Standards for Oncology Registry Entry

STandards for **O**ncology **R**egistry **E**ntry

STORE 2018

Effective for Cases Diagnosed
January 1, 2018

Cancer PROGRAMS

QUALITY PROGRAMS *of the* AMERICAN COLLEGE OF SURGEONS

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STandards for Oncology Registry Entry

Released 2018

(Incorporates all updates to Commission on Cancer, National Cancer Database Data standards since FORDS was revised in 2016)

Effective for cases diagnosed January 1, 2018

See Appendix A for Updates since FORDS: Revised for 2016.

Version 1.0

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Table of Contents

Table of Contents ii
Foreword 1
FROM "FORDS" TO "STORE" 1
Preface 2018 2
Comorbidities and Complications 2
Revisions to Staging Requirements 2
Staging Data Items No Longer Required for Cases Diagnosed in 2018 and Later (Required for Cases Diagnosed 2017 and Earlier) 2
Specific Staging Data Items with Continuing Requirement 2
Newly-required AJCC 8th Edition Staging Data Items (Required for cases diagnosed 2018+) 3
Other Newly-Required Stage-associated Data Items 3
Implementation of New Sentinel and Regional Node Data Items 3
Revisions to Radiation Treatment Requirements 3
Radiation Treatment Data Items No Longer Required 3
Specific Radiation Treatment Data Items with Continuing Requirement 4
Newly-required Radiation Data Items 4
New Radiation Treatment Phase-specific Data Items 4
Other New Radiation Data items 4
Radiation Data Item Conversion 5
New Follow-up Data items 5
New Case Administration Data Item 5
Non-STORE Code Modifications 5
AJCC 8th Edition 5
New chapters/staging systems 6
Divided chapters 6
Merged chapters 7
Deleted chapters 7
Site-Specific Data Items (SSDIs) 7
Schema ID and AJCC ID 7
Schema discriminators 7
SSDIs Replacing CS SSFs 8
Required for stage 8
Grade 8
Examples of Other New Data Items in Addition to "Required for Stage" and Grade 8
SSDI coding conventions 8

SSDI Questions 9
ICD-O-3 Histologies 9
2018 ICD-O-3 Documents 9
ICD-O-3 Questions 9
SEER Site/Histology Validation List 9
SEER Site/Histology Validation List Questions 10
2018 Solid Tumor Coding Rules (formerly known as Multiple Primary and Histology Rules) 10
New Site-Specific Instructions 10
Important Details 10
2018 Solid Tumor Coding Rules Questions 10
SEER Hematopoietic and Lymphoid Neoplasm Database 10
SEER Heme Database Questions 11
Summary Stage 2018 11
SEER Summary Stage 2018 Questions 11
STORE 2018 Overview 11
Other Revisions 12
2018 Coding Reference List 12
Additional Coding References 12
Section One: Case Eligibility and Overview of Coding Principles 14
Case Eligibility 15
Tumors Required by the CoC to be Accessioned, Abstracted, Followed and Submitted to the National Cancer Database (NCDB) 15
Reportable-by-Agreement Cases 15
Ambiguous Terms at Diagnosis 15
Ambiguous Terminology Lists: References of Last Resort 17
Class of Case 18
Analytic Cases 18
Nonanalytic Cases 18
Modifications to Class of Case in 2010 18
Date of First Contact 18
Overview of Coding Principles 20
Unique Patient Identifier Codes 20
National Provider Identifier 20
Coding Dates 21
Cancer Identification 21
Primary Site 21
Occult Cervical Lymph Node 21
Cutaneous Carcinoma of the Head and Neck 22

Hematopoietic and Lymphoid Cancers 22
Kaposi Sarcoma 22
Melanoma 22
Specific Tissues with Ill-Defined Sites 22
Laterality 23
Revising the Original Diagnosis 24
Patient Address and Residency Rules 25
Rules for Persons with Ambiguous Residences 25
Coding Country and State 26
In Utero Diagnosis and Treatment 27
Comorbidities and Complications/Secondary Diagnoses 27
Stage of Disease at Initial Diagnosis 28
AJCC Prognostic Staging 28
Ambiguous Terminology 29
Ambiguous Terms Describing Tumor Spread 29
First Course of Treatment 29
Treatment Plan 30
Time Periods for First Course of Treatment 30
Surgery 31
Relationships among Surgical Items 31
Radiation Therapy 34
Relationships among Radiation Items 35
Systemic Therapy 36
Relationships among Systemic Therapy Items 38
Other Treatment 38
Palliative Care 39
Treatment, Palliative, and Prophylactic Care 39
Embolization 40
Outcomes 40
Case Administration 42
Section Two: Instructions for Coding 45
Patient Identification 46
Accession Number 47
Description 47
Rationale 47
Coding Instructions 47
Examples 47
Sequence Number 49

Description 49
Rationale 49
Coding Instructions 49
Malignant or In Situ Primaries 49
Non-Malignant Primaries 50
Examples 50
Medical Record Number 51
Description 51
Rationale 51
Coding Instructions 51
Social Security Number 52
Description 52
Rationale 52
Coding Instructions 52
Last Name 53
Description 53
Rationale 53
Coding Instructions 53
Examples 53
First Name 54
Description 54
Rationale 54
Coding Instructions 54
Examples 54
Middle Name (Middle Initial) 55
Description 55
Rationale 55
Coding Instructions 55
Examples 55
Patient Address (Number and Street) at Diagnosis 56
Description 56
Rationale 56
Coding Instructions 56
Examples 56
Patient Address at Diagnosis–Supplemental 58
Description 58
Rationale 58
Coding Instructions 58

Examples 58
City/Town at Diagnosis (City or Town) 59
Description 59
Rationale 59
Coding Instructions 59
Examples 59
State at Diagnosis (State) 60
Description 60
Rationale 60
Coding Instructions 60
Postal Code at Diagnosis (Zip Code) 62
Description 62
Rationale 62
Coding Instructions 62
Address at Dx--Country 63
Description 63
Rationale 63
Coding Instructions 63
Examples 63
County at Diagnosis 64
Description 64
Rationale 64
Coding Instructions 64
Patient Address (Number and Street) Current 65
Description 65
Rationale 65
Coding Instructions 65
Examples 65
Patient Address Current–Supplemental 67
Description 67
Rationale 67
Coding Instructions 67
Examples 67
City/Town–Current 68
Description 68
Rationale 68
Coding Instructions 68
Examples 68

State–Current **69**
Description 69
Rationale 69
Coding Instructions 69
Postal Code–Current (Zip Code) **71**
Description 71
Rationale 71
Coding Instructions 71
Examples 71
Address Current—Country **72**
Description 72
Rationale 72
Coding Instructions 72
Examples 72
Telephone **73**
Description 73
Rationale 73
Coding Instructions 73
Birthplace—State **74**
Description 74
Rationale 74
Coding Instructions 74
Examples 74
Birthplace—Country **75**
Description 75
Rationale 75
Coding Instructions 75
Examples 75
Date of Birth **76**
Description 76
Rationale 76
Coding Instructions 76
Date of Birth Flag **77**
Description 77
Rationale 77
Coding Instructions 77
Age at Diagnosis **78**
Description 78

Rationale 78
Coding Instructions 78
Race 1 79
Description 79
Rationale 79
Coding Instructions 79
Examples 80
Race 2 81
Description 81
Rationale 81
Coding Instructions 81
Race 3 83
Description 83
Rationale 83
Coding Instructions 83
Race 4 85
Description 85
Rationale 85
Coding Instructions 85
Race 5 87
Description 87
Rationale 87
Coding Instructions 87
Spanish Origin–All Sources (Spanish/Hispanic Origin) 89
Description 89
Rationale 89
Coding Instructions 89
Sex 90
Description 90
Rationale 90
Coding Instructions 90
Primary Payer at Diagnosis 91
Description 91
Rationale 91
Coding Instructions 91
Examples 93
Comorbidities and Complications #1 (Secondary Diagnoses) 94
Description 94

Rationale 94
Coding Instructions 94
Examples 95
Comorbidities and Complications #2 (Secondary Diagnoses) 96
Description 96
Rationale 96
Coding Instructions 96
Comorbidities and Complications #3 (Secondary Diagnoses) 97
Description 97
Rationale 97
Coding Instructions 97
Comorbidities and Complications #4 (Secondary Diagnoses) 98
Description 98
Rationale 98
Coding Instructions 98
Comorbidities and Complications #5 (Secondary Diagnoses) 99
Description 99
Rationale 99
Coding Instructions 99
Comorbidities and Complications #6 (Secondary Diagnoses) 100
Description 100
Rationale 100
Coding Instructions 100
Comorbidities and Complications #7 (Secondary Diagnoses) 101
Description 101
Rationale 101
Coding Instructions 101
Comorbidities and Complications #8 (Secondary Diagnoses) 102
Description 102
Rationale 102
Coding Instructions 102
Comorbidities and Complications #9 (Secondary Diagnoses) 103
Description 103
Rationale 103
Coding Instructions 103
Comorbidities and Complications #10 (Secondary Diagnoses)..... 104
Description 104
Rationale 104

Coding Instructions 104
Secondary Diagnosis #1 (Secondary Diagnoses) 105
Description 105
Rationale 105
Coding Instructions 105
Examples 106
Secondary Diagnosis #2 (Secondary Diagnoses) 107
Description 107
Rationale 107
Coding Instructions 107
Examples 107
Secondary Diagnosis #3 (Secondary Diagnoses) 108
Description 108
Rationale 108
Coding Instructions 108
Examples 108
Secondary Diagnosis #4 (Secondary Diagnoses) 109
Description 109
Rationale 109
Coding Instructions 109
Examples 109
Secondary Diagnosis #5 (Secondary Diagnoses) 110
Description 110
Rationale 110
Coding Instructions 110
Examples 110
Secondary Diagnosis #6 (Secondary Diagnoses) 111
Description 111
Rationale 111
Coding Instructions 111
Examples 111
Secondary Diagnosis #7 (Secondary Diagnoses) 112
Description 112
Rationale 112
Coding Instructions 112
Examples 112
Secondary Diagnosis #8 (Secondary Diagnoses) 113
Description 113

Rationale 113
Coding Instructions 113
Examples 113
Secondary Diagnosis #9 (Secondary Diagnoses) 114
Description 114
Rationale 114
Coding Instructions 114
Examples 114
Secondary Diagnosis #10 (Secondary Diagnoses) 115
Description 115
Rationale 115
Coding Instructions 115
Examples 115
NPI–Managing Physician 116
Description 116
Rationale 116
Coding Instructions 116
NPI–Following Physician 117
Description 117
Rationale 117
Coding Instructions 117
NPI–Primary Surgeon 118
Description 118
Rationale 118
Coding Instructions 118
NPI–Physician #3 (Radiation Oncologist–CoC Preferred) 119
Description 119
Rationale 119
Coding Instructions 119
NPI–Physician #4 (Medical Oncologist–CoC Preferred) 120
Description 120
Rationale 120
Coding Instructions 120
Cancer Identification 121
Class of Case 122
Description 122
Rationale 122
Coding Instructions 122

Examples 124
NPI–Institution Referred From 126
Description 126
Rationale 126
Coding Instructions 126
NPI–Institution Referred To 127
Description 127
Rationale 127
Coding Instructions 127
Date of First Contact 128
Description 128
Rationale 128
Coding Instructions 128
Examples 129
Date of First Contact Flag 130
Description 130
Rationale 130
Coding Instructions 130
Date of Initial Diagnosis 131
Description 131
Rationale 131
Coding Instructions 131
Examples 131
Primary Site 133
Description 133
Rationale 133
Coding Instructions 133
Examples 133
Laterality 135
Description 135
Rationale 135
Coding Instructions 135
Histology 136
Description 136
Rationale 136
Coding Instructions 136
Examples 136
Behavior Code 137

Description 137
Rationale 137
Coding Instructions 137
Examples 138
Grade Clinical 139
Description 139
Rationale 139
Coding Instructions 139
Grade Pathological 140
Description 140
Rationale 140
Coding Instructions 140
Grade Post Therapy 141
Description 141
Rationale 141
Coding Instructions 141
Diagnostic Confirmation 142
Description 142
Rationale 142
Coding Instructions – Solid Tumors (all tumors *except* M9590-9992) 142
Coding Instructions – Hematopoietic or Lymphoid Tumors (M9590-9992) 143
Stage of Disease at Diagnosis 145
Date of Surgical Diagnostic and Staging Procedure 146
Description 146
Rationale 146
Coding Instructions 146
Rx Date–Dx/Stg Proc Flag 147
Description 147
Rationale 147
Coding Instructions 147
Surgical Diagnostic and Staging Procedure 148
Description 148
Rationale 148
Coding Instructions 148
Examples 149
Surgical Diagnostic and Staging Procedure at This Facility 150
Description 150
Rationale 150

Coding Instructions 150
Lymphovascular Invasion 152
Description 152
Rationale 152
Coding Instructions 152
Sentinel and Regional Lymph Nodes 157
Date of Sentinel Lymph Node Biopsy 158
Description 158
Rationale 158
Coding Instructions 158
Date of Sentinel Lymph Node Biopsy Flag 160
Description 160
Rationale 160
Coding Instructions 160
Sentinel Lymph Nodes Examined 161
Description 161
Rationale 161
Coding Instructions 161
Sentinel Lymph Nodes Positive 163
Description 163
Rationale 163
Coding Instructions 163
Date Regional Lymph Node Dissection 165
Description 165
Rationale 165
Coding Instructions 165
Date Regional Lymph Node Dissection Flag 166
Description 166
Rationale 166
Coding Instructions 166
Regional Lymph Nodes Examined 167
Description 167
Rationale 167
Coding Instructions 167
Regional Lymph Nodes Positive 170
Description 170
Rationale 170
Coding Instructions 170

Tumor Size and Mets **173**
Tumor Size Summary **174**
Description 174
Rationale 174
Coding Instructions 174
Coding Rules 174
Mets at Diagnosis – Bone **178**
Description 178
Rationale 178
Coding Instructions 178
Mets at Diagnosis – Brain **180**
Description 180
Rationale 180
Coding Instructions 180
Mets at Diagnosis – Distant Lymph Nodes **182**
Description 182
Rationale 182
Coding Instructions 182
Mets at Diagnosis – Liver **184**
Description 184
Rationale 184
Coding Instructions 184
Mets at Diagnosis – Lung **186**
Description 186
Rationale 186
Coding Instructions 186
Mets at Diagnosis – Other **188**
Description 188
Rationale 188
Coding Instructions 188
Summary Stage 2018 ..... **190**
Description 190
Rationale 190
Coding Instructions 190
AJCC 8th Edition TNM Stage **192**
AJCC TNM Clin T **193**
Description 193
Rationale 193

Coding Instructions 193
AJCC TNM Clin T Suffix 196
Description 196
Rationale 196
Coding Instructions 196
AJCC TNM Clin N 197
Description 197
Rationale 197
Coding Instructions 197
AJCC TNM Clin N Suffix 199
Description 199
Rationale 199
Coding Instructions 199
AJCC TNM Clin M 200
Description 200
Rationale 200
Coding Instructions 200
AJCC TNM Clin Stage Group 203
Description 203
Rationale 203
Coding Instructions 203
AJCC TNM Path T 206
Description 206
Rationale 206
Coding Instructions 206
AJCC TNM Path T Suffix 209
Description 209
Rationale 209
Coding Instructions 209
AJCC TNM Path N 210
Description 210
Rationale 210
Coding Instructions 210
AJCC TNM Path N Suffix 212
Description 212
Rationale 212
Coding Instructions 212
AJCC TNM Path M 213

