction/Restoration–First Course

Code

0 No reconstruction/restoration

1 Colostomy (permanent)

2 Ileostomy, NOS
- 3 **without** a reservoir or pouch
- 4 **with** an abdominal reservoir or pouch
- 5 **with** an anal reservoir or pouch; artificial sphincter

9 Unknown; not stated; death certificate **only**

Anus

C21.0–C21.8

Surgical Approach

Code

0 None; no cancer-directed surgery of primary site

1 Endoscopy, NOS
- 2 Not image guided
- 3 Image guided

4 Open, NOS
- 5 Not assisted by endoscopy
- 6 Assisted by endoscopy

9 Unknown; not stated; death certificate **only**

Surgery of Primary Site

Code

00 None; no cancer-directed surgery of primary site

Procedures for codes 10-14 include, but are not limited to:
- Cryosurgery
- Electrocautery
- Excisional biopsy
- Laser
- Thermal ablation

10 Local tumor destruction, NOS (**without pathology specimen**)
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from this surgical event.

20 Local tumor excision, NOS (**with pathology specimen**)
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision
- 26 Polypectomy
- 27 Excisional biopsy

Specimen sent to pathology from this surgical event. Margins of resection may have microscopic involvement.

Anus (Continued)

60 Abdominal perineal resection, NOS

90 Surgery, NOS

99 Unknown if cancer-directed surgery performed; death certificate **only**

Surgical Margins

Code

0 All margins grossly and microscopically negative

1 Margins involved, NOS
- 2 Microscopic involvement
- 5 Macroscopic involvement

7 Margins not documented

8 No cancer-directed surgery of primary site

9 Unknown whether margins were involved or negative; death certificate **only**

Scope of Regional Lymph Node Surgery

Code

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS
- 2 Perirectal, anorectal lymph nodes
- 3 Internal iliac lymph nodes (hypogastric), unilateral
- 4 Inguinal lymph nodes, unilateral
- 5 Combination of 2 and 4
- 6 Bilateral internal iliac and/or bilateral inguinal lymph nodes

9 Unknown; not stated; death certificate **only**

Number of Regional Lymph Nodes Removed

Code

00 No regional lymph nodes removed
01 One regional lymph node removed
02 Two regional lymph nodes removed
..
90 90 or more regional lymph nodes removed
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate **only**

Anus (Continued)

Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)

Code

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
- 2 Other regional sites
- 3 Distant lymph node(s)
- 4 Distant site(s)
- 5 Combination of 4 **with** 2 or 3

9 Unknown; not stated; death certificate **only**

Reconstruction/Restoration–First Course

Code

0 No reconstruction/restoration

1 Colostomy (permanent)

2 Ileostomy, NOS
- 3 **without** a reservoir or pouch
- 4 **with** an abdominal reservoir or pouch
- 5 **with** an anal reservoir or pouch; artificial sphincter

9 Unknown; not stated; death certificate **only**

Liver and Intrahepatic Bile Ducts

C22.0–C22.1

Surgical Approach

Code

0 None; no cancer-directed surgery of primary site

1 Endoscopy **only**, NOS (laparoscopy)
- 2 Not image guided
- 3 Image guided

4 Open, NOS
- 5 Not assisted by endoscopy
- 6 Assisted by endoscopy

9 Unknown; not stated; death certificate **only**

Surgery of Primary Site

Code

00 None; no cancer-directed surgery of primary site

10 Local tumor destruction, NOS
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Alcohol (PEI)
- 16 Heat
- 17 Other (ultrasound, acetic acid)

20 Wedge resection, NOS; segmental resection

30 Lobectomy, NOS
- 31 Simple
- 32 Extended

Extended lobectomy: resection of a single lobe plus a segment of another lobe.

40 Excision of a bile duct (for an intrahepatic bile duct primary only)

70 Total hepatectomy with transplant

Liver transplant must also be coded under the data item Reconstruction/Restoration.

80 Hepatectomy, NOS

90 Surgery, NOS

99 Unknown if cancer-directed surgery performed; death certificate **only**

Liver and Intrahepatic Bile Ducts (Continued)

Surgical Margins

Code

0 All margins grossly and microscopically negative

1 Margins involved, NOS
- 2 Microscopic involvement
- 5 Macroscopic involvement

7 Margins not documented

8 No cancer-directed surgery of primary site

9 Unknown whether margins were involved or negative; death certificate **only**

Scope of Regional Lymph Node Surgery

Regional lymph nodes are the hilar nodes:

Along the portal vein
Along the inferior vena cava
Along the proper hepatic artery
At the hepatic pedicle

Code

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS

9 Unknown; not stated; death certificate **only**

Number of Regional Lymph Nodes Removed

Code

00 No regional lymph nodes removed
01 One regional lymph node removed
02 Two regional lymph nodes removed
..
90 Ninety or more regional lymph nodes removed
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate **only**

Liver and Intrahepatic Bile Ducts (Continued)

Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)

Code

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
- 2 Other regional sites
- 3 Distant lymph node(s) (includes inferior phrenic lymph nodes)
- 4 Distant site(s)
- 5 Combination of 4 **with** 2 or 3

9 Unknown; not stated; death certificate **only**

Reconstruction/Restoration–First Course

Code

0 No reconstruction/restoration

1 Rioux-en-Y; hepatojejunostomy including stent

2 Liver transplant

9 Unknown; not stated; death certificate **only**

Pancreas

C25.0–C25.9

Surgical Approach

Code

0 None; no cancer-directed surgery of primary site

1 Endoscopy, NOS (laparoscopy)
- 2 Not image guided
- 3 Image guided

4 Open, NOS
- 5 Not assisted by endoscopy
- 6 Assisted by endoscopy

9 Unknown; not stated; death certificate **only**

Surgery of Primary Site

Code

00 None; no cancer-directed surgery of primary site

10 Local excision of tumor, NOS

20 Partial pancreatectomy, NOS

40 Total pancreatectomy

50 Local or partial pancreatectomy and duodenectomy
- 51 Without subtotal gastrectomy
- 52 With subtotal gastrectomy (Whipple)

60 Total pancreatectomy and subtotal gastrectomy or duodenectomy

70 Extended pancreatoduodenectomy

80 Pancreatectomy, NOS

90 Surgery, NOS

99 Unknown if cancer-directed surgery performed; death certificate **only**

Pancreas (Continued)

Surgical Margins

Code

0 All margins grossly and microscopically negative

1 Margins involved, NOS
- 2 Microscopic involvement
- 5 Macroscopic involvement

7 Margins not documented

8 No cancer-directed surgery of primary site

9 Unknown whether margins were involved or negative; death certificate **only**

Scope of Regional Lymph Node Surgery

The regional lymph nodes are:

Celiac (head only)
Hepatic artery
Infrapyloric (head only)
Lateral aortic
Pancreaticolienal (body and tail only)
Peripancreatic (superior, inferior, anterior, posterior splenic)
Retroperitoneal
Splenic (body and tail only)
Subpyloric (head only)
Superior mesenteric

Code

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS

2 Extended lymphadenectomy

An extended pancreaticoduodenectomy incorporates selected aspects of the Whipple procedure and regional pancreatectomy. A wide Kocher maneuver removes all lymphatic tissue over the medical aspect of the right kidney, inferior vena cava, and left renal vein.

9 Unknown; not stated; death certificate **only**

Pancreas (Continued)

Number of Regional Lymph Nodes Removed

Code

00 No regional lymph nodes removed
01 One regional lymph node removed
02 Two regional lymph nodes removed
..
90 Ninety or more regional lymph nodes removed
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate **only**

Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)

Code

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
- 2 Removal of other regional sites, **only**
- 3 Removal of distant node(s)
- 4 Removal of distant site
- 5 Combination of 2 **with** 3 and/or 4

9 Unknown; not stated; death certificate **only**

Reconstruction/Restoration–First Course

Code

9 Not applicable (There are no known reconstructive procedures for this site.)

Larynx

C32.0–C32.9

Surgical Approach

Code

0 None; no cancer-directed surgery of primary site

1 Endoscopy, NOS
- 2 Not image guided
- 3 Image guided

4 Open, NOS
- 5 Not assisted by endoscopy
- 6 Assisted by endoscopy

9 Unknown; not stated; death certificate **only**

Surgery of Primary Site

Code

00 None; no cancer-directed surgery of primary site

10 Local tumor destruction, NOS (**without pathology specimen**)
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 Stripping

No specimen sent to pathology from this surgical event.