Description 213
Rationale 213
Coding Instructions 213
AJCC TNM Path Stage Group 215
Description 215
Rationale 215
Coding Instructions 215
AJCC TNM Post Therapy T 218
Description 218
Rationale 218
Coding Instructions 218
AJCC TNM Post Therapy T Suffix 220
Description 220
Rationale 220
Coding Instructions 220
AJCC TNM Post Therapy N 221
Description 221
Rationale 221
Coding Instructions 221
AJCC TNM Post Therapy N Suffix 223
Description 223
Rationale 223
Coding Instructions 223
AJCC TNM Post Therapy M 224
Description 224
Rationale 224
Coding Instructions 224
AJCC TNM Post Therapy Stage Group 226
Description 226
Rationale 226
Coding Instructions 226
Site-Specific Data Items 229
First Course of Treatment 231
Date of First Course of Treatment 232
Description 232
Rationale 232
Coding Instructions 232
Examples 232

Date 1st Crs Rx Flag 233
Description 233
Rationale 233
Coding Instructions 233
Rx Summ – Treatment Status 234
Description 234
Rationale 234
Coding Instructions 234
Examples 234
Surgery Data Items 235
Date of First Surgical Procedure 236
Description 236
Rationale 236
Coding Instructions 236
Examples 236
Rx Date–Surgery Flag 237
Description 237
Rationale 237
Coding Instructions 237
Date of Most Definitive Surgical Resection of the Primary Site 238
Description 238
Rationale 238
Coding Instructions 238
Rx Date Mst Defn Srg Flag 239
Description 239
Rationale 239
Coding Instructions 239
Surgical Procedure of Primary Site 240
Description 240
Rationale 240
Coding Instructions 240
Surgical Procedure of Primary Site at this Facility 242
Description 242
Rationale 242
Coding Instructions 242
Approach - Surgery of the Primary Site at this Facility (RxHospSurgApp 2010) 244
Description 244
Rationale 244

Coding Instructions 244
Examples 244
Surgical Margins of the Primary Site 246
Description 246
Rationale 246
Coding Instructions 246
Example 247
Scope of Regional Lymph Node Surgery 248
Description 248
Rationale 248
Coding Instructions 248
Codes and Labels 249
Examples 254
Scope of Regional Lymph Node Surgery at this Facility 255
Description 255
Rationale 255
Coding Instructions 255
Codes and Labels 256
Surgical Procedure/Other Site 261
Description 261
Rationale 261
Coding Instructions 261
Examples 262
Surgical Procedure/Other Site at this Facility 263
Description 263
Rationale 263
Coding Instructions 263
Date of Surgical Discharge 265
Description 265
Rationale 265
Coding Instructions 265
Rx Date Surg Disch Flag 266
Description 266
Rationale 266
Coding Instructions 266
Readmission to the Same Hospital within 30 Days of Surgical Discharge 267
Description 267
Rationale 267

Coding Instructions 267
Examples 268
Reason for No Surgery of Primary Site 269
Description 269
Rationale 269
Coding Instructions 269
Examples 270
Radiation Data Items 271
Date Radiation Started 272
Description 272
Rationale 272
Coding Instructions 272
Examples 272
Rx Date–Radiation Flag 274
Description 274
Rationale 274
Coding Instructions 274
Location of Radiation Treatment 275
Description 275
Rationale 275
Coding Instructions 275
Examples 276
Phase I Radiation Primary Treatment Volume 277
Description 277
Rationale 277
Coding Instructions 277
Phase I Radiation to Draining Lymph Nodes 283
Description 283
Rationale 283
Coding Instructions 283
Phase I Radiation Treatment Modality 285
Description 285
Rationale 285
Coding Instructions 285
Phase I External Beam Radiation Planning Technique 287
Description 287
Rationale 287
Coding Instructions 287

Phase I Dose per Fraction 290
Description 290
Rationale 290
Coding Instructions 290
Examples 291
Phase I Number of Fractions 292
Description 292
Rationale 292
Coding instructions 292
Examples 293
Phase I Total Dose 294
Description 294
Rationale 294
Coding instructions 294
Examples 295
Phase II Radiation Primary Treatment Volume 296
Description 296
Rationale 296
Coding Instructions 296
Phase II Radiation to Draining Lymph Nodes 302
Description 302
Rationale 302
Coding Instructions 302
Phase II Radiation Treatment Modality 304
Description 304
Rationale 304
Coding Instructions 304
Phase II External Beam Radiation Planning Technique 306
Description 306
Rationale 306
Coding Instructions 306
Phase II Dose per Fraction 309
Description 309
Rationale 309
Coding Instructions 309
Examples 310
Phase II Number of Fractions 311
Description 311

Rationale 311
Coding Instructions 311
Examples 312
Phase II Total Dose 313
Description 313
Rationale 313
Coding Instructions 313
Examples 314
Phase III Radiation Primary Treatment Volume 315
Description 315
Rationale 315
Coding Instructions 315
Phase III Radiation to Draining Lymph Nodes 321
Description 321
Rationale 321
Coding Instructions: 321
Phase III Radiation Treatment Modality 323
Description 323
Rationale 323
Coding Instructions 323
Phase III External Beam Radiation Planning Technique 325
Description 325
Rationale 325
Coding instructions 325
Phase III Dose per Fraction 328
Description 328
Rationale 328
Coding Instructions 328
Examples 329
Phase III Number of Fractions 330
Description 330
Rationale 330
Coding Instructions 330
Examples 331
Phase III Total Dose 332
Description 332
Rationale 332
Coding Instructions 332

Examples 333
Number of Phases of Radiation Treatment to this Volume 334
Description 334
Rationale 334
Coding Instructions 334
Examples 334
Radiation Treatment Discontinued Early 335
Description 335
Rationale 335
Coding Instructions 335
Total Dose 336
Description 336
Rationale 336
Coding Instructions 336
Radiation/Surgery Sequence 338
Description 338
Rationale 338
Coding Instructions 338
Examples 339
Date Radiation Ended 340
Description 340
Rationale 340
Coding Instructions 340
Examples 340
Rx Date Rad Ended Flag 342
Description 342
Rationale 342
Coding Instructions 342
Reason for No Radiation 343
Description 343
Rationale 343
Coding Instructions 343
Examples 344
Systemic Therapy Data Items 345
Date Systemic Therapy Started 346
Description 346
Rationale 346
Coding Instructions 346

Examples 346
Rx Date Systemic Flag 347
Description 347
Rationale 347
Coding Instructions 347
Chemotherapy 348
Date Chemotherapy Started 349
Description 349
Rationale 349
Coding Instructions 349
Rx Date–Chemo Flag 350
Description 350
Rationale 350
Coding Instructions 350
Chemotherapy 351
Description 351
Rationale 351
Coding Instructions 351
Examples 353
Chemotherapy at this Facility 354
Description 354
Rationale 354
Coding Instructions 354
Hormone Therapy 357
Date Hormone Therapy Started 358
Description 358
Rationale 358
Coding Instructions 358
Rx Date–Hormone Flag 359
Description 359
Rationale 359
Coding Instructions 359
Hormone Therapy (Hormone/Steroid Therapy) 360
Description 360
Rationale 360
Coding Instructions 360
Examples 361
Hormone Therapy at this Facility (Hormone/Steroid Therapy) 362

Description 362
Rationale 362
Coding Instructions 362
Immunotherapy 364
Date Immunotherapy Started 365
Description 365
Rationale 365
Coding Instructions 365
Rx Date–BRM Flag 365
Description 365
Rationale 365
Coding Instructions 366
Immunotherapy 367
Description 367
Rationale 367
Coding Instructions 367
Examples 368
Immunotherapy at this Facility 369
Description 369
Rationale 369
Coding Instructions 369
Hematologic Transplant and Endocrine Procedures 371
Description 371
Rationale 371
Coding Instructions 371
Systemic/Surgery Sequence 373
Description 373
Rationale 373
Coding Instructions 373
Examples 374
Other Treatment 375
Date Other Treatment Started 376
Description 376
Rationale 376
Coding Instructions 376
Examples 376
Rx Date–Other Flag 377
Description 377

Rationale 377
Coding Instructions 377
Other Treatment 378
Description 378
Rationale 378
Coding Instructions 378
Other Treatment at this Facility 380
Description 380
Rationale 380
Coding Instructions 380
Palliative Care (Palliative Procedure) 382
Description 382
Rationale 382
Coding Instructions 382
Examples 383
Palliative Care at this Facility (Palliative Procedure at this Facility) 384
Description 384
Rationale 384
Coding Instructions 384
Outcomes 385
Date of First Recurrence 386
Description 386
Rationale 386
Coding Instructions 386
Recurrence Date–1st Flag 387
Description 387
Rationale 387
Coding Instructions 387
Type of First Recurrence 388
Description 388
Rationale 388
Coding Instructions 388
Examples 390
Date of Last Cancer (tumor) Status 391
Description 391
Rationale 391
Coding Instructions 391
Date of Last Cancer (tumor) Status Flag 392

Description 392
Rationale 392
Coding Instructions 392
Cancer Status 393
Description 393
Rationale 393
Coding Instructions 393
Examples 393
Date of Last Contact or Death 394
Description 394
Rationale 394
Coding Instructions 394
Date of Last Contact Flag 395
Description 395
Rationale 395
Coding Instructions 395
Vital Status 396
Description 396
Rationale 396
Coding Instructions 396
Examples 396
NPI–Following Registry 397
Description 397
Rationale 397
Coding Instructions 397
Follow-Up Source 398
Description 398
Rationale 398
Coding Instructions 398
Next Follow-Up Source (Next Follow-Up Method) 399
Description 399
Rationale 399
Coding Instructions 399
Case Administration 400
Abstracted By 401
Description 401
Rationale 401
Coding Instructions 401

Facility Identification Number (FIN) 402
Description 402
Rationale 402
Coding Instructions 402
Examples 402
NPI–Reporting Facility 403
Description 403
Rationale 403
Coding Instructions 403
Examples 403
Archive FIN 404
Description 404
Rationale 404
Coding Instructions 404
Examples 405
NPI–Archive FIN 406
Description 406
Rationale 406
Coding Instructions 406
Examples 406
Date Case Completed – CoC 407
Description 407
Rationale 407
Coding Instructions 407
RQRS NCDB Submission Flag 408
Description 408
Rationale 408
Coding Instructions 408
Override Acsn/Class/Seq 409
Description 409
Rationale 409
EDITS Use 409
Coding Instructions 409
Override HospSeq/DxConf 410
Description 410
Rationale 410
EDITS Use 410
Coding Instructions 410

Override CoC–Site/Type 411
Description 411
Rationale 411
EDITS Use 411
Coding Instructions 411
Override HospSeq/Site 412
Description 412
Rationale 412
EDITS Use 412
Coding Instructions 412
Override Site/TNM-Stage Group 414
Description 414
Rationale 414
EDITS Use 414
Coding Instructions 414
Override Age/Site/Morph 415
Description 415
Rationale 415
EDITS Use 415
Coding Instructions 415
Override Surg/DxConf 416
Description 416
Rationale 416
EDITS Use 416
Coding Instructions 416
Override Site/Type 417
Description 417
Rationale 417
EDITS Use 417
Coding Instructions 417
Override Histology 418
Description 418
Rationale 418
EDITS Use 418
Coding Instructions 418
Override Leuk, Lymphoma 420
Description 420
Rationale 420

EDITS Use 420
Coding Instructions 420
Override Site/Behavior 421
Description 421
Rationale 421
EDITS Use 421
Coding Instructions 421
Override Site/Lat/Morph 423
Description 423
Rationale 423
EDITS Use 423
Coding Instructions 423
CoC Coding System–Current 424
Description 424
Rationale 424
Coding Instructions 424
Examples 424
CoC Coding System–Original 426
Description 426
Rationale 426
Coding Instructions 426
Examples 427
Race Coding System–Current 428
Description 428
Rationale 428
Coding Instructions 428
Race Coding System–Original 429
Description 429
Rationale 429
Coding Instructions 429
Site Coding System–Current 430
Description 430
Rationale 430
Coding Instructions 430
Site Coding System–Original 431
Description 431
Rationale 431
Coding Instructions 431

Morphology Coding System–Current 432
Description 432
Rationale 432
Coding Instructions 432
Morphology Coding System–Original 433
Description 433
Rationale 433
Coding Instructions 433
ICD-O-2 Conversion Flag 434
Description 434
Rationale 434
Coding Instructions 434
ICD-O-3 Conversion Flag 435
Description 435
Rationale 435
Coding Instructions 435
TNM Edition Number 436
Description 436
Rationale 436
Coding Instructions 436
Rx Coding System–Current 437
Description 437
Rationale 437
Coding Instructions 437
APPENDIX A: STORE UPDATES for 2018 438
APPENDIX B: Site-Specific Surgery Codes 439
ORAL CAVITY 440
PAROTID AND OTHER UNSPECIFIED GLANDS 442
PHARYNX 444
ESOPHAGUS 446
STOMACH 447
COLON 449
RECTOSIGMOID 451
RECTUM 453
ANUS 455
LIVER AND INTRAHEPATIC BILE DUCTS 456
PANCREAS 458
LARYNX 459

LUNG 461
HEMATOPOIETIC/RETICULOENDOTHELIAL/ 463
IMMUNOPROLIFERATIVE/MYELOPROLIFERATIVE DISEASE 463
BONES, JOINTS, AND ARTICULAR CARTILAGE 464
PERIPHERAL NERVES AND AUTONOMIC NERVOUS SYSTEM 464
CONNECTIVE, SUBCUTANEOUS, AND OTHER SOFT TISSUES 464
SPLEEN 465
SKIN 466
BREAST 468
CERVIX UTERI 471
CORPUS UTERI 473
OVARY 475
PROSTATE 477
TESTIS 479
KIDNEY, RENAL PELVIS, AND URETER 480
BLADDER 482
BRAIN 484
THYROID GLAND 485
LYMPH NODES 486
ALL OTHER SITES 487
UNKNOWN AND ILL-DEFINED PRIMARY SITES 489
APPENDIX C: *Date Case Completed – CoC* 490
APPENDIX D: Country and State Codes 496
General 505
Obsolete 506

Foreword

FROM "FORDS" TO "STORE"

The Facility Oncology Registry Data Standards, better known as FORDS, was developed in 2003 by the Commission on Cancer (CoC) of the American College of Surgeons (ACS) for its CoC accredited programs. Although updated periodically to ensure that appropriate codes were being assigned by registrars in reporting required tumors, there had not been any major overhaul of the manual since its inception. Prior updates of FORDS, while benefiting from the expertise of cancer registrars and others involved in the cancer surveillance community, had never included the recommendations of cancer clinicians working in the major oncologic specialties.

In 2014, Dr. David P. Winchester, Director of Cancer Programs at the ACS, asked me to lead a concerted effort to update and ensure that FORDS would have greater relevance to current oncologic practice and data collection. A multidisciplinary approach was begun to include leading registrars representing CoC hospitals, state registries and the SEER program of the National Cancer Institute. This effort was coordinated by the outstanding professional staff at the National Cancer Database (NCDB) of the CoC. In addition, many clinicians representing surgical oncology, medical oncology and radiation oncology were invited to join in this effort to assure that diagnostic and treatment codes were updated and reflected current practice. This coding structure is vital to hospital registry data that ultimately are entered into the NCDB and also determines the CoC quality measures which are currently being used in the Rapid Quality Reporting System (RQRS), Cancer Quality Improvement Program (CQIP) and the CP^3R Program which tracks quality within all of the CoC-accredited institutions.

The culmination of these efforts over the last four years has resulted in an entirely new and updated coding compendium: STORE--Standards for Oncology Registry Entry. This new name was selected to reflect our entirely new approach to this revision that includes both registry and surveillance leaders and clinicians who care for the cancer patient.

To all these dedicated individuals and our dedicated NCDB staff – especially Kathleen Thoburn whose hard work and commitment has brought the STORE manual to fruition – I offer my sincere gratitude for a job well done.

Frederick L. Greene, MD FACS

August 2018

Preface 2018

For all cases diagnosed on or after January 1, 2018, the American College of Surgeons Commission on Cancer (CoC) will require its accredited programs to use STandards for Oncology Registry Entry (STORE); *AJCC Cancer Staging Manual, Eighth Edition* (8th Edition), Site-Specific Data Items (SSDIs) for collection of site-specific information; NAACCR Guidelines for ICD-O-3 Update Implementation; 2018 Solid Tumor Coding Rules; SEER Summary Stage 2018 Manual to assign Summary Stage; most current SEER Hematopoietic and Lymphoid Neoplasm Database and rules; and SEER*RX systemic therapy application.

Revisions to CoC reporting requirements for 2018 accommodate the transition from Collaborative Stage Site-Specific Factors to the new SSDI and Grade data items, as well as implementation of new data items for the collection of radiation therapy, information associated with sentinel and regional lymph nodes, and cancer recurrence. Other than the below-specified revisions, CoC data reporting requirements remain the same.

Comorbidities and Complications

CoC will no longer be requiring the ICD-9-CM-based *Comorbidities and Complications 1-10* [3110-3164] or *ICD Revision Comorbid* [3165] data items. As of cases diagnosed January 1, 2018 and later, only ICD-10-CM codes will be accepted to document secondary diagnoses. The ICD-10-CM code-based data items of *Secondary Diagnosis 1- 10* [3780-3798] will continue to be required. Some CoC programs are currently not documenting this information. **Please note**: The documentation and submission of secondary diagnosis information is required for all CoC-accredited programs.

Revisions to Staging Requirements

Staging Data Items No Longer Required for Cases Diagnosed in 2018 and Later (Required for Cases Diagnosed 2017 and Earlier)

To accommodate the implementation of the AJCC 8th Edition Staging System, collection of SSDIs and SEER Summary Stage 2018, the following data items are no longer required for cases diagnosed January 1, 2018 and later:

- *TNM Path T, N, and M* [880, 890, 900]
- *TNM Path Stage Group* [910]
- *TNM Path Descriptor* [920]
- *TNM Path Staged By* [930]
- *TNM Clin T, N, and M* [940, 950, 960]
- *TNM Clin Stage Group* [970]
- *TNM Clin Descriptor* [980]
- *TNM Clin Staged By* [990]
- *CS Site-Specific Factors* [2861-2880, 2890-2930]
- *CS Version Input Original, Derived, Input Current* [2935-2937]
- *Summary Stage 2000* [759]

Specific Staging Data Items with Continuing Requirement

- *Tumor Size Summary* [756] (Required 2016+)
- *Regional Nodes Positive* [820] (Required 2004+)
- *Regional Nodes Examined* [830] (Required 2004+)
- *Mets at Diagnosis – Bone, Brain, Distant LN, Liver, Lung, Other* [1112-1117] (Required 2016+)
- *Lymphovascular Invasion* [1182] (Required 2010+)

Newly-required AJCC 8th Edition Staging Data Items (Required for cases diagnosed 2018+)

Required 8th Edition AJCC Stage T, N, M Data Items (may be blank as appropriate)

- *AJCC TNM Clin T, N, M* [1001-1003]
- *AJCC TNM Path T, N, M* [1011-1013]
- *AJCC TNM Post Therapy T, N, M* [1021-1023]

Required 8th Edition AJCC Stage Groups

- *AJCC TNM Clin Stage Group* [1004] **AND**
- *AJCC TNM Path Stage Group* [1014] **OR** *AJCC TNM Post Therapy Stage Group* [1024]

Newly-required when appropriate for the tumor being abstracted

- *AJCC TNM Clin T Suffix* [1031]
- *AJCC TNM Path T Suffix* [1032]
- *AJCC TNM Post Therapy T Suffix* [1033]
- *AJCC TNM Clin N Suffix* [1034]
- *AJCC TNM Path N Suffix* [1035]
- *AJCC TNM Post Therapy N Suffix* [1036]

Other Newly-Required Stage-associated Data Items

- *Summary Stage 2018* [764]
- *Clinical, Pathological and Post Therapy Grade* [3843-3845]
- Site-Specific Data Items: Please refer to the CoC data item requirements listed in the Data Standards and Data Dictionary, Version 18, Chapter VIII Required Status Table for the CoC's required status of the new/revised SSDIs for cases diagnosed 1/1/2018 and later.

Implementation of New Sentinel and Regional Node Data Items

Because sentinel lymph node biopsies have been generally under-reported and the timing and results of sentinel lymph node biopsy procedures are used in multiple CoC Quality of Care Measures, the CoC developed six new data items for collection of more specific information on sentinel and regional nodes.

- *Date of Regional Lymph Node Dissection* [682]
- *Date Regional Lymph Node Dissection Flag* [683]
- *Date of Sentinel Lymph Node Biopsy (for breast and melanoma only)* [832]
- *Date of Sentinel Lymph Node Biopsy Flag (for breast and melanoma only)* [833]
- *Sentinel Lymph Nodes Examined (for breast and melanoma only)* [834]
- *Sentinel Lymph Nodes Positive (for breast and melanoma only)* [835]

Revisions to Radiation Treatment Requirements

Radiation Treatment Data Items No Longer Required

The following data items are no longer required as of 2018. They have been replaced by new 2018 radiation data items. Values in the existing v16 data items below will be converted to the new data items upon conversion to v18-compliant software.

- *Regional Dose: cGy* [1510]
- *Number of Treatments to this Volume* [1520]
- *Radiation Treatment Volume* [1540]
- *Regional Treatment Modality* [1570]
- *Boost Treatment Modality* [3200]

- *Boost Radiation Dose cGy* [3210]

Specific Radiation Treatment Data Items with Continuing Requirement

- *Reason for No Radiation* [1430] (Required 2003+)
- *Date Radiation Started* [1210] (Required All Years)
- *Date Radiation Ended* [3220] (Required 2003+)
- *Location of Radiation Treatment* [1550] (Required 2003+)
- *RX Date–Radiation Flag* [1211] (Required 2010+)
- *RX Date–Rad Ended Flag* [3211] (Required 2010+)

Newly-required Radiation Data Items

The CoC has developed 24 new data items associated with radiation treatment in order to update the way radiation treatment and the treatment target volumes are described to better reflect modern nomenclature and practice and to enable patterns of care, comparative effectiveness, clinical guideline concordance and other large database studies.

New Radiation Treatment Phase-specific Data Items

To promote consistency across the clinical and registry community, new "phase" terminology has been adopted, replacing the traditional terms of "regional" and "boost." The first phase (Phase I) of a radiation treatment may be commonly referred to as an initial plan and a subsequent phase (Phase II) may be referred to as a boost or cone down. A new phase begins when there is a change in the target volume of a body site, treatment fraction size, modality or treatment technique. Up to three phases of radiation treatment can now be documented.

Typically, in each phase, the primary tumor or tumor bed is treated. However, radiation treatment also commonly includes draining lymph node regions that are associated with the primary tumor or tumor bed. Because of this, the historical *Radiation Treatment Volume* [1540] has been divided into the phase-specific data items of *Radiation Primary Treatment Volume* and *Radiation to Draining Lymph Nodes*.

Historically, the previously-named *Regional Treatment Modality* [1570] utilized codes that were not mutually exclusive. Rather, it included codes describing a mix of modalities, treatment planning techniques, and delivery techniques that are commonly utilized by radiation oncologists. The implementation of separate phase-specific data items for the recording of radiation modality (Radiation Treatment Modality) and radiation treatment planning techniques (Radiation External Beam Planning Technique) will clarify this information using mutually exclusive categories.

The following are the new phase-specific data items (*Phase I* [1501-1507], *Phase II* [1511-1517], *Phase III* [1521-1527]):

- *Radiation Primary Treatment Volume*
- *Radiation to Draining Lymph Nodes*
- *Radiation Treatment Modality*
- *Radiation External Beam Planning Technique*
- *Dose per Fraction*
- *Number of Fractions*
- *Total Dose*

Other New Radiation Data items

Three other new summary radiation data items are being implemented that are **cumulative** across phases of radiation treatment given in the first course of treatment:

- *Number of Phases of Radiation Treatment to this Volume* [1532]
- *Radiation Discontinued Early* [1531]
- *Total Dose* [1533]

Radiation Data Item Conversion

Although the 2018 implementation of new radiation data items and terminology sounds extensive, the information being collected is similar to what is already being collected in CoC-accredited facilities. As a result, conversion/mapping of values from historical radiation data items will occur upon upgrade to v18-compliant software, and once upgraded, only the new data items will be displayed and abstracted within the v18-compliant software.

New STORE Radiation Data Item	Historical FORDS Radiation Data Item
Phase I Radiation Primary Treatment Volume [1504]	Converted from *Radiation Treatment Volume* [1540]
Phase I Radiation to Draining Lymph Nodes [1505]	Converted from *Radiation Treatment Volume* [1540]
Phase I Radiation Treatment Modality [1506]	Converted from *Regional Treatment Modality* [1570]
Phase I Radiation External Beam Planning Tech [1502]	Converted from *Regional Treatment Modality* [1570]
Phase I Dose per Fraction [1501]	99999
Phase I Number of Fractions [1503]	1-1 Map from *Number of Treatments to this Volume* [1520]
Phase I Total Dose [1507]	1-1 Map from *Regional Dose: cGy* [1510]
Phase II Radiation Primary Treatment Volume [1514]	Converted from *Radiation Treatment Volume* [1540] when *Boost Radiation Treatment Modality* [3200] administered
Phase II Radiation to Draining Lymph Nodes [1515]	99
Phase II Radiation Treatment Modality [1516]	Converted from *Boost Radiation Treatment Modality* [3200]
Phase II Radiation External Beam Planning Tech [1512]	Converted from *Boost Radiation Treatment Modality* [3200]
Phase II Dose per Fraction [1511]	99999
Phase II Number of Fractions [1513]	999
Phase II Total Dose [1517]	1-1 Map from *Boost Radiation Dose: cGy* [#3210]

New Follow-up Data items

In order to facilitate research on cancer recurrence, two new follow-up data items have been added for 2018 that allow for the recording of the last date on which the patient's cancer status has been updated.

Unlike the *Date of Last Contact or Death* [1750], which is a patient-specific data item, these new data items are tumor-specific to better document tumor recurrence/no evidence of disease (NED).

- *Date of Last Cancer (Tumor) Status* [1772]
- *Date of Last Cancer (Tumor) Status Flag* [1773]

New Case Administration Data Item

The National Cancer Database (NCDB) is moving to submission of data via a single data portal rather than the current separate data portals for Rapid Quality Reporting System (RQRS) and NCDB. The new *RQRS NCDB Submission Flag* [2155] will facilitate identification of the purpose of the data submission at the receiving end.

Non-STORE Code Modifications

AJCC 8th Edition

The *AJCC Cancer Staging Manual, Eighth Edition*, was released in October 2016 and is to be used for cases diagnosed on or after January 1, 2018.

Perhaps the most important change introduced in the *AJCC Cancer Staging Manual, Eighth Edition* from the perspective of registry staff is a completely rewritten Principles of Cancer Staging (Chapter 1). The revised chapter responds to a range of questions raised over the years by registrars. Chapter 1 should be more useful to registrars than in the past.

The histology code ranges introduced in the *AJCC Cancer Staging Manual, Seventh Edition* to correspond with Collaborative Stage have been replaced by a distinct list of applicable WHO and ICD-O-3 histology codes in each chapter. This change was made in order to align with the clinical terminology from most recent editions of the WHO Classification of Tumors – the primary reference used by oncologists and pathologists for histologic and genetic typing of human neoplasia. A full list of histology and topography codes, sortable by chapter and staging system, is also available on cancerstaging.org.

Histologies appropriate for clinical use in patient care, using current preferred terminology from the WHO and ICD-O-3, are listed in each chapter. Also included are histologies (not included in the first and second print versions) requested by the surveillance community to reduce the number of unstaged cases in population-based data. In the third and subsequent printings, these are denoted with an asterisk and italicized in the histology code table in each chapter. Many of these additional histologies represent vague or non-specific information such as "carcinoma, NOS"; more specific terms using features no longer part of current terminology; and other non-standard or outdated histologic terms.

Staging forms are available online in the AJCC Cancer Staging Form Supplement. The 104 staging forms in this supplement are numbered according to their corresponding chapters in the *AJCC Cancer Staging Manual, Eighth Edition*. Some chapters have multiple staging forms as they describe distinct TNM, Prognostic Factors, and AJCC Prognostic Stage Groups for unique topographical sites, histologic types or a combination of the two. These forms may provide more data elements than required for collection by standard setters such as NCI SEER, CDC NPCR, and CoC NCDB.

The 8th Edition has specific chapters for more cancers than in the past, and some chapters have been divided for more targeted discussion on staging classification.

New chapters/staging systems

- Risk Assessment Models
- Cervical Nodes and Unknown Primary Tumors of the Head and Neck
- Oropharynx, HPV-Mediated (p16+)
- Cutaneous Carcinoma of the Head and Neck (includes cutaneous carcinoma of external lip)
- Thymus
- Bone: Appendicular Skeleton/Trunk/Skull/Face, Pelvis, and Spine
- Soft Tissue Sarcoma of the Head and Neck
- Soft Tissue Sarcoma of the Trunk and Extremities
- Soft Tissue Sarcoma of the Abdomen and Thoracic Visceral Organs
- Soft Tissue Sarcoma of the Retroperitoneum
- Soft Tissue Sarcoma—Unusual Histologies and Sites (no staging system)
- Parathyroid
- Leukemia

Divided chapters

- Oral Cavity (previously Lip and Oral Cavity)
- Cutaneous carcinoma of the external lip (previously Lip and Oral Cavity) is now staged with Cutaneous Carcinoma of the Head And Neck
- Oropharynx (p16−) and Hypopharynx (previously Pharynx)
- Nasopharynx (previously Pharynx)
- Pancreas—Exocrine (previously Endocrine/Exocrine Pancreas)

- Neuroendocrine Tumors of the Pancreas (previously Endocrine/Exocrine Pancreas)
- Neuroendocrine Tumors of the Stomach
- Neuroendocrine Tumors of the Duodenum and Ampulla of Vater
- Neuroendocrine Tumors of the Jejunum and Ileum
- Neuroendocrine Tumors of the Appendix
- Neuroendocrine Tumors of the Colon and Rectum
- Thyroid—Differentiated and Anaplastic
- Thyroid—Medullary
- Adrenal Cortical Carcinoma
- Adrenal—Neuroendocrine

Merged chapters

- Ovary, Fallopian Tube, and Primary Peritoneal Carcinoma

Deleted chapters

- Cutaneous Squamous Cell Carcinoma and Other Cutaneous Carcinomas for all topographies, except Head and Neck

In addition to new and reorganized chapters, there are a number of important new staging paradigms introduced in the 8th Edition. Human papillomavirus (HPV) is a key discriminator in staging oropharyngeal carcinoma. Esophagus and stomach have separate staging systems for patients who have received neoadjuvant therapy. Bone and soft tissue sarcoma now have different staging systems based on anatomic sites. Finally, heritable cancer trait (H Category) has been introduced to retinoblastoma staging.

Additional updates to the *AJCC Cancer Staging Manual* are always available at cancerstaging.org and available for software developers via the AJCC API.

AJCC Cancer Staging questions should be directed to the CAnswer Forum at: http://cancerbulletin.facs.org/forums/forum/ajcc-tnm-staging-8th-edition

Site-Specific Data Items (SSDIs)

As of 2018, Collaborative Stage Site-Specific Factors (CS SSFs) have been discontinued and Site-Specific Data Items (SSDIs) are used for collection of site-specific information. SSDIs have unique names and NAACCR data item numbers and can be applied to as many sites as needed. Unlike SSFs, field length is not limited to 3 digits, and for measurements and lab values, explicit decimal points (rather than implied) are accommodated, and different coding conventions are used to record actual values, percentages and ranges. NAACCR is the custodian of the SSDIs, and the Site-Specific Data Item Task Force (SSDI TF) is responsible for their development and updates. Documentation for the SSDIs is available at https://apps.naaccr.org/ssdi/list/.