20 Local tumor excision, NOS (**with pathology specimen**)
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision
- 26 Polypectomy
- 27 Excisional biopsy
- 28 Stripping

Specimen sent to pathology from this surgical event.

30 Partial excision of the primary site, NOS; subtotal/partial laryngectomy NOS; hemilaryngectomy NOS
- 31 Vertical laryngectomy
- 32 Anterior commissure laryngectomy
- 33 Supraglottic laryngectomy

Larynx (Continued)

40 Total or radical laryngectomy, NOS
- 41 Total laryngectomy **only**
- 42 Radical laryngectomy **only**

50 Pharyngolaryngectomy

80 Laryngectomy, NOS

90 Surgery, NOS

99 Unknown if cancer-directed surgery performed; death certificate **only**

Surgical Margins

Code

0 All margins grossly and microscopically negative

1 Margins involved, NOS
- 2 Microscopic involvement
- 5 Macroscopic involvement

7 Margins not documented

8 No cancer-directed surgery of primary site

9 Unknown whether margins were involved or negative; death certificate **only**

Scope of Regional Lymph Node Surgery

The regional cervical lymph nodes are:

Buccal (facial)
Caudal jugular (deep cervical)
Cranial jugular (deep cervical)
Dorsal cervical (superficial cervical)
Medial jugular (deep cervical)
Occipital
Paratracheal (anterior cervical)
Parotid
Prelaryngeal (anterior cervical)
Retroauricular (mastoid, posterior auricular)
Retropharyngeal
Submandibular (submaxillary)
Submental
Supraclavicular

Larynx (Continued)

Code

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS
- 2 Neck dissection, NOS
  - 3 Selective, limited; nodal sampling; "berry picking"
  - 4 Modified/modified radical
  - 5 Radical

9 Unknown; not stated; death certificate **only**

Terminology of neck dissection (Robbins et al. 1991):

A radical neck dissection includes the removal of all ipsilateral cervical lymph node groups, i.e., lymph nodes from levels I through V (submental, submandibular, cranial jugular, medial jugular, caudal jugular, dorsal cervical nodes along the accessory nerve, and supraclavicular), and removal of the spinal accessory nerve, internal jugular vein and sternocleidomastoid muscle.

In a modified radical neck dissection the same lymph nodes are removed as in a radical neck dissection; however, one or more nonlymphatic structures are preserved.

A selective neck dissection preserves one or more lymph node groups routinely removed in radical neck dissection.

Number of Regional Lymph Nodes Removed

Code

00 No regional lymph nodes removed
01 One regional lymph node removed
02 Two regional lymph nodes removed
..
90 Ninety or more regional lymph nodes removed
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate **only**

Larynx (Continued)

Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)

Code

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
- 2 Other regional sites
- 3 Distant lymph node(s)
- 4 Distant site(s)
- 5 Combination of 4 **with** 2 or 3

9 Unknown; not stated; death certificate **only**

Reconstruction/Restoration–First Course

Code

0 No reconstruction/restoration

1 Flaps, grafts, or any "plastys," NOS
- 2 **without** implant/prosthesis
- 3 **with** implant/prosthesis

8 Reconstruction/restoration recommended, unknown if performed

9 Unknown; not stated; death certificate **only**

Lung

C34.0–C34.9

Surgical Approach

Code

0 None; no cancer-directed surgery of primary site

1 Endoscopy, NOS
- 2 Bronchoscopy
- 3 Mediastinoscopy
- 4 Thoracoscopy

5 Open, NOS (thoracotomy, sternotomy)
- 6 Not assisted by endoscopy
- 7 Assisted by endoscopy

9 Unknown; not stated; death certificate **only**

Surgery of Primary Site

Code

00 None; no cancer-directed surgery of primary site

10 Local tumor destruction or excision, NOS
- 11 Excision
- 12 Laser ablation or excision
- 13 Cautery; fulguration
- 14 Bronchial sleeve resection **only**

20 Resection of less than one lobe
- 21 Wedge resection
- 22 Segmental resection, including lingulectomy

30 Resection of at least one lobe, but less than the whole lung (partial pneumonectomy, NOS)
- 31 Lobectomy
- 32 Bilobectomy

Procedures coded 40 include, but are not limited to:
- Complete pneumonectomy
- Pneumonectomy, NOS
- Sleeve pneumonectomy
- Standard pneumonectomy
- Total pneumonectomy

40 Resection of whole lung

Lung (Continued)

50 Resection of lung **with** an en bloc resection of other organs
- 51 Wedge resection
- 52 Lobectomy
- 53 Bilobectomy
- 54 Pneumonectomy (less than a radical or extended pneumonectomy)

En bloc resection is the removal of organs in one piece at one time.

60 Radical pneumonectomy

Radical pneumonectomy is a complete pneumonectomy **with** removal of mediastinal lymph nodes. Removal of mediastinal nodes is also coded in the data fields Scope of Regional Lymph Node Surgery and Number of Regional Lymph Nodes Removed.

70 Extended radical pneumonectomy

An extended radical pneumonectomy is a radical pneumonectomy (including removal of mediastinal nodes) and the removal of other tissues or nodes. Removal of mediastinal nodes is also coded in the data fields Scope of Regional Lymph Node Surgery and Number of Regional Lymph Nodes Removed.

80 Resection of lung, NOS

90 Surgery, NOS

99 Unknown if cancer-directed surgery performed; death certificate **only**

Surgical Margins

Code

0 All margins grossly and microscopically negative

1 Margins involved, NOS
- 2 Microscopic involvement
- 5 Macroscopic involvement

7 Margins not documented

8 No cancer-directed surgery of primary site

9 Unknown whether margins were involved or negative; death certificate **only**

Lung (Continued)

Scope of Regional Lymph Node Surgery

Mediastinal nodes are:

Aortic (includes subaortic, aorticopulmonary window, periaortic, including ascending aorta or including azygos)
Periesophageal
Peritracheal (including those that may be designated tracheobronchial, i.e., lower peritracheal, phrenic)
Pre- and retrotracheal (includes precarinal)
Pulmonary ligament
Subcarinal

Code

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS
- 2 Intrapulmonary (includes interlobar, lobar, segmental), ipsilateral hilar and/or ipsilateral peribronchial nodes
- 3 Ipsilateral mediastinal and/or subcarinal nodes
- 4 Combination of 2 and 3
- 5 Contralateral mediastinal, contralateral hilar, ipsilateral or contralateral scalene and/or supraclavicular nodes
- 6 Combination of 5 **with** 2 or 3

9 Unknown; not stated; death certificate **only**

Number of Regional Lymph Nodes Removed

Code

00 No regional lymph nodes removed
01 One regional lymph node removed
02 Two regional lymph nodes removed
..
90 Ninety or more regional lymph nodes removed
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate **only**

Lung (Continued)

Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)

Do not code the incidental removal of ribs. Ribs are removed to provide access to the lung.

Code

0 None; no surgery to other regional sites, distant sites or distant lymph nodes

1 Surgery to other site(s)or node(s), NOS; unknown if regional or distant

2 Surgery to a regional site **only**

3 Removal of a solitary lesion in the same lung (primary site), different (non-primary) lobe

There is one primary. Patient has two tumors with the same histology in different lobes of the same lung.

4 Resection of metastasis in a distant site(s) or resection of distant lymph nodes(s), NOS

5 Removal of a solitary lesion in the contralateral lung

Patient has one primary. There is a primary tumor or tumor(s) in one lung and a solitary metastatic lesion in the contralateral lung.

6 Removal of a solitary lesion in a distant site or a distant lymph node, NOS

This includes, but is not limited to the removal of a solitary metastatic brain lesion.