Schema ID and AJCC ID

In CSv2, 153 Schemas were defined based on site/histology and used to assign applicable site-specific factors (SSFs) and staging algorithms. For 2018, Schema ID [3800] is used to link all combinations of sites and histologies with the appropriate stage data collection systems and site-specific data items. AJCC ID [995] is used to link AJCC staging eligible sites/histologies with the appropriate AJCC chapter and staging algorithm. Schema ID and AJCC ID will be derived by registry software based on site and histology codes entered by the registrar. Refer to SSDI Manual Appendix A (https://www.naaccr.org/SSDI/SSDI-Manual-Appendix-A.pdf) for crosswalks for sites/histology, AJCC ID and Schema ID.

Schema discriminators

Introduced in CSv2, schema discriminators are used when primary site and/or histology are not sufficient to identify the correct AJCC staging algorithm. Due to the complexity of some of the 8th Edition

chapters, more than one schema discriminator may be needed to define the correct schema. Three SSDIs [3926, 3927 and 3928] are available to collect the information needed to define schema, although most chapters that require a schema discriminator need only one. Schema discriminators are used to define both AJCC ID and Schema ID. Refer to the SSDI Manual (https://www.naaccr.org/SSDI/SSDI-Manual.pdf) for the schema discriminators and for codes and coding instructions.

SSDIs Replacing CS SSFs

Of the approximately 260 unique SSFs defined in CS, 101 were discontinued, 12 were obsolete, and 147 were required by at least one standard setter in 2017. Of the required data items for 2017, 27 are not needed in 2018, so approximately 120 CS SSF data items have been replaced with analogous SSDIs. However, none of the CS SSF data will be mapped to the new data items. To minimize the number of new data items, a single SSDI applies to multiple schemas whenever possible. For each data item, the SSDI TF reviewed and incorporated any new information from the AJCC 8th Edition and updated College of American Pathologists (CAP) guidelines. The SSDI TF also attempted to reconcile inconsistencies between AJCC and CAP so that the codes developed for each data item would align with the associated CAP protocol. In contrast to the fixed length of the CS SSF fields, the SSDI fields vary in length. The length of each data item was determined based on the highest value recommended by AJCC 8th Edition or by other pertinent documentation. Refer to Appendix B in the SSDI Manual (https://www.naaccr.org/SSDI/SSDI-Manual-Appendix-B.pdf) to identify SSDIs replacing CS SSFs, with cross reference to SSF number, and to the SSDI Manual for codes and coding instructions.

Required for stage

The SSDIs include 25 new data items required for staging (AJCC or EOD), 15 of which are not previous SSFs, as well as grade, which is required in AJCC 8th Edition for some stage groups. Refer to the SSDI Manual (https://www.naaccr.org/SSDI/SSDI-Manual.pdf) to identify SSDIs required for stage in the AJCC 8th Edition and for codes and coding instructions.

Grade

The AJCC 8th Edition has specific grade tables listed for many chapters, some but not all of which follow the definitions of the historical standard grade data item *Grade/Differentiation* [440] as used in cancer registries, which has been discontinued for 2018. Three new data items have been defined for collection of *Grade Clinical, Pathological and Post Therapy* [3843, 3844 and 3845, respectively]. New grade values were developed following the format of T, N, and M, where definitions differ based on the schema and use schema-specific grade tables. Each schema-specific grade table includes the standard grade definition for those cases where the schema-specific grading system is not available in the pathology report or other medical documentation. The SSDI TF has developed a Grade Manual to provide information and coding instructions on the new grade data items and site/schema-specific grade tables (https://www.naaccr.org/SSDI/Grade-Manual.pdf).

Examples of Other New Data Items in Addition to "Required for Stage" and Grade

- Breast biomarkers: Nine new SSDIs were developed for collection of ER, PR and HER2 laboratory test results [3826, 3828, 3850-3854, 3914 and 3916]. These replace Breast SSFs 4-6 and 8-14 which were not brought over from CS due to changes in laboratory methods and interpretation.
- Brain biomarkers: One new SSDI, *Brain Molecular Markers* [3816], was developed at the request of CBTRUS to collect data on specific markers needed to define clinically important histological subtypes that are not differentiated in updated ICD-O-3 codes.

SSDI coding conventions

Each SSDI applies only to selected schemas. SSDI fields should be blank for schemas where they do not apply.

The "Not applicable" code is only used when a data item is appropriate for a schema but the standard setter does not require collection of the data item.

For laboratory tests, values for "not applicable" and "unknown" differ based on length of data item; the codes for not applicable ALWAYS end in '8' and the codes for unknown ALWAYS end in '9'.

SSDI Questions

Questions regarding SSDIs should be directed to the CAnswer Forum at:
http://cancerbulletin.facs.org/forums/forum/site-specific-data-items-grade-2018

ICD-O-3 Histologies

In developing the 2018 ICD-O update, a particular effort was made to use the nomenclature appearing in the World Health Organization's *International Histological Classification of Tumors* series (WHO "Blue Books"). This series covers all the principal sites of cancer and includes ICD-O morphology codes for each neoplasm. Since 2011, WHO has published seven editions covering eight organs/body systems. Each new edition underwent thorough review to identify new histologies and ICD-O codes, changes to behavior to existing ICD-O codes, and new terminology. The ICD-O-3 Implementation Work Group recommended changes were approved by the standard setting agencies.

At this time, WHO has no plans to release either an updated ICD-O-3 or ICD-O-4. The Work Group strongly recommends using the 2018 ICD-O-3 Histology and Behavior Code Update tables jointly with ICD-O-3, Hematopoietic and Lymphoid Neoplasm Database, and Solid Tumor (MP/H) rules. While we are aware of the release of ICD-O-3.1, this document has not been approved by the standard setting agencies for use in North America.

The 2018 ICD-O-3 histology code and behavior update includes comprehensive tables listing all changes to ICD-O-3 effective for solid tumor cases diagnosed 1/1/2018 and forward. Information from the NAACCR document, "What You Need to Know for 2017" Appendix A: Continued Use of ICD-O-3 Histology Code Crosswalk has been incorporated into the updated 2018 ICD-O-3 New Histology and Behavior Code Implementation Guidelines. The 2018 tables include coding instructions for cases diagnosed prior to 1/1/2018. Edits will enforce the new codes/behaviors allowed only for cases diagnosed 1/1/2018 forward. Date driven edits will also be implemented for those histology codes no longer valid, such as mucinous NOS 8480 for lung after 1/1/2018.

The ICD-O-3 Implementation Work Group created a guide for users which provides important information on the background and issues for this update along with how to use the tables.

NOTE: Use of these guidelines is required for determining reportability and accurate coding.

2018 ICD-O-3 Documents

The 2018 ICD-O-3 update includes four documents and errata which can be found at:
https://www.naaccr.org/implementation-guidelines/#ICDO3

ICD-O-3 Questions

Questions regarding ICD-O-3 Histology changes should be directed to Ask a SEER Registrar at:
https://seer.cancer.gov/registrars/contact.html

SEER Site/Histology Validation List

The SEER Site/Histology Validation List, used in software and edit development, will be updated to include the new ICD-O-3 code and behavior changes per the 2018 ICD-O-3 updates. This site/histology list is provided in both PDF and Excel formats and will be available on the following link:
https://seer.cancer.gov/icd-o-3/

Note: The Site/Histology Validation List is not intended to be used for casefinding or to determine reportability.

SEER Site/Histology Validation List Questions

Questions regarding the SEER Site/Histology Validation List should be directed to Ask a SEER Registrar at: https://seer.cancer.gov/registrars/contact.html

2018 Solid Tumor Coding Rules (formerly known as Multiple Primary and Histology Rules)

The 2018 Solid Tumor Coding Rules are a comprehensive revision to the 2007 site-specific Multiple Primary and Histology Rules, which were developed to promote consistent and standardized coding for cancer surveillance.

New Site-Specific Instructions

The 2018 rules provide new site-specific instructions for:

- Brain (benign)
- Brain (malignant)
- Breast
- Colon
- Head and neck
- Kidney
- Lung
- Renal pelvis/ureter/bladder

No changes were made to the site-specific instructions for Melanoma of the Skin or for Other Sites. The 2018 rules guide and standardize the process of determining the number of primaries. The histology rules include detailed histology coding instructions. For example, grouping histologic terms, differentiating between general (NOS) terms and specific histologic types and subtypes, and identifying mixed and combination codes are covered.

Important Details

- Solid Tumor Rules available in text format only.
- Terms and Definitions are now included with the M-rules and H-rules.
- New table for determining primary site in Head & Neck primaries.
- WHO grade tables for benign and malignant brain tumors.
- Reportable and non-reportable histology tables.
- Histology tables revised to include 2018 ICD-O-3 updates.
- Additional notes and examples for all site groups except Cutaneous Melanoma and Other Sites.
- Rules for Cutaneous Melanoma and for Other Sites have not been revised in the 2018 update. They will be revised for release in 2019.

The 2018 Solid Tumor Rules apply to all cases diagnosed in 2018 and later. For cases diagnosed 2007 to 2017, continue to apply the 2007 Multiple Primary and Histology Coding Rules.

Please visit the https://seer.cancer.gov/tools/solidtumor/ to obtain a copy of the 2018 Solid Tumor Rules Manual.

2018 Solid Tumor Coding Rules Questions

Questions regarding the Solid Tumor Rules should be directed to Ask a SEER Registrar at: https://seer.cancer.gov/registrars/contact.html

SEER Hematopoietic and Lymphoid Neoplasm Database

The Hematopoietic and Lymphoid Neoplasm Database has been updated based on the latest edition of the WHO Classification of Tumors for Hematopoietic and Lymphoid Neoplasms. Changes include

updating primary sites based on clarifications from AJCC 8th Edition authors, additional information on specific histologies and adding sources. The update, which can be found at https://seer.cancer.gov/tools/heme/, will continue to be applicable for cases diagnosed 2010 and forward.

SEER Heme Database Questions

Questions regarding the SEER Hematopoietic and Lymphoid Neoplasm Database should be directed to Ask a SEER Registrar at: https://seer.cancer.gov/registrars/contact.html

Summary Stage 2018

Summary Stage 2018 is effective for cases diagnosed 1/1/2018 and later. The link for the relevant coding manuals: https://seer.cancer.gov/tools/ssm/.

The Summary Stage 2018 schemas were developed based mainly on SS2000 with the goal of maintaining long term trends (incidence, staging, and survival). Summary Stage 2018 groups cases into broad categories of in situ, local, regional (by direct extension, by regional nodes, or by both), distant, benign, and unstaged. Summary Stage 2018 [764] is a directly coded field.

SEER Summary Stage 2018 Questions

Questions regarding Summary Stage 2018 should be directed to Ask a SEER Registrar at: https://seer.cancer.gov/registrars/contact.html

STORE 2018 Overview

- Implementation of the AJCC 8th Edition Staging System: Originally scheduled for release in 2017, the CoC worked directly with AJCC and its surveillance partners to delay implementation until 2018. The lessons learned and experience will guide future efforts and updates.
- Reclassification of the CS SSFs as discrete data items: The *majority* of these data items have not changed in terms of the information collected, except for the codes used to document the data. In addition, all of the CS SSFs were reviewed in conjunction, and aligned with, the CAP Protocols. It is the CoC's hope that this will facilitate the abstraction work necessary for the SSDIs, enabling rapid abstraction into the hospital registry from the CAP checklist. This alignment will become instrumental to the eventual direct filling of values from the electronic health record (EHR) into the registry and will eventually *save* abstraction efforts and time.
- Implementation of the new data collection infrastructure for Grade: The new way of collecting grade will greatly simplify the abstractor's task. There is no more guessing at whether you are dealing with a 2, 3, or 4 level grading system; there will be no more manual "calculation" of what value to enter for grade. The new site-specific look-ups for grade leave no room for error and will result in high quality grade data.
- New radiation data items from CoC: When the CoC re-engineered the way radiation data are collected, we did so with several higher goals in mind. At the same time that CoC developed the new data items, we have been working with radiation oncology groups at the national level to adopt and implement a standard End of Treatment Summary (EOTS) to be used by all radiation oncologists across the nation and by all EHRs. This standardized template is directly aligned with the new radiation data items, and when fully implemented will greatly facilitate abstraction of radiation therapy and communication between registrars and radiation oncologists. As with the SSDIs, this alignment will become instrumental to the eventual direct filling of values from the EHR into the hospital registry database and will eventually *save* abstraction efforts and time.
- Although the CoC is pursuing more rapid casefinding and reporting by CoC-accredited programs, this is being conducted via a long-term plan at a gradual, feasible pace over several years. It is CoC's hope that the integration of the EHR into hospital registry vendor software over the next

few years will revolutionize the art of cancer case abstraction and free up valuable registrar resources for timelier reporting.

- CoC will have NO CHANGES in cancer data standards until 2020. CoC will be using the NAACCR Version 18 standards throughout 2019, and any changes that are made for 2020 will be completed far in advance of implementation.

Other Revisions

A small number of other modifications made for clarification to *FORDS: Revised for 2016* were included in the STORE. Appendix A lists all content changes made subsequent to *FORDS: Revised for 2016*. Note that the generation of the STORE 2018 Manual resulted in pagination changes, and communications about STORE content should refer to the Case Eligibility Overview of Coding Principles sections or the actual STORE item definition in which the information is located rather than to page numbers.

2018 Coding Reference List

AJCC Cancer Staging Manual, Eighth Edition: https://cancerstaging.org/references-tools/Pages/Cancer-Staging-Resources.aspx

Site-Specific Data Items (SSDIs): https://apps.naaccr.org/ssdi/list/

Grade: https://www.naaccr.org/SSDI/Grade-Manual.pdf

ICD-O-3 Histologies: http://codes.iarc.fr/

SEER Site/Histology Validation List: https://seer.cancer.gov/icd-o-3/

2018 Solid Tumor Coding Rules: https://seer.cancer.gov/tools/solidtumor/

SEER Hematopoietic and Lymphoid Neoplasm Database: https://seer.cancer.gov/tools/heme/

Summary Stage 2018: https://seer.cancer.gov/tools/ssm/

SEER*Rx – Interactive Drug Database: http://seer.cancer.gov/tools/seerrx

Additional Coding References

Fritz A, Percy C, Jack A, et al (eds). *ICD-O: International Classification of Diseases for Oncology*, 3rd ed. Geneva, World Health Organization: 2000.

Edge S, Byrd D, Compton C, et al (eds): *AJCC Cancer Staging Manual*, 7th ed. American Joint Committee on Cancer, Chicago IL. Springer: 2009.

Collaborative Stage Data Collection System, Version 02.05. Available at *www.cancerstaging.org/cstage*. Site-specific factor requirements by schema, diagnosis year and standard-setter (including CoC) are available at http://seer.cancer.gov/csreqstatus/.

The 2007 Multiple Primary and Histology Coding Rules, revised 2012. National Cancer Institute, Surveillance, Epidemiology and End Results Program. Bethesda, MD: 2007. Available for download at *http://seer.cancer.gov/tools/mphrules/*.

NAACCR Inc. 2018 Implementation Guidelines and Recommendations. North American Association of Central Cancer Registries, Springfield IL: 2018. Available at *http://www.naaccr.org/StandardsandRegistryOperations/ImplementationGuidelines.aspx*

NAACCR, Inc. *Standards for Cancer Registries, Volume II: Data Standards and Data Dictionary*, version 18. North American Association of Central Cancer Registries, Springfield IL: 2018. Available at *http://www.naaccr.org/StandardsandRegistryOperations/VolumeII.aspx*.