7 Removal of multiple lesions in distant site(s)

9 Unknown; not stated; death certificate **only**

Reconstruction/Restoration–First Course

Code

0 No reconstruction/restoration

1 Chest wall reconstruction/restoration, NOS

9 Unknown; not stated; death certificate **only**

Bones, Joints, and Articular Cartilage C40.0–C41.9
Peripheral Nerves and Autonomic Nervous System C47.0–C47.9
Connective, Subcutaneous and Other Soft Tissues C49.0–C49.9

Surgical Approach

Code

0 None; no cancer-directed surgery of primary site

1 Endoscopy, NOS
- 2 Not image guided
- 3 Image guided

4 Open, NOS
- 5 Not assisted by endoscopy
- 6 Assisted by endoscopy

9 Unknown; not stated; death certificate **only**

Surgery of Primary Site

Code

00 None; no cancer-directed surgery of primary site

10 Local tumor destruction or excision

20 Partial resection/internal hemipelvectomy (pelvis)

30 Radical excision or resection of lesion with limb salvage

40 Amputation of limb
- 41 Partial amputation of limb
- 42 Total amputation of limb

50 Major amputation, NOS
- 51 Forequarter, including scapula
- 52 Hindquarter, including ilium/hip bone
- 53 Hemipelvectomy

90 Surgery, NOS

99 Unknown if cancer-directed surgery performed; death certificate **only**

Bones, Joints, and Articular Cartilage
Peripheral Nerves and Autonomic Nervous System
Connective, Subcutaneous and Other Soft Tissues (Continued)

Surgical Margins

Code

0 All margins grossly and microscopically negative

1 Margins involved, NOS
- 2 Microscopic involvement
- 5 Macroscopic involvement

7 Margins not documented

8 No cancer-directed surgery of primary site

9 Unknown whether margins were involved or negative; death certificate **only**

Scope of Regional Lymph Node Surgery

Code

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS

9 Unknown; not stated; death certificate **only**

Number of Regional Lymph Nodes Removed

Code

00 No regional lymph nodes removed
01 One regional lymph node removed
02 Two regional lymph nodes removed
..
90 Ninety or more regional lymph nodes removed
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate **only**

Bones, Joints, and Articular Cartilage
Peripheral Nerves and Autonomic Nervous System
Connective, Subcutaneous and Other Soft Tissues (Continued)

Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)

Code

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
- 2 Other regional site(s)
- 5 Distant lymph node(s)
- 6 Distant site(s)
- 7 Combination of 6 **with** 2 or 5

9 Unknown; not stated; death certificate **only**

Reconstruction/Restoration–First Course

Code

0 No reconstruction/restoration

1 Flap, graft, or any "plasty," NOS
- 2 **without** implant/prosthesis
- 3 **with** implant/prosthesis

8 Reconstruction/restoration recommended, unknown if performed

9 Unknown; not stated; death certificate **only**

Spleen and Lymph Nodes

Spleen C42.2, Lymph Nodes C77.0–C77.9

Surgical Approach

Code

0 None; no cancer-directed surgery of primary site

1 Endoscopy, NOS
- 2 Not image guided
- 3 Image guided

4 Open, NOS
- 5 Not assisted by endoscopy
- 6 Assisted by endoscopy

9 Unknown; not stated; death certificate **only**

Surgery of Primary Site

Code

00 None; no cancer-directed surgery of primary site

10 Local excision, destruction, NOS

20 Splenectomy, NOS
- 21 Partial splenectomy
- 22 Total splenectomy

30 Lymph node dissection, NOS
- 31 One chain
- 32 Two or more chains

40 Lymph node dissection, NOS plus splenectomy
- 41 One chain
- 42 Two or more chains

50 Lymph node dissection, NOS and partial/total removal of adjacent organ(s)
- 51 One chain
- 52 Two or more chains

60 Lymph node dissection, NOS and partial/total removal of adjacent organ(s) **plus** splenectomy
- 61 One chain
- 62 Two or more chains

90 Surgery, NOS

99 Unknown if cancer-directed surgery performed; death certificate **only**

Spleen and Lymph Nodes (Continued)

Surgical Margins

Code

0 All margins grossly and microscopically negative

1 Margins involved, NOS
- 2 Microscopic involvement
- 5 Macroscopic involvement

7 Margins not documented

8 No cancer-directed surgery of primary site

9 Unknown whether margins were involved or negative; death certificate **only**

Scope of Regional Lymph Node Surgery

Note: Spleen only. For lymphomas, code this field as 9

Code

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS

9 Unknown; not stated; death certificate **only**

Number of Regional Lymph Nodes Removed

Note: Spleen only. For lymphomas, code this field to 99.

Code

00 No regional lymph nodes removed
01 One regional lymph node removed
02 Two regional lymph nodes removed
..
90 Ninety or more regional lymph nodes removed
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate **only**

Spleen and Lymph Nodes (Continued)

Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)

Code

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
- 2 Other regional site(s)
- 5 Distant lymph node(s)
- 6 Distant site(s)
- 7 Combination of 6 **with** 2 or 5

9 Unknown; not stated; death certificate **only**

Reconstruction/Restoration–First Course

Code

9 At this time, reconstructive procedures are not being collected for these sites

Skin

C44.0–C44.9

Surgical Approach

Code

0 None; no cancer-directed surgery of primary site

4 Open approach

9 Death certificate **only**

Surgery of Primary Site

Code

00 None; no cancer-directed surgery of primary site

10 Local tumor destruction, NOS **(without pathology specimen)**
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery

14 Laser ablation

No specimen sent to pathology from this surgical event.

20 Local tumor excision, NOS (**with pathology specimen**)
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision
- 26 Polypectomy
- 27 Excisional biopsy

Specimen sent to pathology from this surgical event.

30 Biopsy of primary tumor followed by a gross excision of the lesion
- 31 Shave biopsy followed by a gross excision of the lesion
- 32 Punch biopsy followed by a gross excision of the lesion
- 33 Incisional biopsy followed by a gross excision of the lesion

Less than a wide excision, less than 1 cm margin.

Skin (Continued)

40 Wide excision or reexcision of lesion or minor (local) amputation, NOS

Margins of excision are 1 cm or more. Margins may be microscopically involved. Local amputation is the surgical resection of digits, ear, eyelid, lip, or nose.

50 Radical excision of a lesion, NOS

Margins of excision are greater than 1 cm and grossly tumor free. The margins may be microscopically involved.

60 Major amputation, NOS

90 Surgery, NOS

99 Unknown if cancer-directed surgery performed; death certificate **only**

Surgical Margins

Code

0 All margins grossly and microscopically negative

1 Margins involved, NOS
- 2 Microscopic involvement
- 5 Macroscopic involvement

7 Margins not documented

8 No cancer-directed surgery of primary site

9 Unknown whether margins were involved or negative; death certificate **only**

Scope of Regional Lymph Node Surgery

Regional lymph nodes are different for each anatomical subsite.

Head, neck	Cervical, ipsilateral preauricular, submandibular, and supraclavicular
Thorax	Ipsilateral axillary
Arm	Ipsilateral epitrochlear and axillary
Abdomen, loins, and buttocks	Ipsilateral inguinal
Anal margin and perianal skin	Ipsilateral inguinal
Leg	Ipsilateral inguinal and popliteal

Skin (Continued)

There are boundary zones between the subsites (i.e., between the thorax and arm, the boundary zone is the shoulder and axilla). The boundary zones do not belong to either subsite. If a tumor originates in one of these 4 cm boundary zones, the nodes on either side of the bands are regional.

Between the subsites		**The boundary zone is**
Head and neck **and**	Thorax	Clavicula-acromion-upper shoulder blade edge
Thorax **and**	Arm	Shoulder-axilla-shoulder
Thorax **and**	Abdomen, loins, and buttocks	Front: Middle between navel and costal arch Back: Lower border of thoracic vertebrae (midtransverse axis)
Abdomen, loins, and buttock **and**	Leg	Groin-trochanter-gluteal sulcus
Right **and**	Left	Midline

Iliac, other pelvic, abdominal or intrathoracic lymph nodes are distant. Code the removal of these nodes under the data item, Surgery of Other Regional Site(s), Distant Site(s), or Distant Node(s).