Section One: Case Eligibility and Overview of Coding Principles

Case Eligibility

The American College of Surgeons Commission on Cancer (CoC) requires registries in accredited programs to accession, abstract, and conduct follow-up activities for required tumors diagnosed and/or initially treated at the abstracting facility. The tumors must meet the criteria for analytic cases (*Class of Case* 00-22), and pathologically and clinically diagnosed inpatients and outpatients must be included.

Tumors Required by the CoC to be Accessioned, Abstracted, Followed and Submitted to the National Cancer Database (NCDB)

Malignancies with an ICD-O-3 behavior code of 2 or 3 are required for all sites.

> EXCEPTION 1: Juvenile astrocytoma, listed as 9421/1 in ICD-O-3, *is required* and should be recorded as 9421/3 in the registry.
>
> EXCEPTION 2: Effective in 2015, code 8240/1 for Carcinoid tumor, NOS, of appendix (C18.1) becomes obsolete. Carcinoid tumors of the appendix (C18.1) must be coded to 8240/3, effective with 2015. This is *required* and must be coded with a behavior 3. Prior appendix primaries coded 8240/1 are converted to 8240/3 by the implementation conversions for 2015.
>
> EXCEPTION 3: Malignant primary skin cancers (C44._) with histology codes 8000–8110 *are not required* by the CoC. Skin primaries with those histologies diagnosed prior to January 1, 2003, were required to be accessioned and followed if the AJCC stage group at diagnosis was II, III, or IV. Those cases should remain in the registry data and continue to be followed.
>
> EXCEPTION 4: Carcinoma in situ of the cervix (CIS), intraepithelial neoplasia grade III (8077/2) of the cervix (CIN III), prostate (PIN III), vulva (VIN III), vagina (VAIN III), anus (AIN III), larynx (LIN III), and squamous intraepithelial neoplasia excluding cervix (SIN III) *are not required* by CoC. SIN III is a specific instance of intraepithelial neoplasia, grade III which is listed in ICD-O-3 as /2.

Nonmalignant primary intracranial and central nervous system tumors diagnosed on or after January 1, 2004, with an ICD-O-3* behavior code of 0 or 1 are required for the following sites: meninges (C70._), brain (C71._), spinal cord, cranial nerves, and other parts of central nervous system (C72._), pituitary gland (C75.1), craniopharyngeal duct (C75.2) and pineal gland (C75.3).

Gastro-intestinal stromal tumors (GIST) and thymomas are frequently non-malignant. However, they must be abstracted and assigned a *Behavior Code* of 3 if they are noted to have multiple foci, metastasis or positive lymph nodes.

Reportable-by-Agreement Cases

Registries may be requested to collect information about tumors that are not required to be abstracted by the CoC for accredited programs. Ordinarily, such requests will come from the facility's cancer committee or the central registry. The CoC does not require that reportable-by-agreement cases be accessioned, abstracted, followed, or submitted, but the requestor may identify the extent of information needed.

Examples of Reportable-by-Agreement Cases:

- The cancer committee requests abstracting and follow-up of *Class of Case* 30 cases.
- The state central registry requests abstracting and reporting of pathology-only cases.

Ambiguous Terms at Diagnosis

As part of the registry casefinding activities, all diagnostic reports should be reviewed to confirm whether a case is required. If the terminology is ambiguous, use the following guidelines to determine whether a particular case should be included. Words or phrases that appear to be synonyms of these terms do not constitute a diagnosis. For example, "likely" alone does not constitute a diagnosis.

Ambiguous Terms that Constitute a Diagnosis	
Apparent(ly)	Presumed
Appears	Probable
Comparable with	Suspect(ed)
Compatible with	Suspicious (for)
Consistent with	Tumor* (beginning with 2004 diagnoses and only for C70.0–C72.9, C75.1–75.3)
Favors	Typical of
Malignant appearing	
Most likely	
Neoplasm* (beginning with 2004 diagnoses and only for C70.0–C72.9, C75.1–75.3)	

*additional terms for nonmalignant primary intracranial and central nervous system tumors only

EXCEPTION: If cytology is identified only with an ambiguous term, 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.

Examples of Diagnostic Terms:

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

- The pathology report states *suspicious for malignancy*. *Suspicious for malignancy* is indicative of cancer.

Ambiguous Terms That *Do Not* Constitute a Diagnosis *without additional information*	
Cannot be ruled out	Questionable
Equivocal	Rule out
Possible	Suggests
Potentially malignant	Worrisome

Examples of Nondiagnostic Terms:

•The inpatient discharge summary documents a chest x-ray *consistent with neoplasm* of the right upper lobe. The patient refused further work-up or treatment. *Consistent with neoplasm* is not indicative of cancer. While "consistent with" can indicate involvement, "neoplasm" without specification of malignancy is not diagnostic except for non-malignant primary intracranial and central nervous system tumors.

•Final diagnosis is reported as *possible carcinoma* of the breast. *Possible* is not a diagnostic term for cancer.

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

Ambiguous Terminology Lists: References of Last Resort

This section clarifies the use of Ambiguous Terminology as listed in STORE 2018 for case reportability and staging in Commission on Cancer (CoC)-accredited programs. When abstracting, registrars are to use the "Ambiguous Terms at Diagnosis" list with respect to case reportability, and the "Ambiguous Terms Describing Tumor Spread" list with respect to tumor spread for staging purposes. However, these lists need to be used correctly.

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

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

Class of Case

All accessioned cases are assigned a *Class of Case* [610] based on the nature of involvement of the facility in the care of the patient.

Analytic Cases

Cases diagnosed and/or administered any of the first course of treatment at the accessioning facility after the registry's reference date are analytic (*Class of Case* 00-22). A network clinic or outpatient center belonging to the facility is part of the facility. The CoC is aligned with the Joint Commission accreditation status for your hospital/facility. Any services or facility covered under your Joint Commission accreditation would then be covered under your CoC accreditation and you would be responsible for reporting the associated data that is reportable as defined in the STORE.

Analytic cases *Class of Case* 10-22 are included in treatment and survival analysis.

Analytic cases *Class of Case* 00 are not required to be staged or followed, regardless of the year of diagnosis. *Class of Case* 00 is reserved for patients who are originally diagnosed by the reporting facility and receive all of their treatment elsewhere or a decision not to treat is made elsewhere. If the patient receives no treatment, either because the patient refuses recommended treatment or a decision is made not to treat, the *Class of Case* is 14. If there is no information about whether or where the patient was treated, the *Class of Case* is *10*.

Nonanalytic Cases

Nonanalytic cases (*Class of Case* 30-99) are not usually included in routine treatment or survival statistics. The CoC does not require registries in accredited programs to accession, abstract, or follow these cases, but the program or central registry may require them.

Modifications to Class of Case in 2010

Class of Case was redefined for use beginning in 2010. The codes in this manual allow differentiation between analytic and nonanalytic cases and make additional distinctions. For analytic cases, the codes distinguish cases diagnosed in a staff physician's office from those diagnosed initially by the facility and patients fully treated at the facility from those partially treated by the reporting facility. Nonanalytic cases are distinguished by whether the patient received care at the facility or did not personally appear there. Patients who received care from the facility are distinguished by the reasons a case may not be analytic: diagnosed prior to the patient's reference date, type of cancer that is not required by CoC to be abstracted, consultation, in-transit care, and care for recurrent or persistent disease. Patients who did not receive care from the reporting facility are distinguished by care given in one or more staff physician offices, care given through an agency whose cancer cases are abstracted by the reporting facility but are not part of it, pathology only cases, and death certificate only cases. Treatment in staff physician offices is now coded "treated elsewhere" because the hospital has no more responsibility over this treatment than it would if the patient were treated in another hospital.

Date of First Contact

The *Date of First Contact* [580] is the date of the facility's first inpatient or outpatient contact with the patient for diagnosis or treatment of the cancer. For analytic cases, the *Date of First Contact* is the date the patient qualifies as an analytic case *Class of Case* 00-22. Usually, the *Date of First Contact* is the date of admission for diagnosis or for treatment. If the patient was admitted for noncancer-related reasons, the *Date of First Contact* is the date the cancer was first suspected during the hospitalization. If the patient's diagnosis or treatment is as an outpatient of the facility, the *Date of First Contact* is the date the patient first appeared at the facility for that purpose.

If the patient was initially diagnosed at the facility and went elsewhere for treatment (*Class of Case* 00), but then returned for treatment that was initially expected to occur elsewhere, the *Class of Case* is updated to 13 or 14 but the *Date of First Contact* is not changed because it still represents the date the patient became analytic. If the *Class of Case* changes from nonanalytic (for example, consult only, *Class of Case* 30) to analytic (for example, part of first course treatment administered at the facility, *Class of Case* 21), the *Date of First Contact* is updated to the date the case became analytic (the date the patient was admitted for treatment).

When a pathology specimen is collected off site and submitted to the facility to be read (and the specimen is positive for cancer), the case is not required by the Commission on Cancer to be abstracted unless the patient receives first course treatment from the facility.

- If the patient subsequently receives first course treatment at the facility, the case is analytic and must be abstracted and followed. The *Date of First Contact* is the date the patient reported to the facility for the treatment; and the *Class of Case* [610] is 11 or 12 if the diagnosing physician is a staff physician at the reporting facility or 20 or 21 for any other physician. A staff physician is one who is employed by the facility, is under contract with it, or has routine admitting privileges there.

When a staff physician performs a biopsy off site, and the specimen is not submitted to the facility to be read, the case is not required to be abstracted unless the patient receives some first course care at the facility.

- If the patient subsequently receives first course treatment at the facility, the case is analytic and must be abstracted and followed. The *Date of First Contact* is the date the patient reported to the facility for the treatment and the *Class of Case* is 11 or 12.

For nonanalytic cases, the *Date of First Contact* is the date the patient's nonanalytic status begins with respect to the cancer. For example, for a patient diagnosed and treated entirely in a staff physician's office (*Class of Case* 40), the date the physician initially diagnosed the cancer is the *Date of First Contact*. For autopsy only cases, the *Date of First Contact* is the date of death.

If the state or regional registry requires pathology-only cases to be abstracted and reported, the *Date of First Contact* is the date the specimen was collected and the *Class of Case* is 43. If a patient whose tumor was originally abstracted as a *Class of Case* 43 receives first course treatment subsequently as an inpatient or outpatient at the facility, update both *Class of Case* and *Date of First Contact* to reflect the patient's first in-person contact with the facility.

Overview of Coding Principles

Unique Patient Identifier Codes

Accession Number [550] and *Sequence Number* [560] uniquely identify the patient and the tumor. Each cancer patient in a registry is assigned a unique accession number, and each primary diagnosed for that patient is assigned a sequence number. The accession number *never* changes.

- Accession numbers are never reassigned, even if a patient is removed from the registry.
- Once cases are submitted to RQRS or the NCDB, accession numbers are not to be changed for any reason. Even if there is a clerical error, or if cases are found in an out-of-order fashion when casefinding (i.e., find an old case after abstraction of a newer one), the accession number serves as a permanent identifier for a patient at your facility. NCDB does not accommodate any requests for accession number changes for cases already submitted.
- The sequence number is the sequence of all tumors over the lifetime of a patient and is counted throughout the patient's lifetime.
- Only tumors that would have been reportable at the time of diagnosis for CoC or by agreement with a central registry or the program's cancer committee are required to be counted when assigning sequence numbers. A registry may contain a single abstract for a patient with a sequence number of 02, because the first tumor was not cared for by the program or was not otherwise required to be accessioned. Because of differences in requirements, it is possible for two registries with dissimilar eligibility requirements (for example, a facility registry and a state central registry) to assign different sequence numbers to the same tumor, even though the sequence number codes and instructions applied are the same.

National Provider Identifier

The National Provider Identifier (NPI) is a unique identification number for health care providers that was implemented in 2007 and 2008 by the Centers for Medicare and Medicaid Services (CMS) as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For billing purposes, large practices and large group providers were required to use NPI codes by May 2007; small health plans were required to use NPI codes by May 2008. Individual item descriptions in Section Two of this manual should be consulted for specific coding instructions.

The NPI data items are:

NPI–Archive FIN [3105]
NPI–Following Physician [2475]
NPI–Following Registry [2445]
NPI–Institution Referred From [2415]
NPI–Institution Referred To [2425]
NPI–Managing Physician [2465]
NPI–Physician #3 [2495]
NPI–Physician #4 [2505]
NPI–Primary Surgeon [2485]
NPI–Reporting Facility [545]

Coding Dates

Beginning in 2010, the way dates are transmitted between facility registries and central registries or the National Cancer Database (NCDB) was changed to improve the interoperability or communication of cancer registry data with other electronic record systems. Registry software may display dates in the traditional manner or in the interoperable format. Traditional dates are displayed in MMDDCCYY form, with 99 representing unknown day or month portions, and 99999999 representing a completely unknown date. In the traditional form, some dates also permit 88888888 or 00000000 for special meaning. Interoperable dates are displayed in CCYYMMDD form, with the unknown portions of the date filled with blank spaces. If a date is entirely blank, an associated date flag is used to explain the missing date. The following table illustrates the relationship among these items for *Date of Most Definitive Surgical Resection of the Primary Site*, where *each lower case 'b' represents a blank space*. Flags are not used for software-generated dates.

Description	***Traditional Date* of Most Definitive Surgical Resection of the Primary Site**	***Interoperable Date* of Most Definitive Surgical Resection of the Primary Site**	**Rx Date Mst Defn Srg Flag**
	Date entered in MMDDCCYY sequence; unknown portions represented by 99 or 9999	Date entered in CCYYMMDD sequence, leaving unknown portions blank (spaces) indicated as 'b'; omit the date if the date is completely unknown or not applicable.	
Full date known	MMDDCCYY (example: 02182007)	CCYYMMDD (example: 20070218)	bb
Month and year known	MM99CCYY (example: 02992007)	CCYYMMbb (example: 200702bb)	bb
Year only known	9999CCYY (example: 99992007)	CCYYbbbb (example: 2007bbbb)	bb
Unknown if any surgery performed	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	10
No surgery performed	00000000 (example: 00000000)	bbbbbbbb (example: bbbbbbbb)	11
Date is unknown, surgery performed	99999999 (example: 99999999)	bbbbbbbb (example: bbbbbbbb)	12

Cancer Identification

The following instructions apply to *Primary Site* [400], *Laterality* [410], *Histology* [522], *Behavior Code* [523] and *Grade Clinical* [3843], *Grade Pathological* [3844], and *Grade Post Therapy* [3845].

Primary Site

The instructions for coding primary site are found in the "Topography" section of the ICD-O-3 "Coding Guidelines for Topography and Morphology" (ICD-O-3 pp. 23–26). The following guidelines should be followed for consistent analysis of primary sites for particular histologies.

Occult Cervical Lymph Node

Beginning with cases diagnosed 1/1/2018 and later, for a head and neck primary lymph node involvement with no head and neck tumor found or specified by a physician (i.e., Occult Head and Neck Lymph Node), the primary site will be coded:

- C76.0 if the neck node has not been tested or is negative for both HPV and EBV. The AJCC Cervical Lymph Nodes and Unknown Primary Tumor of the Head and Neck will be used.
- C10.9 if the neck node is p16 positive indicating human papillomavirus (HPV). The AJCC HPV-Mediated (p16+) Oropharyngeal Cancer will be used.
- C11.9 if the neck node is EBER positive, or both EBER and p16 positive, indicating Epstein Barr Virus (EBV). The AJCC Nasopharynx will be used.

Please refer to the SSDI Manual schema discriminators for further information and follow the instructions provided within the SSDI Schema Discriminator to assign the final primary site.

Cutaneous Carcinoma of the Head and Neck

Beginning with cases diagnosed 1/1/2018 and later, for skin cancers overlapping sites in the head and neck ONLY, assign the primary site code for the site where the bulk of the tumor is or where the epicenter is. These cases will be staged with AJCC Cutaneous Carcinoma of the Head and Neck. Do not use code C44.8 Overlapping lesion of skin. Cases coded to C44.8 will represent skin lesions overlapping between head and neck sites AND/OR skin in other parts of the body. These cases will not be staged with AJCC 8th Edition.

Hematopoietic and Lymphoid Cancers

Beginning with cases diagnosed in 2010, the Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual is to be used for coding primary site and histology of hematopoietic and lymphoid tumors (M-9590-9992) and to determine whether multiple conditions represent one or more tumors to be abstracted. *Appendix A* in FORDS 2016 has the former table for use for tumors diagnosed prior to January 1, 2010, for determining unique or same hematopoietic tumors.

Kaposi Sarcoma

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

Melanoma

- Code to Skin, NOS (C44.9) if a patient is diagnosed with metastatic melanoma and the primary site is not identified.

Specific Tissues with Ill-Defined Sites

- If any of the following histologies appears only with an ill-defined site description (e.g., “abdominal” or “arm”), code it to the tissue in which such tumors arise rather than the ill-defined region (C76._) of the body, which contains multiple tissues. Use the alphabetic index in **ICD-O-3** to assign the most specific site if only a general location is specified in the record.

Histology	Description	Code to This Site
8720–8790	Melanoma	C44._, Skin
8800–8811, 8813–8830, 8840–8921, 9040–9044	Sarcoma except periosteal fibrosarcoma and dermatofibrosarcoma	C49._, Connective, Subcutaneous and Other Soft Tissues
8990–8991	Mesenchymoma	C49._, Connective, Subcutaneous and Other Soft Tissues
9120–9170	Blood vessel tumors, lymphatic vessel tumors	C49._, Connective, Subcutaneous and Other Soft Tissues

9580–9582	Granular cell tumor and alveolar soft part sarcoma	C49._, Connective, Subcutaneous and Other Soft Tissues
9240–9252	Mesenchymal chondrosarcoma and giant cell tumors	C40._, C41._ for Bone and Cartilage C49._, Connective, Subcutaneous and Other Soft Tissues
8940–8941	Mixed tumor, salivary gland type	C07._ for Parotid Gland C08._ for Other and Unspecified Major Salivary Glands

Laterality

Laterality [410] must be recorded for the following paired organs as 1-5 or 9. Organs that are not paired, unless they are recorded "right" or "left" laterality, are coded 0. Midline origins are coded 5. "Midline" in this context refers to the point where the "right" and "left" sides of paired organs come into direct contact and a tumor forms at that point. Most paired sites cannot develop midline tumors. For example, skin of the trunk can have a midline tumor, but the breasts cannot.

Paired Organ Sites	
ICD-O-3	**Site**
C07.9	Parotid gland
C08.0	Submandibular gland
C08.1	Sublingual gland
C09.0	Tonsillar fossa
C09.1	Tonsillar pillar
C09.8	Overlapping lesion of tonsil
C09.9	Tonsil, NOS
C30.0	Nasal cavity (excluding nasal cartilage and nasal septum)
C30.1	Middle ear
C31.0	Maxillary sinus
C31.2	Frontal sinus
C34.0	Main bronchus (excluding carina)
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)
C41.4	Pelvic bones (excluding sacrum, coccyx, and symphysis pubis)
C44.1	Skin of eyelid
C44.2	Skin of external ear
C44.3	Skin of other and unspecified parts of face

Paired Organ Sites	
ICD-O-3	**Site**
C44.5	Skin of trunk
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
C70.0	Cerebral meninges, NOS (excluding diagnoses prior to 2004)
C71.0	Cerebrum (excluding diagnoses prior to 2004)
C71.1	Frontal lobe (excluding diagnoses prior to 2004)
C71.2	Temporal lobe (excluding diagnoses prior to 2004)
C71.3	Parietal lobe (excluding diagnoses prior to 2004)
C71.4	Occipital lobe (excluding diagnoses prior to 2004)
C72.2	Olfactory nerve (excluding diagnoses prior to 2004)
C72.3	Optic nerve (excluding diagnoses prior to 2004)
C72.4	Acoustic nerve (excluding diagnoses prior to 2004)
C72.5	Cranial nerve, NOS (excluding diagnoses prior to 2004)
C74.0–C74.9	Adrenal gland
C75.4	Carotid body

Revising the Original Diagnosis

Data are gathered from multiple sources using the most recent and complete information available. Over time, the patient's records may contain new information such as tests, scans, and consults. Change the primary site, laterality, histology, grade and stage as the information becomes more complete. If the primary site or histology is changed, it may also be necessary to revise site-specific staging and treatment codes. There is no time limit for making revisions that give better information about the

original diagnosis or stage. However, if staging information is updated, it is important to adhere to the staging timeframe and criteria for the respective staging system applicable at the time of the original diagnosis. Most cases that require revision are unknown primaries.

Example 1

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 that meets the AJCC time frame requirements for staging, change the stage from not applicable (88) to the appropriate staging classification, TNM categories, and stage group, or to unknown. If first course surgery was performed, the surgery codes should be reviewed. For cases diagnosed 2004-2015, update the Collaborative Stage input items and rerun the derivation program.

Example 2

A physician decides that a previously clinically diagnosed malignancy is a benign lesion. The patient is referred from a nursing home to the facility. 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 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. If the deleted case is the patient’s only primary, do not reuse the accession number.

Patient Address and Residency Rules

The patient’s address at diagnosis is the patient’s place of residence at the time of original diagnosis. It does not change if the patient moves. If the patient has more than one primary tumor, the address at diagnosis may be different for each primary.

The current address initially is the patient’s residence at the time the patient was first seen at the accessioning facility for this primary. The current address is updated if the patient moves. If the patient has more than one primary tumor, the current address should be the same for each primary.

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.” State Vital Statistics rules may differ from Census rules. Do not record residence from the death certificate. Review each case carefully.

Rules for Persons with Ambiguous 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 the patient was staying when the cancer was diagnosed. This location may be a shelter or the diagnosing facility.

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

Persons in Institutions: The Census Bureau states, "Persons under formally authorized, supervised care or custody" are residents of the institution. This classification 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 Affairs (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 families. Military personnel may use the installation address or the surrounding community's address. The Census Bureau has detailed residency rules for Navy personnel, Coast Guard, and maritime ships. Refer to Census Bureau publications for the detailed rules.

Coding Country and State

Beginning in 2013, "country" fields accompany "state" fields in addresses. The following state and country address data items are found in FORDS/STORE:

State at Diagnosis (not changed)
Addr at Diagnosis--Country (associated with State at Diagnosis)
State—Current (not changed)
Address Current – Country (associated with State—Current)
Place of Birth (discontinued, replaced by Birthplace—State and Birthplace—Country)
Birthplace—State (coded similarly to the other two "state" fields)
Birthplace—Country (associated with Birthplace—State)

Appendix D has a list of all country codes and corresponding state codes. State codes for all U.S. states and possessions and all Canadian provinces are included in Appendix D. State codes for the United States and its possessions are those used by the United States Postal Service. Canadian province or territory codes are from Canada Post sources. Country codes are based on the International Standards Organization (IS) 3166-1 Country Three Character Codes. State and country codes also include some custom codes, which are included in Appendix D.

The list in Appendix D is divided into three parts.

- The first part is the preferred codes to use when sufficient detail is known to identify the U.S. state, Canadian province, or other country to assign precise codes.
- The second part consists of codes for more general regions for use when a precise code cannot be assigned (for example, "Near East"). If there is no indication at all of location in the patient record, the country is coded ZZU and the state will be ZZ.
- The third section is a list of obsolete codes that may have been assigned when the registry data were upgraded from former codes. This information is provided to assist registries in

interpreting their historic data, but the obsolete codes must not be assigned for current abstracting.

In Utero Diagnosis and Treatment

Beginning in 2009, diagnosis and treatment dates for a fetus prior to birth are to be assigned the actual date of the event. In the past, those dates were set by rule to the date the baby was born. The exact date may be used for cases diagnosed prior to 2009.

Comorbidities and Complications/Secondary Diagnoses

The CoC requires that the registry record include up to 10 comorbid conditions, factors influencing the health status of the patient, and treatment complications, to be copied from the patient record. All are secondary diagnoses. Prior to 2018, the information was recorded in the International Classification of Diseases, Ninth or Tenth Revision, Clinical Modification (ICD-9-CM or ICD-10-CM) code form, typically on the patient's discharge abstract or face sheet of the medical/billing record. Most hospitals in the United States were expected to implement use of ICD-10-CM in 2015. Separate data item series were used to record the two series. ICD-10-CM codes can have up to 7 characters, whereas ICD-9-CM codes only have 5 characters or fewer. Both the specific codes and the rules for recording them differ. The underlying meanings of the codes are similar. That is, the concepts originally described as "comorbidities and complications" are also known as "secondary diagnoses"; in this instance, the separate names are given to distinguish the separate registry data items.

Beginning with cases diagnosed in 2018, the following data items are no longer required:

The items describing patient comorbid conditions and complications ICD-9-CM codes are:

Comorbidities and Complications #1 [3110]
Comorbidities and Complications #2 [3120]
Comorbidities and Complications #3 [3130]
Comorbidities and Complications #4 [3140]
Comorbidities and Complications #5 [3150]
Comorbidities and Complications #6 [3160]
Comorbidities and Complications #7 [3161]
Comorbidities and Complications #8 [3162]
Comorbidities and Complications #9 [3163]
Comorbidities and Complications #10 [3164]

Beginning with cases diagnosed in 2018, only the following data items are required:

The items describing patient comorbid secondary diagnoses ICD-10-CM codes are:

Secondary Diagnosis #1 [3780]
Secondary Diagnosis #2 [3782]
Secondary Diagnosis #3 [3784]
Secondary Diagnosis #4 [3786]
Secondary Diagnosis #5 [3788]
Secondary Diagnosis #6 [3790]
Secondary Diagnosis #7 [3792]
Secondary Diagnosis #8 [3794]
Secondary Diagnosis #9 [3796]

Secondary Diagnosis #10 [3798]

Three general categories of information are collected: comorbidities, complications, and factors influencing the health status of patients.

Comorbidities are preexisting medical conditions or conditions that were present at the time the patient was diagnosed with this cancer (for example, chronic conditions such as COPD, diabetes, and hypertension).

Complications are conditions that occur during the hospital stay, while the patient is being treated for the cancer (for example, postoperative urinary tract infection or pneumonia). Complications may also occur following the completion of therapy and be a cause for readmission to the hospital. Complications are identified by codes which classify environmental events, circumstances, and conditions as the cause of injury, poisoning, and other adverse effects. Only complication codes that describe adverse effects occurring during medical care are collected in this data item. They include misadventures to patients during surgical and medical care, and drugs and medicinal and biologic substances causing adverse effects in therapeutic use.

Factors influencing the health status of patients are circumstances or problems that are not themselves a current illness or injury (for example, women receiving postmenopausal hormone replacement therapy, or a history of malignant neoplasm). Only specific codes which describe health characteristics are collected in this data item. They include prophylactic measures, personal health history, pregnancy, contraception, artificial opening and other postsurgical states, and prophylactic organ removal.

Stage of Disease at Initial Diagnosis

AJCC Prognostic Staging

AJCC Prognostic Stage is based on the clinical, operative, and pathologic assessment of the anatomic extent of disease – plus additional prognostic factors as required – and is used to make appropriate treatment decisions, determine prognosis, and measure end results. Use the rules in the current *AJCC Cancer Staging Manual* to assign AJCC T, N, M, required prognostic factor(s), and Stage Group values. The following general rules apply to AJCC staging of all sites.

- *Clinical staging* includes any information obtained about the extent of cancer before initiation of definitive treatment (surgery, systemic or radiation therapy, active surveillance, or palliative care) or within four months after the date of diagnosis, whichever is *shorter*, as long as the cancer has not clearly progressed during that time frame. This stage classification is designated as cTNM.
- *Pathological staging* includes any information obtained about the extent of cancer through completion of definitive surgery as part of first course treatment or identified within 4 months after the date of diagnosis, whichever is *longer*, as long as there is no systemic or radiation therapy initiated or the cancer has not clearly progressed during that time frame. This stage classification is designated as pTNM.
- *Post therapy staging* (post-neoadjuvant therapy staging) includes any information obtained about the extent of cancer after completion of neoadjuvant therapy followed by surgery, and the time frame should be such that the post neoadjuvant surgery and staging occur within a time frame that accommodates disease specific circumstances. This stage classification is designated as ypTNM.
- If a patient has multiple primaries, stage each primary independently.

- If the stage group cannot be determined from the recorded categories, then record it as unknown.
- When a patient with multiple primaries develops metastases, a biopsy may distinguish the source of distant disease. Stage both primaries as having metastatic disease if the physician is unable to conclude which primary has metastasized. If, at a later time, the physician identifies which primary has metastasized, update the stage(s) as appropriate.
- If pediatric staging is used and AJCC staging is not applied, code 88 for clinical and pathological T, N, and M as well as stage group. If either clinical or pathological staging was applied for a pediatric tumor, enter the appropriate codes and do not code 88.
- If a site/histology combination is not defined in the AJCC Manual code 88 for clinical and pathological T, N, and M as well as stage group.
- For in situ tumors that are considered as "impossible diagnoses" in the AJCC manual code 88 for clinical and pathological T, N, and M as well as stage group.
- For additional information on AJCC's general staging rules, download Chapter 1: Principles of Cancer Staging from www.cancerstaging.org.

Ambiguous Terminology

If the wording in the patient record is ambiguous with respect to tumor spread, use the following guidelines:

Ambiguous Terms Describing Tumor Spread

Terms that Constitute Tumor Involvement or Extension		Terms that *Do Not* Constitute Tumor Involvement or Extension
Adherent	Into	Approaching
Apparent	Onto	Equivocal
Compatible with	Out onto	Possible
Consistent with	Probable	Questionable
Encroaching upon	Suspect	Suggests
Fixation, fixed	Suspicious	Very close to
Induration	To	

Refer to Ambiguous Terminology Lists: References of Last Resort for additional information.

First Course of Treatment

The first course of treatment includes all methods of treatment recorded in the treatment plan and administered to the patient before disease progression or recurrence. "Active surveillance" is a form of planned treatment for some patients; its use is coded in the *RX Summ–Treatment Status* [1285]. "No therapy" is a treatment option that occurs if the patient refuses treatment, the family or guardian refuses treatment, the patient dies before treatment starts, or the physician recommends no treatment be given. If the patient refuses all treatment, code "patient refused" (code 7 or 87) for all treatment modalities. Maintenance treatment given as part of the first course of planned care (for example, for leukemia) is first course treatment, and cases receiving that treatment are analytic.

Treatment Plan

A treatment plan describes the type(s) of therapies intended to modify, control, remove, or destroy proliferating cancer cells. The documentation confirming a treatment plan may be found in several different sources; for example, medical or clinic records, consultation reports, and outpatient records.

- All therapies specified in the physician(s) treatment plan are a part of the first course of treatment if they are actually administered to the patient.
- A discharge plan must be a part of the patient's record in The Joint Commission-accredited hospital's EHR and may contain part or all of the treatment plan.
- An established protocol or accepted management guidelines for the disease can be considered a treatment plan in the absence of other written documentation.
- 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."

Time Periods for First Course of Treatment

If first course treatment was provided, the *Date of First Course of Treatment* [1270] is the earliest of *Date of First Surgical Procedure* [1200], *Date Radiation Started* [1210], *Date Systemic Therapy Started* [3230], or *Date Other Treatment Started* [1250].

- If no treatment is given, record the date of the decision not to treat, the date of patient refusal, or the date the patient expired if the patient died before treatment could be given.
- If active surveillance ("watchful waiting") was selected, record the date of that decision.
- Additional data items further define the parameters for specific treatments and treatment modalities, as described in the following sections.