Code

0 No regional lymph nodes removed

1 Sentinel node, NOS

A sentinel node is the first node to receive drainage from a primary tumor. It is identified by an injection of a dye or radio label at the site of the primary tumor

2 Regional lymph nodes removed, NOS

9 Unknown; not stated; death certificate **only**

Number of Regional Lymph Nodes Removed

Code

00 No regional lymph nodes removed
01 One regional lymph node removed
02 Two regional lymph nodes
..
90 Ninety or more regional lymph nodes removed
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate **only**

Skin (Continued)

Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)

Code

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
- 2 Other regional sites
- 3 Distant lymph node(s)
- 4 Distant site(s)
- 5 Combination of 4 **with** 2 or 3

9 Unknown; not stated; death certificate **only**

Reconstruction/Restoration–First Course

Code

0 No reconstruction/restoration

1 Pedicle flap, free flap, skin graft, NOS

8 Reconstruction/restoration recommended, unknown if performed

9 Unknown; not stated; death certificate **only**

Breast

C50.0–C50.9

Surgical Approach

Code

0 None; no cancer-directed surgery of primary site

4 Open approach, NOS
- 5 **without** dye or needle localization
- 6 **with** dye or needle localization

9 Death certificate **only**

Surgery of Primary Site

Code

00 None; no cancer-directed surgery of primary site

Procedures coded as 10-17 remove the gross primary tumor and some of the breast tissue (breast-conserving or preserving). There may be microscopic residual tumor.

10 Partial mastectomy, NOS; less than total mastectomy, NOS
- 11 Nipple resection
- 12 Lumpectomy or excisional biopsy
- 13 Reexcision of the biopsy site (usually for gross or microscopic residual disease)
- 14 Wedge resection
- 15 Quadrantectomy
- 16 Segmental mastectomy
- 17 Tylectomy

30 Subcutaneous mastectomy

A subcutaneous mastectomy is the removal of breast tissue without the nipple and areolar complex or overlying skin. **This procedure is rarely performed to treat malignancies.**

40 Total (simple) mastectomy, NOS
- 41 **without** removal of uninvolved contralateral breast
- 42 **with** removal of uninvolved contralateral breast

A simple mastectomy removes all breast tissue, the nipple, and areolar complex. An axillary dissection is not done.

For single primaries only, code removal of involved contralateral breast under the data item Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s).

Breast (Continued)

50 Modified radical mastectomy
- 51 **without** removal of uninvolved contralateral breast
- 52 **with** removal of uninvolved contralateral breast

Removes all breast tissue, the nipple, the areolar complex, and variable amounts of breast skin. The procedure involves an en bloc resection of the axilla. The specimen may or may not include a portion of the pectoralis major muscle. Includes an en bloc axillary dissection.

For single primaries only, code removal of involved contralateral breast under the data item Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s).

60 Radical mastectomy, NOS
- 61 **without** removal of uninvolved contralateral breast
- 62 **with** removal of uninvolved contralateral breast

Removal of breast tissue, nipple, areolar complex, a variable amount of skin, pectoralis minor, and pectoralis major. Includes an en bloc axillary dissection.

For single primaries only, code removal of involved contralateral breast under the data item Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s).

70 Extended radical mastectomy
- 71 **without** removal of uninvolved contralateral breast
- 72 **with** removal of uninvolved contralateral breast

Removal of breast tissue, nipple, areolar complex, variable amounts of skin, pectoralis minor, and pectoralis major. Includes removal of internal mammary nodes and an en bloc axillary dissection.

For single primaries only, code removal of involved contralateral breast under the data item Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s).

80 Mastectomy, NOS

90 Surgery, NOS

99 Unknown if cancer-directed surgery performed; death certificate **only**

Surgical Margins

Since the codes are hierarchical, if more than one code is applicable, use the numerically higher code. For example, if multiple margins are microscopically and macroscopically involved, code the macroscopic involvement(s).

Multiple margins are two separate margins, both of which are microscopically involved with tumor. **Do not code** multiple margins (4) if **one margin** has multiple foci of tumor.

Breast (Continued)

Code

0 All margins grossly and microscopically negative

1 Margins involved, NOS
- 2 Microscopic involvement
  - 3 Single margin
  - 4 Multiple margins
- 5 Macroscopic involvement

7 Margins not documented

8 No cancer-directed surgery of primary site

9 Unknown whether margins were involved or negative; death certificate **only**

Scope of Regional Lymph Node Surgery

Code

0 No regional lymph nodes removed

1 Sentinel lymph node(s) removed

A sentinel node is the first node to receive drainage from a primary tumor. It is identified by an injection of a dye or radio label at the site of the primary tumor

2 Regional lymph node(s) removed, NOS; axillary, NOS (Levels I, II, or III lymph nodes) Intramammary, NOS
- 3 Combination of 1 and 2
- 4 Internal mammary
- 5 Combination of 4 **with** any of 1-3

9 Unknown; not stated; death certificate **only**

Number of Regional Lymph Nodes Removed

Code

00 No regional lymph nodes removed
01 One regional lymph node removed
02 Two regional lymph nodes removed
..
90 Ninety or more regional lymph nodes removed
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate **only**

Breast (Continued)

Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)

Do not code removal of fragments or tags of muscles; removal of the pectoralis minor; the resection of pectoralis muscles, NOS; or the resection of fascia with no mention of muscle.

Code

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
- 2 Other regional site(s)
- 3 Distant lymph node(s)
- 4 Distant site(s)
  - 5 Removal of involved contralateral breast (single primary only)
- 6 Combination of 4 or 5 **with** 2 or 3

9 Unknown; not stated; death certificate **only**

Reconstruction/Restoration–First Course

The insertion of a tissue expander is often the beginning of the reconstructive procedure.

Code

0 No reconstruction/restoration

1 Reconstruction, NOS (unknown if flap)
- 2 Implant; reconstruction **without** flap
- 3 Reconstruction **with** flap, NOS
  - 4 Latissimus dorsi flap
  - 5 Abdominus recti flap
  - 6 Flap, NOS + implant
  - 7 Latissimus dorsi flap + implant
  - 8 Abdominus recti + implant

9 Unknown; not stated; death certificate **only**

Cervix Uteri

C53.0–C53.9

Surgical Approach

Code

0 None; no cancer-directed surgery of primary site

1 Vaginal, NOS

2 Not assisted by endoscopy
- 3 Assisted by colposcopy
- 4 Assisted by laparoscopy

5 Open, NOS

6 Not assisted by endoscopy
- 7 Assisted by endoscopy

9 Unknown; not stated; death certificate **only**

Surgery of Primary Site

For invasive cancers, dilation and curettage is coded as an incisional biopsy (02) under the data item Non Cancer-Directed Surgery.

Code

00 None; no cancer-directed surgery of primary site

10 Local tumor destruction, NOS **(without pathology specimen)**
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 LEEP

No specimen sent to pathology from this surgical event.

20 Local tumor destruction or excision, NOS (**with pathology specimen**)
- 21 Electrocautery
- 22 Cryosurgery
- 23 Laser
- 24 Cone biopsy **with** gross excision of lesion
- 25 Dilatation and curettage; endocervical curettage (cancer-directed for in situ only)
- 26 Excisional biopsy, NOS
- 27 Cone biopsy
- 28 LEEP
- 29 Trachelectomy; removal of cervical stump; cervicectomy

Specimen sent to pathology from this surgical event.

Cervix Uteri (Continued)

30 Total hysterectomy (simple, pan-) **without** removal of tubes and ovaries

Total hysterectomy removes both the corpus and cervix uteri and may also include a portion of vaginal cuff.

40 Total hysterectomy (simple, pan-) **with** removal of tubes or ovary

Total hysterectomy removes both the corpus and cervix uteri and may also include a portion of vaginal cuff.

50 Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy
- 51 Modified radical hysterectomy
- 52 Extended hysterectomy
- 53 Radical hysterectomy; Wertheim's procedure
- 54 Extended radical hysterectomy

60 Hysterectomy, NOS, **with** or **without** removal of tubes and ovaries
- 61 **without** removal of tubes and ovaries
- 62 **with** removal of tubes and ovaries

70 Pelvic exenteration
- 71 Anterior exenteration

Includes bladder, distal ureters, and genital organs **with** their ligamentous attachments and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s).

- 72 Posterior exenteration

Includes rectum and rectosigmoid **with** ligamentous attachments and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s).

- 73 Total exenteration

Includes removal of all pelvic contents and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s).

- 74 Extended exenteration

Includes pelvic blood vessels or bony pelvis

90 Surgery, NOS

99 Unknown if cancer-directed surgery performed; death certificate **only**

Cervix Uteri (Continued)

Surgical Margins

Code

0 All margins grossly and microscopically negative

1 Margins involved, NOS
- 2 Microscopic involvement
- 5 Macroscopic involvement

7 Margins not documented

8 No cancer-directed surgery of primary site

9 Unknown whether margins were involved or negative; death certificate **only**

Scope of Regional Lymph Node Surgery

The regional lymph nodes are:

Common iliac
External iliac
Hypogastric (obturator)
Internal iliac
Paracervical
Parametrial
Presacral
Sacral

Code

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS

9 Unknown; not stated; death certificate **only**

Number of Regional Lymph Nodes Removed

Code

00 No regional lymph nodes removed
01 One regional lymph node removed
02 Two regional lymph nodes removed
..
90 Ninety or more regional lymph nodes removed
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate **only**

Cervix Uteri (Continued)

Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)

Do not code the incidental removal of an appendix. **Do not code** an omentectomy **if** it was the only surgery performed in addition to hysterectomy. Incidental removal is when an organ is removed for a reason unrelated to the malignancy.

Code

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
- 2 Other regional site(s)
- 3 Distant lymph node(s), NOS
  - 4 Periaortic lymph nodes
- 5 Distant site(s)
- 6 Combinations of 5 with 4
- 7 Combination of 5 **with** 2 or 3

9 Unknown; not stated; death certificate **only**

Reconstruction/Restoration–First Course

Code

0 No reconstruction/restoration

1 Vaginal reconstruction

2 Urinary reconstruction

3 Bowel reconstruction/restoration

4 Combination of 3 with 1 or 2

8 Reconstruction/restoration recommended, unknown if performed

9 Unknown; not stated; death certificate **only**

Corpus Uteri

C54.0–C55.9

Surgical Approach

Code

0 None; no cancer-directed surgery of primary site

1 Vaginal, NOS
- 2 Not assisted by endoscopy
- 3 Assisted by colposcopy
- 4 Assisted by laparoscopy

5 Open, NOS
- 6 Not assisted by endoscopy
- 7 Assisted by endoscopy

9 Unknown; not stated; death certificate **only**

Surgery of Primary Site

For invasive cancers, dilation and curettage is coded as an incisional biopsy (02) under the data item Non Cancer-Directed Surgery.

Code

00 None; no cancer-directed surgery of primary site

10 Local tumor destruction, NOS **(without pathology specimen)**
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser
- 15 LEEP

No specimen sent to pathology from this surgical event.

Procedures in code 20 include but are not limited to:

Cryosurgery
Electrocautery
Excisional biopsy
Laser ablation
Thermal ablation

20 Local tumor destruction or excision, NOS; simple excision, NOS (**with pathology specimen**)
- 21 Electrocautery
- 22 Cryosurgery
- 23 Laser
- 24 Excisional biopsy
- 25 Polypectomy
- 26 Myomectomy

Specimen sent to pathology from this surgical event. Margins of resection may have microscopic involvement.

Corpus Uteri (Continued)

30 Subtotal hysterectomy/supracervical hysterectomy/fundectomy **with** or **without** removal of tube(s) and ovary(ies).
- 31 **without** tube(s) and ovary (ies)
- 32 **with** tube(s) and ovary (ies)

Cervix left in place.

40 Total hysterectomy (simple, pan-) **without** removal of tube(s) and ovary (ies)

Removes both the corpus and cervix uteri. It may also include a portion of the vaginal cuff.

50 Total hysterectomy (simple, pan-) **with** removal of tube(s) or ovary (ies)

Removes both the corpus and cervix uteri. It may also include a portion of the vaginal cuff.

60 Modified radical or extended hysterectomy; radical hysterectomy; extended radical hysterectomy
- 61 Modified radical hysterectomy
- 62 Extended hysterectomy
- 63 Radical hysterectomy; Wertheim's procedure
- 64 Extended radical hysterectomy

70 Hysterectomy, NOS, **with** or **without** removal of tube(s) and ovary(ies)
- 71 **without** removal of tube(s) and ovary(ies)
- 72 **with** removal of tube(s) and ovary(ies)

80 Pelvic exenteration
- 81 Anterior exenteration

Includes bladder, distal ureters, and genital organs **with** their ligamentous attachments and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s).

- 82 Posterior exenteration

Includes rectum and rectosigmoid **with** ligamentous attachments and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s).

- 83 Total exenteration

Includes removal of all pelvic contents and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s).

- 84 Extended exenteration

Includes pelvic blood vessels or bony pelvis

Corpus Uteri (Continued)

90 Surgery, NOS

99 Unknown if cancer-directed surgery performed; death certificate **only**

Surgical Margins

Code

0 All margins grossly and microscopically negative

1 Margins involved, NOS
- 2 Microscopic involvement
- 5 Macroscopic involvement

7 Margins not documented

8 No cancer-directed surgery of primary site

9 Unknown whether margins were involved or negative; death certificate **only**

Scope of Regional Lymph Node Surgery

The regional lymph nodes are:

Common iliac and external iliac
Hypogastric (obturator)
Paraaortic
Parametrial
Sacral

Code

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS
- 2 Pariaortic with or without other regional lymph nodes

9 Unknown; not stated; death certificate **only**

Number of Regional Lymph Nodes Removed

00 No regional lymph nodes removed
01 One regional lymph node removed
02 Two regional lymph nodes removed
..
90 Ninety or more regional lymph nodes removed
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate **only**

Corpus Uteri (Continued)

Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)

Do not code the incidental removal of the appendix or an omentectomy **if** it was the only surgery performed in addition to hysterectomy. Incidental removal is when an organ is removed for a reason unrelated to the malignancy.

Code

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
- 2 Other regional site(s)
- 3 Distant lymph node(s)
- 4 Distant site(s)
- 5 Combination of 4 **with** 2 or 3

9 Unknown; not stated; death certificate **only**

Reconstruction/Restoration–First Course

Code

0 No reconstruction/restoration

1 Vaginal reconstruction

2 Urinary reconstruction

3 Bowel reconstruction/restoration

4 Combination of 3 with 1 or 2

8 Reconstruction/restoration recommended, unknown if performed

9 Unknown; not stated; death certificate **only**

Ovary

C56.9

Surgical Approach

Code

0 None; no cancer-directed surgery of primary site

1 Endoscopy, NOS (laparoscopy)
- 2 Not image guided
- 3 Image guided

Open approaches include, but are not limited to:

Low transverse abdominal incision
Vertical abdominal incision

4 Open, NOS
- 5 Not assisted by endoscopy
- 6 Assisted by endosopy

9 Unknown; not stated; death certificate **only**

Surgery of Primary Site

Code

00 None; no cancer-directed surgery of primary site

10 Total removal of tumor or (single) ovary, NOS
- 11 Resection of ovary (wedge, subtotal, or partial) **only**, NOS; unknown if hysterectomy done
  - 12 **without** hysterectomy
  - 13 **with** hysterectomy
- 14 Unilateral (salpingo-) oophorectomy; unknown if hysterectomy done
  - 15 **without** hysterectomy
  - 16 **with** hysterectomy

20 Bilateral (salpingo-) oophorectomy; unknown if hysterectomy done
- 21 **without** hysterectomy
- 22 **with** hysterectomy

30 Unilateral or bilateral (salpingo-) oophorectomy **with omentectomy**, NOS; partial or total; unknown if hysterectomy done
- 31 **without** hysterectomy
- 32 **with** hysterectomy

Ovary (Continued)

60 Debulking; cytoreductive surgery, NOS
- 61 **with** colon (including appendix) and/or small intestine resection (not incidental)
- 62 **with** partial resection of urinary tract (not incidental)
- 63 Combination of 61 and 62

Debulking is a partial removal of the tumor mass and can involve the removal of multiple organ sites. It may include removal of ovaries and/or the uterus (a hysterectomy). The pathology report may or may not identify ovarian tissue.