Data item, *RX Summ–Treatment Status* [1285], implemented in 2010, summarizes whether the patient received any first course treatment, no treatment, or is being managed by active surveillance.

All Malignancies except Leukemias

The first course of treatment includes all therapy planned and administered by the physician(s) during the first diagnosis of cancer. Planned treatment may include multiple modes of therapy and may encompass intervals of a year or more. Any therapy administered after the discontinuation of first course treatment is subsequent treatment.

Leukemias

The first course of treatment includes all therapies planned and administered by the physician(s) during the first diagnosis of leukemia. Record all remission-inducing or remission-maintaining therapy as the first course of treatment. Treatment regimens may include multiple modes of therapy. The administration of these therapies can span a year or more. A patient may relapse after achieving a first remission. All therapy administered after the relapse is secondary or subsequent treatment.

Surgery

First course surgery items describe the most definitive type of surgical treatment the patient received from any facility, when it was performed, and its efficacy. When no surgical treatment is given, the reason is recorded. Major aspects of surgical care provided by the individual facility are also recorded so that hospital cancer programs can evaluate local patient care.

Individual item descriptions in Section Two: Instructions for Coding of this manual should be consulted for specific coding instructions. The paragraphs below describe how the surgery items fit together.

The following summary items apply to all surgical procedures performed at this facility and at other facilities:

Surgical Procedure of Primary Site [1290]
Radiation/Surgery Sequence [1380]
Scope of Regional Lymph Node Surgery [1292]
Date of Regional Lymph Node Dissection [682]
Date Regional Lymph Node Dissection Flag [683]
Date of Sentinel Lymph Node Biopsy (for breast and melanoma only) [832]
Date of Sentinel Lymph Node Biopsy Flag (for breast and melanoma only) [833]
Sentinel Lymph Nodes Examined (for breast and melanoma only) [834]
Sentinel Lymph Nodes Positive (for breast and melanoma only) [835]
Surgical Procedure/Other Site [1294]
Surgical Margins of the Primary Site [1320]
Reason for No Surgery of Primary Site [1340]
Date of First Surgical Procedure [1200]
RX Date–Surgery Flag [1201]
Date of Most Definitive Surgical Resection of the Primary Site [3170]
RX Date Mst Defn Srg Flag [3171]
Date of Surgical Discharge [3180]
RX Date Surg Disch Flag [3181]
Readmission to the Same Hospital Within 30 Days of Surgical Discharge [3190]

The following items apply to surgical procedures performed at this facility:

Surgical Procedure of Primary Site at This Facility [670]
RX Hosp–Surg App 2010 [668]
Scope of Regional Lymph Node Surgery at This Facility [672]
Surgical Procedure/Other Site at This Facility [674]

Relationships among Surgical Items

Date of First Surgical Procedure [1200] is the date that the first *Surgical Procedure of Primary Site* [1290], *Scope of Regional Lymph Node Surgery* [1292], or *Surgical Procedure/Other Site* [1294] is performed as part of first course treatment.

- If surgery was the only type of first course treatment performed or was the first of multiple treatment modalities, *Date of First Surgical Procedure* [1200] is the same as *Date of First Course of Treatment* [1270]. Both dates can be used to describe lag time between diagnosis and initialization of specific aspects of treatment.

Surgical Procedure of Primary Site [1290], *Scope of Regional Lymph Node Surgery* [1292], and *Surgical Procedure/Other Site* [1294] record three distinct aspects of first course therapeutic surgical procedures that may be performed during one or multiple surgical events. If multiple primaries are treated by a single surgical event, code the appropriate surgical items separately for each primary.

When multiple first course procedures coded under the same item are performed for a primary, the most extensive or definitive is the last performed, and the code represents the cumulative effect of the separate procedures. Do not rely on your registry software to accumulate separate surgeries into the correct code.

- *Surgical Procedure of Primary Site* [1290] is a site-specific item that describes the most invasive extent of local tumor destruction or surgical resection of the primary site and of surrounding tissues or organs that are removed in continuity with the primary site.
- *Scope of Regional Lymph Node Surgery* [1292] describes the removal, biopsy, or aspiration of sentinel nodes and other regional lymph nodes that drain the primary site and may include surgical procedures that aspirate, biopsy, or remove regional lymph nodes in an effort to diagnose and/or stage disease as well as removal of nodes for treatment of the disease.
- *Surgical Procedure/Other Site* [1294] describes first course resection of distant lymph node(s) and/or regional or distant tissue or organs beyond the *Surgical Procedure of the Primary Site* range.

If surgery of the respective type was performed, the code that best describes the surgical procedure is recorded whether or not any cancer was found in the resected portion. Incidental removal of tissue or organs, when it is not performed as part of cancer treatment (for example, incidental removal of an appendix), does not alter code assignment.

The code ranges and corresponding descriptions for site-specific *Surgical Procedure of Primary Site* code are grouped according to the general nature of the procedure:

- Codes 10 through 19 are site-specific descriptions of tumor-destruction procedures that do not produce a pathologic specimen.
- Codes 20 through 80 are site-specific descriptions of resection procedures.
- The special code 98 applies to specific tumors that cannot be clearly defined in terms of primary/nonprimary site. *Surgical Procedure of Primary Site* should be coded 98 for any tumor characterized by the specific sites and/or morphologies identified in the site-specific code instructions for *Unknown and Ill-Defined Primary Sites* and *Hematopoietic/ Reticuloendothelial/Immunoproliferating/ Myeloproliferative Disease*. The item *Surgical Procedure/Other Site* is used to indicate whether surgery was performed for these tumors.

Response categories are defined in logical sequence. Within groups of codes, procedures are defined with increasing degrees of descriptive precision. Succeeding groups of codes define progressively more extensive forms of resection.

For codes 00 through 79, the descriptions of the surgical procedures are hierarchical. Last-listed responses take precedence over earlier-listed responses (regardless of the code or numeric value).

To the extent possible, codes and their definitions are the same as those previously assigned in *ROADS/FORDS* to accommodate analysis in registries that maintain unconverted data. As a result of added and modified codes, however, the numeric code sequence may deviate from the order in which the descriptions of the surgical procedures are listed.

Example: A rectosigmoid primary surgically treated by polypectomy with electrocautery, which is listed *after* polypectomy alone, is coded 22.

20 Local tumor excision, NOS
26 Polypectomy
27 Excisional biopsy
Combination of 20 or 26–27 WITH
21 Photodynamic therapy (PDT)
22 Electrocautery
23 Cryosurgery
24 Laser ablation
25 Laser excision

Scope of Regional Lymph Node Surgery [1292] distinguishes between sentinel lymph node biopsy and removal of other regional lymph nodes and distinguishes removal of regional lymph nodes during the same surgical procedure as a sentinel node biopsy from subsequent removal.

- One important use of registry data is the tracking of treatment patterns over time. In order to compare contemporary treatment to previously published treatment based on the former codes, or to data still unmodified from pre-1998 definitions, the ability to differentiate surgeries in which four or more regional lymph nodes are removed is desirable. The compromise incorporated in the *Scope of Regional Lymph Node Surgery* [1292] codes separates removal of one to three nodes (code 4) from removal of four or more nodes in the response categories (code 5). It is **very important** to note that this distinction is made to permit comparison of current surgical procedures with procedures coded in the past when the removal of fewer than four nodes was not reflected in surgery codes. The distinction between fewer than four nodes and four or more nodes removed is not intended to reflect clinical significance when applied to a particular surgical procedure.

Surgical Procedure/Other Site [1294] describes surgery performed on tissue or organs other than the primary site or regional lymph nodes. It is also used to describe whether surgery was performed for tumors having unknown or ill-defined primary sites or hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease morphologies. If any surgical treatment was performed on these cancers, *Surgical Procedure/Other Site* is coded 1.

Surgical Procedure of Primary Site at This Facility [670]*, Scope of Regional Lymph Node Surgery at This Facility* [672]*,* and *Surgical Procedure/Other Site at This Facility* [674] are identical to *Surgical Procedure of Primary Site* [1290]*, Scope of Regional Lymph Node Surgery* [1292]*,* and *Surgical Procedure/Other Site* [1294], respectively, except they each refer solely to surgery provided by the respective facility.

Six surgery items augment the information recorded in *Surgical Procedure of Primary Site* [1290]. The items *Date of Most Definitive Surgical Resection of the Primary Site* [3170]*, Surgical Margins of the Primary Site* [1320]*, Date of Surgical Discharge* [3180]*,* and *Readmission to the Same Hospital Within 30*

Days of Surgical Discharge [3190] apply to the most definitive (most invasive) first course primary site surgery performed, that is, to the event recorded under *Surgical Procedure of Primary Site* [1290]. When no surgical procedure of the primary site is performed, the reason is recorded in the item *Reason for No Surgery of Primary Site* [1340].

- *Date of Most Definitive Surgical Resection* [3170] is the date on which the specific procedure recorded in *Surgical Procedure of Primary Site* [1290] was performed. If only one first course surgical procedure was performed, then the date will be the same as that for *Date of First Surgical Procedure* [1200].
- *Surgical Margins of the Primary Site* [1320] records the pathologist's determination of the presence of microscopic or macroscopic involvement of cancer at the margins of resection following the surgical resection described by *Surgical Procedure of Primary Site* [1290].
- *RX Hosp–Surg App 2010* [668] distinguishes among open surgery, laparoscopic surgery, and robotic assisted surgery when it is performed by the reporting facility. If more than one surgical procedure is performed by the facility, this item refers to the most definitive (most invasive) first course primary site surgery performed.
- *Date of Surgical Discharge* [3180] is the date the patient was discharged following the procedure recorded in *Surgical Procedure of Primary Site* [1290]. It is on or after the *Date of Most Definitive Surgical Resection* [3170].
- *Readmission to the Same Hospital Within 30 Days of Surgical Discharge* [3190] distinguishes a planned from an unplanned hospital admission and is used as a quality of care indicator.
- *Reason for No Surgery of Primary Site* [1340] identifies why surgical therapy was not provided to the patient and distinguishes a physician's not recommending surgical therapy due to contraindicating conditions from a patient's refusal of a recommended treatment plan.

Radiation Therapy

The radiation items in *STORE* are clinically relevant and reflect contemporary practice. These items record new "phase" terminology, replacing the traditional terms of "regional" and "boost." The first phase (Phase I) of a radiation treatment may be commonly referred to as an initial plan and a subsequent phase (Phase II) may be referred to as a boost or cone down. A new phase begins when there is a change in the target volume of a body site, treatment fraction size, modality or treatment technique. Up to three phases of radiation treatment can now be documented.

The following summary items apply to all radiation therapy administered at this facility and at other facilities:

Date Radiation Started [1210]
RX Date–Radiation Flag [1211]
Location of Radiation Treatment [1550]
Radiation/Surgery Sequence [1380]
Date Radiation Ended [3220]
RX Date Rad Ended Flag [3221]
Reason for No Radiation [1430]

The following are the new phase-specific data items (Phase I [1501-1507], Phase II [1511-1517], Phase III [1521-1527]):

Radiation Primary Treatment Volume
Radiation to Draining Lymph Nodes
Radiation Treatment Modality
Radiation External Beam Planning Technique
Dose per Fraction
Number of Fractions
Total Dose

These three other new summary radiation data items are being implemented, which are cumulate across the phases of radiation treatment:

Number of Phases of Radiation Treatment to this Volume [1532]
Radiation Discontinued Early [1531]
Total Dose [1533]

Relationships among Radiation Items

Date Radiation Started [1210] is the date that the first radiation therapy was delivered to the patient as part of all of the first course of therapy. This item in combination with *Date Radiation Ended* [3220] allows the duration of treatment to be calculated.

- If radiation was the only type of first course treatment performed or was the first of multiple treatment modalities, *Date Radiation Started* [1210] is the same as *Date of First Course of Treatment* [1270]. Both dates can be used to describe lag time between diagnosis and initialization of specific aspects of treatment.

Location of Radiation Treatment [1550] can be used to assess where therapy was provided. This item allows for the distinction between summary treatment and treatment given at the accessioning facility. Codes are provided that allow the description of where regional and boost dose therapy were provided, whether all the therapy was provided at the accessioning facility or if all or some of the radiation therapy was referred out to another treatment location.

The targeted anatomic region is described by *Phase I, II and III Radiation Primary Treatment Volume* [1504, 1514 and 1524, respectively]. The treatment volume may be the same as the primary site of disease; however, the available code values provide descriptions of anatomic regions that may extend beyond the primary site of disease and may be used to describe the treatment of metastatic disease. If two distinct volumes are radiated, and one of those includes the primary site, record the radiation involving the primary site in all radiation fields.

In addition to knowing the duration of treatment and the modalities and doses involved, it is critical to know the number of treatments to be able to gauge the intensity of the dose delivered to the patient. The data item *Number of Phases of Radiation Treatment to This Volume* [1532] describes the total

number of therapeutic treatments (phases) delivered to the anatomic volume coded in *Phase I, II and III Radiation Primary Treatment Volume* [1504, 1514, and 1524, respectively].

Two items augment the information recorded in the radiation modality, dose, volume, and number of treatment items.

- *Radiation/Surgery Sequence* [1380] identifies those instances where radiation therapy and the surgical management of the patient are not discrete and overlap with respect to time. Radiation therapy can precede the surgical resection of a tumor and then be continued after the patient's surgery, or radiation can be administered intraoperatively.

- *Reason for No Radiation* [1430] identifies why radiation therapy was not provided to the patient and distinguishes a physician's not recommending this therapy due to contraindicating conditions from a patient's refusal of a recommended treatment plan.

Systemic Therapy

Systemic therapy encompasses the treatment modalities captured by the items chemotherapy, hormone therapy, and immunotherapy. The systemic therapy items in *FORDS*/*STORE* separate the administration of systemic agents or drugs from medical procedures which affect the hormonal or immunologic balance of the patient.

The following summary items apply to all systemic therapy administered at this facility and at other facilities:

Date Systemic Therapy Started [3230]
RX Date Systemic Flag [3231]
Date Chemotherapy Started [1220]
RX Date–Chemo Flag [1221]
Date Hormone Therapy Started [1230]
RX Date–Hormone Flag [1231]
Date Immunotherapy Started [1240]
RX Date BRM Flag [1241]
Systemic/Surgery Sequence [1639]
Chemotherapy [1390]
Hormone Therapy [1400]
Immunotherapy [1410]
Hematologic Transplant and Endocrine Procedures [3250]

The following items describe systemic therapy performed at this facility:

Chemotherapy at This Facility [700]
Hormone Therapy at This Facility [710]
Immunotherapy at This Facility [720]

Clarification of Systemic Therapy Terms	
Term	**Definition**
Chemotherapy	Cancer therapy that achieves its antitumor effect through the use of antineoplastic drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis.
Hormone therapy	Cancer therapy that achieves its antitumor effect through changes in hormonal balance. This type of therapy includes the administration of hormones, agents acting via hormonal mechanisms, antihormones, and steroids.
Immunotherapy	Cancer therapy that achieves its antitumor effect by altering the immune system or changing the host's response to the tumor cells.
Endocrine therapy	Cancer therapy that achieves its antitumor effect through the use of radiation or surgical procedures that suppress the naturally occurring hormonal activity of the patient (when the cancer occurs at another site) and, therefore, alter or affect the long-term control of the cancer's growth.
Hematologic transplants	Bone marrow or stem cell transplants performed to protect patients from myelosuppression or bone marrow ablation associated with the administration of high-dose chemotherapy or radiation therapy.

Important information affecting classification of some systemic therapies. The six drugs listed in the table below were previously classified as Chemotherapy and are now classified as BRM/Immunotherapy. This change is effective for cases diagnosed January 1, 2013, and forward. For cases diagnosed prior to January 1, 2013, registrars have been instructed to continue coding these drugs as Chemotherapy. Coding instructions related to this change have been added to the remarks field for the applicable drugs in *SEER*Rx Interactive Drug Database*.