A debulking is usually followed by another treatment modality such as chemotherapy.

70 Pelvic exenteration, NOS
- 71 Anterior

Includes bladder, distal ureters, and genital organs **with** their ligamentous attachments and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s).

- 72 Posterior

Includes rectum and rectosigmoid **with** ligamentous attachments and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s).

- 73 Total

Includes removal of all pelvic contents and pelvic lymph nodes. The removal of pelvic lymph nodes is also coded under the data item Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s).

- 74 Extended

Includes pelvic blood vessels or bony pelvis.

80 (Salpingo-) oophorectomy, NOS

90 Surgery, NOS

99 Unknown if cancer-directed surgery performed; death certificate **only**

Ovary (Continued)

Surgical Margins

For this site only, this field will describe the residual tumor burden after cancer-directed surgery.

Code

0 No visible residual tumor

1 Visible residual tumor, NOS
- 2 Visible residual tumor, cumulative maximum of less than 1 cm
- 3 Visible residual tumor, cumulative maximum of at least 1 cm, not more than 2 cm
- 4 Visible residual tumor, cumulative maximum of more than 2 cm

8 No cancer-directed surgery of primary site

9 Unknown whether visible residual tumor was present; death certificate **only**

Scope of Regional Lymph Node Surgery

The regional lymph nodes are:

Common iliac
External iliac
Hypogastric (obturator)
Inguinal
Lateral sacral
Paraaortic
Pelvic, NOS
Retroperitoneal, NOS

Code

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS

9 Unknown; not stated; death certificate **only**

Number of Regional Lymph Nodes Removed

Code

00 No regional lymph nodes removed
01 One regional lymph node removed
02 Two regional lymph nodes removed
..
90 Ninety or more regional lymph nodes removed
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate **only**

Ovary (Continued)

Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)

Do not code an incidental removal of the appendix. Incidental removal is when an organ is removed for a reason unrelated to the malignancy.

Code

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
- 2 Other regional site(s)
- 3 Distant lymph node(s)
- 4 Distant site(s)
- 5 Combination of 4 **with** 2 or 3

9 Unknown; not stated; death certificate **only**

Reconstruction/Restoration–First Course

Code

0 No reconstruction/restoration

1 Urinary reconstruction

2 Bowel reconstruction/restoration

3 Combination of 1 and 2

8 Reconstruction/restoration recommended, unknown if performed

9 Unknown; not stated; death certificate **only**

Prostate

C61.9

Surgical Approach

Code

0 None; no cancer-directed surgery of primary site

1 Endoscopy, NOS (transurethral)

2 Laparoscopic, NOS

3 Open, NOS
- 4 Suprapubic
- 5 Perineal
- 7 Trans-sacral
- 8 Retropubic

Code the approach for radical prostatectomy as retropubic unless otherwise specified.

9 Unknown; not stated; death certificate **only**

Surgery of Primary Site

Do not code an orchiectomy in this field. For prostate primaries, orchiectomies are coded in the field Hormone Therapy.

Code

00 None; no cancer-directed surgery of primary site

10 Local tumor destruction or excision, NOS
- 11 Transurethral resection (TURP), NOS
  - 12 TURP – cancer is incidental finding during surgery for benign disease
  - 13 TURP – patient has suspected/known cancer
- 14 Cryoprostatectomy
- 15 Laser
- 16 Hyperthermia
- 17 Other method of local resection or destruction

30 Subtotal or simple prostatectomy, NOS

A segmental resection or enucleation leaving the capsule intact.

40 Less than total prostatectomy, NOS

An enucleation using an instrument such as a Vapotrode which may leave all or part of the capsule intact.

Prostate (Continued)

50 Radical prostatectomy, NOS; total prostatectomy, NOS

Excised prostate, prostatic capsule, ejaculatory ducts, seminal vesicle(s) and may include a narrow cuff of bladder neck.

70 Prostatectomy **with** en bloc resection of other organs; pelvic exenteration

Surgeries coded 70 are any prostatectomy **with** an en bloc resection of any other organs. The other organs may be partially or totally removed.

En bloc resection is the removal of organs in one piece at one time. Procedures that may involve an en bloc resection include, but are not limited to: cystoprostatectomy, radical cystectomy and prostatectomy.

80 Prostatectomy, NOS

90 Surgery, NOS

99 Unknown if cancer-directed surgery performed; death certificate **only**

Surgical Margins

The codes are hierarchical, if more than one code is applicable, use the numerically higher code. For example, if multiple margins are microscopically and macroscopically involved, code the macroscopic involvement (5).

Multiple margins are two separate margins, both of which are microscopically involved with tumor. **Do not code** multiple margins (4) if one margin has multiple foci of tumor.

Code

0 All margins grossly and microscopically negative

1 Margin(s) involved, NOS
- 2 Microscopic involvement
  - 3 Single margin
  - 4 Multiple margins
- 5 Macroscopic involvement, NOS

7 Margins not documented (TURP)

8 No cancer-directed surgery of primary site

9 Unknown whether margins were involved or negative; death certificate **only**

Prostate (Continued)

Scope of Regional Lymph Node Surgery

The regional lymph nodes are:

Hypogastric
Iliac, NOS (internal and external)
Obturator
Pelvic, NOS
Periprostatic
Sacral, NOS (lateral presacral, promontory [Gerota's] or NOS)

Code

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS

9 Unknown; not stated; death certificate **only**

Number of Regional Lymph Nodes Removed

Code

00 No regional lymph nodes removed
01 One regional lymph node removed
02 Two regional lymph nodes removed
..
90 Ninety or more regional lymph nodes removed
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of nodes unknown /not stated and not documented as sampling or dissection
99 Unknown if regional lymph nodes removed; death certificate **only**

Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)

Do not code orchiectomy. For prostate primaries, code orchiectomies under Hormone Therapy.
The most commonly removed distant lymph nodes are: aortic (paraaortic, periaortic, lumbar), common iliac, inguinal, superficial inguinal (femoral), supraclavicular, cervical, and scalene.

Code

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
- 2 Other regional site(s)
- 3 Distant lymph node(s)
- 4 Distant site(s)
- 5 Combination of 4 **with** 2 or 3

9 Unknown; not stated; death certificate **only**

Prostate (Continued)

Reconstruction/Restoration–First Course

Code

0 No reconstruction/restoration

1 Reconstruction/restoration, NOS
- 2 Collagen injection for incontinence
- 3 Penile prosthesis
- 4 Artificial urinary sphincter
- 5 Combinations of 4 **with** 2 or 3

9 Unknown; not stated; death certificate **only**

Testis

C62.0–C62.9

Surgical Approach

Code

0 None; no cancer-directed surgery of primary site

4 Open, NOS
- 5 Scrotal
- 6 Inguinal

9 Death certificate **only**

Surgery of Primary Site

Code

00 None; no cancer-directed surgery of primary site

10 Local or partial excision of testicle

30 Excision of testicle, NOS **without** cord

40 Excision of testicle, NOS **with** cord/or cord not mentioned

80 Orchiectomy, NOS

90 Surgery, NOS

99 Unknown if cancer-directed surgery performed; death certificate **only**

Surgical Margins

Code

0 All margins grossly and microscopically negative

1 Margins involved, NOS
- 2 Microscopic involvement
- 5 Macroscopic involvement

7 Margins not documented

8 No cancer-directed surgery of primary site

9 Unknown whether margins were involved or negative; death certificate **only**

Scope of Regional Lymph Node Surgery

The regional lymph nodes are:

Interaortocaval
Paraaortic (Periaortic)
Paracaval
Preaortic
Precaval
Retroaortic
Retrocaval

Testis (Continued)

Code

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS; not stated if bilateral or unilateral
- 2 Unilateral regional lymph nodes
- 3 Bilateral regional lymph nodes

9 Unknown; not stated; death certificate **only**

Number of Regional Lymph Nodes Removed

Code

00 No regional lymph nodes removed
01 One regional lymph node removed
02 Two regional lymph nodes removed
..
90 Ninety or more regional lymph nodes removed
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate **only**

Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)

Code

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
- 2 Other regional sites
- 3 Distant lymph node(s)
- 4 Distant site(s)
- 5 Combination of 4 **with** 2 or 3

9 Unknown; not stated; death certificate **only**

Reconstruction/Restoration–First Course

Code

0 No reconstruction/restoration

1 Testicular implant

8 Reconstruction/restoration recommended, unknown if performed

9 Unknown; not stated; death certificate **only**

Kidney, Renal Pelvis, and Ureter

Kidney C64.9, Renal Pelvis C65.9, Ureter C66.9

Surgical Approach

Code

0 None; no cancer-directed surgery of primary site

1 Endoscopy, NOS
- 2 Not image guided
- 3 Image guided

4 Open, NOS
- 5 Not assisted by endoscopy
- 6 Assisted by endoscopy

9 Unknown; not stated; death certificate **only**

Surgery of Primary Site

Code

00 None; no cancer-directed surgery of primary site

10 Local tumor destruction, NOS (**without pathology specimen**)
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from this surgical event.

20 Local tumor excision, NOS (**with pathology specimen**)
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision
- 26 Polypectomy
- 27 Excisional biopsy

Specimen sent to pathology from this surgical event.

Kidney, Renal Pelvis, and Ureter (Continued)

Procedures coded 30 include, but are not limited to:

Cryosurgery
Electrocautery
Excisional biopsy
Laser
Segmental resection
Thermal ablation
Wedge resection

30 Partial or subtotal nephrectomy (kidney or renal pelvis) or partial ureterectomy (ureter)

Margins of resection are grossly negative. There may be microscopic involvement

40 Complete/total/simple nephrectomy–for kidney parenchyma Nephroureterectomy

Includes bladder cuff for renal pelvis or ureter

50 Radical nephrectomy

May include removal of a portion of vena cava, adrenal gland(s), Gerota's fascia, perinephric fat, or partial/total ureter

70 Any nephrectomy (simple, subtotal, complete, partial, simple, total, radical) **plus** an en bloc resection of other organ(s) (colon, bladder)

The other organs, such as colon or bladder, may be partially or totally removed.

80 Nephrectomy, NOS
Ureterectomy, NOS

90 Surgery, NOS

99 Unknown if cancer-directed surgery performed; death certificate **only**

Surgical Margins

Code

0 All margins grossly and microscopically negative

1 Margins involved, NOS
- 2 Microscopic involvement
- 5 Macroscopic involvement

7 Margins not documented

8 No cancer-directed surgery of primary site

9 Unknown whether margins were involved or negative; death certificate **only**

Kidney, Renal Pelvis, and Ureter (Continued)

Scope of Regional Lymph Node Surgery

The regional lymph nodes are:

Kidney
- Aortic (paraaortic, periaortic, lateral aortic)
- Paracaval
- Renal hilar
- Retroperitoneal, NOS

Renal pelvis
- Aortic
- Paracaval
- Renal hilar
- Retroperitoneal, NOS

Ureter
- Iliac (common, internal [hypogastric], external)
- Paracaval
- Pelvic, NOS
- Periureteral
- Renal hilar

Code

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS; not stated if bilateral or unilateral
- 2 Unilateral regional lymph nodes
- 3 Bilateral regional lymph nodes

9 Unknown; not stated; death certificate **only**

Number of Regional Lymph Nodes Removed

Code

00 No regional lymph nodes removed
01 One regional lymph node removed
02 Two regional lymph nodes removed
..
90 Ninety or more regional lymph nodes removed
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown if regional lymph nodes removed; death certificate **only**

Kidney, Renal Pelvis, and Ureter (Continued)

Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)

Do not code the incidental removal of ribs during the operative approach.

Code

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
- 2 Other regional site(s)
- 3 Distant lymph node(s)
- 4 Distant site(s)
- 5 Combination of 4 **with** 2 or 3

9 Unknown; not stated; death certificate **only**

Reconstruction/Restoration–First Course

Code

0 No reconstruction/restoration

1 Kidney transplant (primary site)

8 Reconstruction/restoration recommended, unknown if performed

9 Unknown; not stated; death certificate **only**

Bladder

C67.0–C67.9

Surgical Approach

Code

0 None; no cancer-directed surgery of primary site

1 Endoscopy, NOS
- 2 Cystoscopy (TURB)
- 3 Laparoscopy

4 Open, NOS
- 5 Not assisted by endoscopy (laparoscopy)
- 6 Assisted by endoscopy (laparoscopy)

9 Unknown; not stated; death certificate **only**

Surgery of Primary Site

Code

00 None; no cancer-directed surgery of primary site

10 Local tumor destruction, NOS **(without pathology specimen)**
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from this surgical event.

20 Local tumor excision, NOS (**with pathology specimen**)
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision
- 26 Polypectomy
- 27 Excisional biopsy (TURB)

Specimen sent to pathology from this surgical event.

30 Partial cystectomy

50 Simple/total/complete cystectomy

60 Radical cystectomy (male only)

This code is used only for men. It involves the removal of bladder and prostate, with or without urethrectomy. If a radical cystectomy is the procedure name for a woman, use code 71.

Bladder (Continued)

70 Pelvic exenteration, NOS
71 Radical cystectomy (female only); anterior exenteration

A radical cystectomy in a female includes removal of bladder, uterus, ovaries, entire vaginal wall and entire urethra.

72 Posterior exenteration
73 Total exenteration

Includes removal of all pelvic contents and pelvic lymph nodes.

74 Extended exenteration

Includes pelvic blood vessels or bony pelvis.

80 Cystectomy, NOS

90 Surgery, NOS

99 Unknown if cancer-directed surgery performed; death certificate **only**

Surgical Margins

Code

0 All margins grossly and microscopically negative

1 Margins involved, NOS
2 Microscopic involvement
5 Macroscopic involvement

7 Margins not documented

8 No cancer-directed surgery of primary site

9 Unknown whether margins were involved or negative; death certificate **only**

Scope of Regional Lymph Node Surgery

The regional lymph nodes are:

Hypogastric
Iliac (internal, external, NOS)
Obturator
Pelvic, NOS
Pericystic
Perivesical
Presacral
Sacral (lateral, sacral promontory [Gerota's])

Bladder (Continued)

Code

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS; not stated if bilateral or unilateral
- 2 Unilateral regional lymph nodes
- 3 Bilateral regional lymph nodes

9 Unknown; not stated; death certificate **only**

Number of Regional Lymph Nodes Removed

Code

00 No regional lymph nodes removed
01 One regional lymph node removed
02 Two regional lymph nodes removed
..
90 Ninety or more regional lymph nodes removed
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number o lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate **only**

Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)

Do not code the partial or total removal of a ureter during a cystectomy.

Code

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
- 2 Other regional site(s)
- 3 Distant lymph node(s)
- 4 Distant site(s)
- 5 Combination of 4 **with** 2 or 3

9 Unknown; not stated; death certificate **only**

Bladder (Continued)

Reconstruction/Restoration–First Course

Code

0 No reconstruction/restoration

1 Conduit diversion

2 Continent reservoir (a bladder substitute)

Types of continent reservoirs include, but are not limited to:

Hemi-Kock
Ileal reservoir
Ileocecal reservoir
Indiana or Mainz pouch
Koch
Studer pouch
W-shaped ileoneobladder by Hautmann

8 Reconstruction/restoration recommended, unknown if performed

9 Unknown; not stated; death certificate **only**

Brain and Other Parts of Central Nervous System

Meninges C70.0–C70.9, Brain C71.0–C71.9, Other Parts of Central Nervous System C72.0–C72.9

Surgical Approach

Code

0 None; no cancer-directed surgery of primary site

4 Open

9 Unknown; not stated; death certificate **only**

Surgery of Primary Site

Do not code laminectomiesfor spinal cord primaries.

Code

00 None; no cancer-directed surgery of primary site

10 Local tumor destruction

20 Excision of tumor, lesion, or mass
- 21 Subtotal resection, NOS
- 22 Partial resection
- 23 Debulking

30 Excision of tumor, lesion, or mass, NOS
- 31 Total resection
- 32 Gross resection

40 Partial resection, NOS
- 41 Partial lobe
- 42 Partial meninges
- 43 Partial nerve(s)

50 Total resection (lobectomy of brain)

60 Radical resection

Resection of primary site plus partial or total removal of surrounding organs/tissue

90 Surgery, NOS

99 Unknown if cancer-directed surgery performed; death certificate **only**

Surgical Margins

Code

0 All margins grossly and microscopically negative

1 Margins involved, NOS
- 2 Microscopic involvement
- 5 Macroscopic involvement

7 Margins not documented

8 No cancer-directed surgery of primary site

9 Unknown whether margins were involved or negative; death certificate **only**

Brain and Other Parts of Central Nervous System (Continued)

Scope of Regional Lymph Node Surgery

There are no regional lymph nodes for brain. Code no regional lymph nodes removed (0).

Code

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS

9 Unknown; not stated; death certificate **only**

Number of Regional Lymph Nodes Removed

There are no regional lymph nodes for brain. Code no regional lymph nodes removed (00).

Code

00 No regional lymph nodes removed
01 One regional lymph node removed
02 Two regional lymph nodes removed
..
90 Ninety or more regional lymph nodes removed
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate **only**

Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)

Code

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
- 2 Other regional site(s)
- 5 Distant lymph node(s)
- 6 Distant site(s)
- 7 Combination of 6 **with** 2 or 5

9 Unknown; not stated; death certificate **only**

Reconstruction/Restoration–First Course

Code

9 Not applicable (There are no known reconstructive procedures for this site.)

Thyroid Gland

C73.9

Surgical Approach

Code

0 None; no cancer-directed surgery of primary site

1 Endoscopy, NOS
- 2 Not image guided
- 3 Image guided

4 Open, NOS
- 5 Not assisted by endoscopy
- 6 Assisted by endoscopy

9 Unknown; not stated; death certificate **only**

Surgery of Primary Site

Code

00 None; no cancer-directed surgery of primary site

10 Removal of less than a lobe, NOS
- 11 Local surgical excision
- 12 Removal of a partial lobe **only**

20 Lobectomy and/or isthmectomy
- 21 Lobectomy **only**
- 22 Isthmectomy **only**
- 23 Lobectomy **with** isthmus

30 Removal of a lobe and partial removal of the contralateral lobe

40 Subtotal or near total thyroidectomy

50 Total thyroidectomy

80 Thyroidectomy, NOS

90 Surgery, NOS

99 Unknown if cancer-directed surgery performed; death certificate **only**

Thyroid Gland (Continued)

Surgical Margins

Code

0 All margins grossly and microscopically negative

1 Margins involved, NOS
- 2 Microscopic involvement
- 5 Macroscopic involvement

7 Margins not documented

8 No cancer-directed surgery of primary site

9 Unknown whether margins were involved or negative; death certificate **only**

Scope of Regional Lymph Node Surgery

The regional lymph nodes are the cervical and upper mediastinal lymph nodes.

Terminology of neck dissection (Robbins et al. 19):

A radical neck dissection includes the removal of all ipsilateral cervical lymph node groups, i.e., lymph nodes from levels I through V (submental, submandibular, cranial jugular, medial jugular, caudal jugular, dorsal cervical nodes along the accessory nerve, and supraclavicular), and removal of the spinal accessory nerve, internal jugular vein and sternocleidomastoid muscle.

In a modified radical neck dissection the same lymph nodes are removed as in a radical neck dissection; however, one or more nonlymphatic structures are preserved.

A selective neck dissection preserves one or more lymph node groups routinely removed in radical neck dissection.

Code

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS
- 2 Neck dissection, NOS
  - 3 Selective, limited; nodal sampling; “berry picking”
  - 4 Modified/modified radical
  - 5 Radical

9 Unknown; not stated; death certificate **only**

Thyroid Gland (Continued)

Number of Regional Lymph Nodes Removed

Code

00 No regional lymph nodes removed
01 One regional lymph node removed
02 Two regional lymph nodes removed
..
90 Ninety or more regional lymph nodes removed
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate **only**

Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)

Code

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
- 2 Other regional site(s)
- 3 Distant lymph node(s)
- 4 Distant site(s)
- 5 Combination of 4 **with** 2 or 3

9 Unknown; not stated; death certificate **only**

Reconstruction/Restoration–First Course

Code

9 Not applicable (There are no known reconstructive procedures for this site.)

All Other Sites

C14.1–C14.8, C17.0–C17.9, C23.9, C24.0–C24.9, C26.0–C26.9, C30.0–C30.1, C31.0–C31.9, C33.9, C37.9, C38.0–C38.8, C39.0–C39.9, C42.0–C42.1, C42.3–C42.4, C48.0–C48.8, C51.0C51.9, C52.9, C57.0–C57.9, C58.9, C60.0–C60.9, C63.0–C63.9, C68.0–C69.9, C74.0–C76.8, C80.9

Surgical Approach

Code

0 None; no cancer-directed surgery of primary site

1 Endoscopy, NOS
- 2 Not image guided
- 3 Image guided

4 Open, NOS
- 5 Not assisted by endoscopy
- 6 Assisted by endoscopy

9 Unknown; not stated; death certificate **only**

Surgery of Primary Site

Code

00 None; no cancer-directed surgery of primary site

10 Local tumor destruction, NOS **(without pathology specimen)**
- 11 Photodynamic therapy (PDT)
- 12 Electrocautery; fulguration
- 13 Cryosurgery
- 14 Laser

No specimen sent to pathology from this surgical event.

20 Local tumor excision, NOS (**with pathology specimen**)
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation
- 25 Laser excision
- 26 Polypectomy
- 27 Excisional biopsy

Specimen sent to pathology from this surgical event.

30 Simple/partial surgical removal of primary site

40 Total surgical removal of primary site

All Other Sites (Continued)

50 Surgery stated to be "debulking"

60 Radical surgery

Partial or total removal of the primary site **with** an en bloc resection (partial or total removal) of other organs.

90 Surgery, NOS

99 Unknown if cancer-directed surgery performed; death certificate **only**

Surgical Margins

Code

0 All margins grossly and microscopically negative

1 Margins involved, NOS
- 2 Microscopic involvement
- 5 Macroscopic involvement

7 Margins not documented

8 No cancer-directed surgery of primary site

9 Unknown whether margins wre involved or negative; death certificate **only**

Scope of Regional Lymph Node Surgery

Code

0 No regional lymph nodes removed

1 Regional lymph node(s) removed, NOS

9 Unknown; not stated; death certificate **only**

Number of Regional Lymph Nodes Removed

Code

00 No regional lymph nodes removed
01 One regional lymph node removed
02 Two regional lymph nodes removed
..
90 Ninety or more regional lymph nodes removed
95 No regional lymph node(s) removed but aspiration of regional lymph node(s) was performed
96 Regional lymph node removal documented as a sampling and number of lymph nodes unknown/not stated
97 Regional lymph node removal documented as dissection and number of lymph nodes unknown/not stated
98 Regional lymph nodes surgically removed but number of lymph nodes unknown/not stated and not documented as sampling or dissection
99 Unknown; not stated; death certificate **only**

All Other Sites (Continued)

Surgery of Other Regional Site(s), Distant Site(s), or Distant Lymph Node(s)

Code

0 None; no surgery to other regional or distant sites

1 Surgery to other site(s) or node(s), NOS; unknown if regional or distant
- 2 Other regional sites
- 3 Distant lymph node(s)
- 4 Distant site(s)
- 5 Combination of 4 **with** 2 or 3

9 Unknown; not stated; death certificate **only**

Reconstruction/Restoration–First Course

Code

9 At this time, reconstructive procedures are not being collected for these sites