Drug Name(s)	Category Prior to 2013	Category 2013 +
Alemtuzumab/Campath	Chemotherapy	BRM/Immunotherapy
Bevacizumab/Avastin	Chemotherapy	BRM/Immunotherapy
Rituximab	Chemotherapy	BRM/Immunotherapy
Trastuzumab/Herceptin	Chemotherapy	BRM/Immunotherapy
Pertuzumab/Perjeta	Chemotherapy	BRM/Immunotherapy
Cetuxumab/Erbitux	Chemotherapy	BRM/Immunotherapy

Chemotherapy and hormone therapy agents are administered in treatment cycles, either singly or in a combination regimen of two or more drugs. If a patient has an adverse reaction, the managing physician may change one of the agents in a combination regimen. If the replacement agent belongs to the same group as the original agent, there is no change in the regimen. However, if the replacement agent is of a different group than the original agent, the new regimen represents the start of subsequent therapy, *only the original agent or regimen is recorded as first course therapy*. Refer to the *SEER*Rx Interactive Drug Database (https://seer.cancer.gov/tools/seerrx/)* for a list of systemic therapy agents.

Systemic agents may be administered by intravenous infusion or given orally. Other methods of administration include the following:

Method	Administration
Intrathecal	Administered directly into the cerebrospinal fluid through a lumbar puncture needle into an implanted access device (for example, 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.

Relationships among Systemic Therapy Items

The data item *Date Systemic Therapy Started* describes the first date on which any first course systemic treatment was administered to the patient. Nine out of 10 patients treated with systemic therapy receive only a single class of drugs (chemotherapy, hormone therapy, or immunotherapy). Of the remaining patients who receive a combined regimen of systemic therapies, two-thirds begin these combined regimens simultaneously. For the purposes of clinical surveillance, the collection of multiple dates to describe the sequence of systemic therapy administration is not necessary.

The data items *Chemotherapy, Hormone Therapy,* and *Immunotherapy* describe whether or not each respective class of agent(s) or drug(s) were administered to the patient as part of first course therapy, based on *SEER*Rx*. In the case of chemotherapy, additional distinction is allowed for instances where single or multiagent regimens were administered. Each of these three items includes code values that describe the reason a particular class of drugs is not administered to the patient and distinguishes a physician's not recommending systemic therapy due to contraindicating conditions from a patient's refusal of a recommended treatment plan. The associated date items were previously defined by CoC, though discontinued in ***FORDS*** from 2003 through 2009 and the same fields may be used in STORE to collect them now, if allowed by the registry software.

Hematologic Transplant and Endocrine Procedures captures those infrequent instances in which a medical, surgical, or radiation procedure is performed on a patient that has an effect on the hormonal or immunologic balance of the patient. Hematologic procedures, such as bone marrow transplants or stem cell harvests, are typically employed in conjunction with administration of systemic agent(s), usually chemotherapy.

- Endocrine procedures, either radiologic or surgical, may be administered in combination with systemic agent(s), typically hormonal therapeutic agents.
- As first course therapy, hematologic procedures will rarely be administered in conjunction with endocrine radiation or surgery. The use of code 40 in response to this data item should be reviewed and confirmed with the managing physician(s).

Other Treatment

Other Treatment encompasses first course treatment that cannot be described as surgery, radiation, or systemic therapy according to the defined data items found in this manual.

This item is also used for supportive care treatment for reportable hematopoietic diseases that do not meet the usual definition in which treatment "modifies, controls, removes, or destroys proliferating cancer tissue." Treatments such as phlebotomy, transfusions, and aspirin are recorded in *Other Treatment* data item for certain hematopoietic diseases, and should be coded 1. Consult the most recent version of the Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual for instructions for coding care of specific hematopoietic neoplasms in this item.

The following items apply to all Other Treatment provided at this facility and at other facilities:

Date Other Treatment Started [1250]
RX Date–Other Flag [1251]
Other Treatment [1420]
Other Treatment at This Facility [730]

Palliative Care

Palliative care is provided to prolong the patient's life by controlling symptoms, to alleviate persistent pain, or to make the patient comfortable. Palliative care provided to relieve symptoms may include surgery, radiation therapy, systemic therapy (chemotherapy, hormone therapy, or other systemic drugs), and/or other pain management therapy. Palliative care is not used to diagnose or stage the primary tumor.

The following items apply to all palliative care provided at this facility and at other facilities*:*

Palliative Care [3270]
Palliative Care at This Facility [3280]

Any surgical procedure, radiation therapy, and/or systemic therapy that is provided to modify, control, remove, or destroy primary or metastatic cancer tissue, is coded in the respective first course of treatment fields and also identified in the *Palliative Care* items. Refer to the preceding discussion of the surgery, radiation and systemic therapy data items for specific coding guidelines. Because these treatments are less aggressive when given for palliation than for treatment, the treatment plan or treatment notes will indicate when they are performed for palliative purposes.

- Record as palliative care any of the treatment recorded in the first course therapy items that was provided to prolong the patient's life by managing the patient's symptoms, alleviating pain, or making the patient more comfortable.
- Palliative care can involve pain management that may not include surgery, radiation or systemic treatment.
- It is possible for a patient to receive one or a combination of treatment modalities in conjunction with palliative care intended to reduce the burden of pain. For example, a patient with metastatic prostate cancer may receive an orchiectomy and systemic hormone therapy in combination with palliative radiation for bone metastasis.

Treatment, Palliative, and Prophylactic Care

Any first course radiation or systemic treatment that acts to kill cancer cells is to be reported as treatment. For example, when total body irradiation (TBI) is given to prepare the patient for a bone marrow transplant (BMT), the TBI acts in two ways. First, it suppresses the immune system to reduce the body's ability to reject the BMT. Second, it contributes to the patient's treatment by destroying cancer cells in the bone marrow, though its use alone would generally not be sufficient to produce a cure. Both the TBI and the BMT should be coded as treatment. The situation is analogous to the use of breast-conserving surgery and adjuvant radiation when the surgery or radiation alone may not be sufficient to produce a cure, though together they are more effective.

When first course surgery, systemic treatment, or radiation is undertaken to reduce the patient's symptoms, that treatment should be coded as palliative care. An example is radiation to bone metastases for prostate cancer to reduce bone pain, which is palliative when there is no expectation that the radiation will effectively reduce the cancer burden. Palliative care involving surgery, systemic

treatment, or radiation is also coded as treatment. This treatment qualifies the patient as analytic if it is given as part of planned first course treatment.

The term "prophylactic" is used in medical practice in a variety of ways. An action taken to prevent cancer from developing (such as a double mastectomy for a healthy woman who has several relatives diagnosed with breast cancer when they were young) is not reportable; there is no cancer to report. Actions taken as part of planned first course treatment to prevent spread or recurrence of the cancer are sometimes characterized as "prophylactic" (for example, performing an oophorectomy or providing Tamoxifen to a breast cancer mastectomy patient). These treatments are to be coded as treatment.

Embolization

The term *embolization* refers to the intentional blocking of an artery or vein. The mechanism and the reason for embolization determine how and whether it is to be recorded.

Chemoembolization is a procedure in which the blood supply to the tumor is blocked surgically or mechanically and anticancer drugs are administered directly into the tumor. This procedure permits a higher concentration of drug to be in contact with the tumor for a longer period of time. Code chemoembolization as *Chemotherapy* when the embolizing agent(s) is a chemotherapeutic drug(s) or when the term *chemoembolization* is used with no reference to the agent. Use *SEER*Rx Interactive Drug Database (https://seer.cancer.gov/tools/seerrx/)* to determine whether the drugs used are classified as chemotherapeutic agents. Also code as *Chemotherapy* when the patient has primary or metastatic cancer in the liver and the only information about embolization is a statement that the patient had chemoembolization, tumor embolization or embolization of the tumor in the liver. However, if alcohol is specified as the embolizing agent, even in the liver, code the treatment as *Other Therapy*.

Radioembolization is embolization combined with injection of small radioactive beads or coils into an organ or tumor. Code *Radiation Modality* as brachytherapy when tumor embolization is performed using a radioactive agent or radioactive seeds.

Embolization is coded as *Other Therapy* (code 1) if the embolizing agent is alcohol, or if the embolized site is other than the liver and the only information in the record is that the patient was given "embolization" with no reference to the agent.

Do not code presurgical embolization of hypervascular tumors with particles, coils or alcohol. These presurgical embolizations are typically performed to make the resection of the primary tumor easier. Examples where presurgical embolization is used include meningiomas, hemangioblastomas, paragangliomas, and renal cell metastases in the brain.

Outcomes

The outcomes data items describe the known clinical and vital status of the patient. Follow-up information is obtained at least annually for all living *Class of Case* 10-22 patients included in a cancer registry's database. Recorded follow-up data should reflect the most recent information available to the registry that originates from reported patient hospitalizations, known patient readmissions, contact with the patient's physician, and/or direct contact with the patient.

Individual item descriptions in Section Two of this manual should be consulted for specific coding instructions. The paragraphs below describe the range of follow-up information that should be obtained.

Follow-up items that are required to be in the facility's database

There may be times when first course treatment information is incomplete. Therefore, it is important to continue follow-up efforts to be certain the necessary treatment information is collected. This includes:

- Complete first course of treatment information when *Surgical Procedure of Primary Site* [1290] is delayed six months or more following the *Date of First Contact* [580].
- *Readmission to the Same Hospital Within 30 Days of Surgical Discharge* [3190] following the most definitive surgery.
- Radiation, chemotherapy, hormone therapy, immunotherapy, hematologic transplant and endocrine procedures, or other treatment that had been indicated as being planned as part of first course of treatment, but not been started or completed as of the most recent follow-up date. Use "reason for no" treatment codes of 88 or 8 as ticklers to identify incomplete treatment information.
- When all planned first course treatment has been recorded, first course treatment items no longer need to be followed.
- The CoC does not require Class 00 cases to be followed.
- Follow-up for disease recurrence should be conducted until (a) evidence of disease recurrence is reported, or (b) the patient dies. If the *Type of First Recurrence* [1880] is coded 70 (never cancer free), when the patient was last seen, but treatment was still underway, then check at follow-up to see whether the patient subsequently became cancer-free. Occasionally, if first course treatment ends due to disease progression, it may be the second course or subsequent treatment that results in a cancer-free status. If the *Type of First Recurrence* is coded 00 (became cancer-free and has had no recurrence), then continue to follow for recurrence and record the type and date when it occurs.

In order to facilitate research on cancer recurrence, two new follow-up data items have been added for 2018 that allow for the recording of the last date on which the patient's cancer status has been updated.

Unlike the *Date of Last Contact or Death* [1750], which is a patient-specific data item, these new data items are tumor-specific to better document tumor recurrence/no evidence of disease (NED).

- *Date of Last Cancer (Tumor) Status* [1772]
- *Date of Last Cancer (Tumor) Status Flag* [1773]

Recurrence Definition

Local recurrence: recurs in initial primary organ

Trocar recurrence: organ removed, recurs in scar tissue from removal

Regional recurrence: recurs in adjacent organ or lymph nodes draining the organ

Distant recurrence: recurs in a location beyond regional

Once the first recurrence has been recorded, do not update recurrence items further.

While the patient is alive, be sure that contact information is kept current. Contact information includes:

Patient Address–Current [2350]
City/Town–Current [1810]
State–Current [1820]

Postal Code–Current [1830]
Telephone [2360]
Date of Last Contact or Death [1750]
Follow-Up Source, [1790]
Next Follow-Up Source [1800]

Follow-up for *Vital Status* [1760] and *Cancer Status* [1770] should be conducted annually for all analytic cases in the cancer program's registry. *Class of Case* 00 patients that are not followed will have the most recent information as of the *Date of Last Contact or Death [1750]*.

Once the patient's death has been recorded and all care given prior to death is recorded, no further follow-up is performed.

Case Administration

Correct and timely management of case records in a registry data set are necessary to describe the nature of the data in the cancer record and to facilitate meaningful analysis of data, and it is necessary to understand each item's respective purpose to ensure their accuracy and how to use them in facility analysis.

Administrative Tracking

The following administrative tracking items are required to be in the facility's database:

Abstracted By [570]
Facility Identification Number (*FIN)* [540]
NPI-Reporting Facility [545]
Archive FIN [3100]
NPI-Archive FIN [3105]

Abstracted By [570]*, Facility Identification Number (FIN)* [540], and *NPI-Reporting Facility* [545] identify the individual and facility responsible for compiling the record. *Archive FIN* and *NPI-Archive FIN* store the identification numbers assigned to the original abstracting facility and are used to convey the original identity assigned to a facility that has since merged with another. In a registry with more than one abstractor or serving more than one facility, it will ordinarily be necessary to enter these three numbers only when they change. All of these items should be autocoded by the registry software.

Note: A complete list of FINs is available on the American College of Surgeons Web site at *https://www.facs.org/quality-programs/cancer/accredited/info/fin.* NPI numbers are available through the facility's billing or accounting department or at https://nppes.cms.hhs.gov/NPPES/Welcome.do.

EDITS Overrides

Some of the CoC edits identify rare, but possible, code combinations. For these edits, an override flag can be set if, upon review, the unusual combination is verified as being correct. Once set, the error message will not be repeated on subsequent EDITS passes.

- When no error message is generated by an edit that uses an override item, no action by the registrar is needed.
- If an error message is generated, the problem can often be resolved by checking the accuracy of the entry for each item that contributes to the edit and correcting any problems identified. If correction of data entry errors resolves the problem, do not make an override entry. If the codes reflect the information in the patient record, check for physician notes indicating the unusual

combination of circumstances (for example, a colon adenocarcinoma in a child) has been confirmed.

- Enter the override code according to the instructions for the data item. If no comment regarding the unusual circumstances can be found in the record, it may be necessary to check with the managing physician or pathologist to determine whether it is appropriate to override the edit.

The following override items are required to be in the facility's database:

Override Acsn/Class/Seq [1985]
Override Age/Site/Morph [1990]
Override CoC– Site/Type [1987]
Override Site/Type [2030]
Override Histology [2040]
Override Leuk/Lymphoma [2070]
Override Site/Behavior [2071]
Override Site/Lat/Morph [2074]
Override HospSeq/DxConf [1986]
Override HospSeq/Site [1988]
Override Site/TNM-StgGrp [1989]
Override Surg/DxConf [2020]
Over-ride CS 1-19 [3750-3768]

Code Versions Used

Fifteen items describe the version of codes applied to record information in the registry record. Because registries cover many years of cases, registry data will be recorded according to many different coding systems. These items are necessary for the analysis of registry data and for further conversions, so it is important that they be maintained accurately.

The following code version items are required to be in the facility's database:

CoC Coding System–Current [2140]
CoC Coding System–Original [2150]
Race Coding System–Current [170]
Race Coding System–Original [180]
Site Coding System–Current [450]
Site Coding System–Original [460]
Morphology Coding System–Current [470]
Morphology Coding System–Original [480]
ICD-O-2 Conversion Flag [1980]
ICD-O-3 Conversion Flag [2116]
TNM Edition Number [1060]
RX Coding System–Current [1460]
CS Version Input Original [2935; for cases diagnosed 2004-2017]
CS Version Input Current [2937; for cases diagnosed 2004-2017]
CS Version Derived [2936; for cases diagnosed 2004 through 2015]

All of these items are capable of being autocoded. Registry software operations differ, but typically the registrar will need to update the version of CoC codes, race coding system, site coding system, and morphology coding system whenever it changes.

For newly abstracted cases, code version information will be applied both as the current and original code versions. When registry data are converted to an updated version for a coding system, the code for the current version should be updated automatically by the conversion.

It is not possible to convert from one version of AJCC TNM to another. The registrar should ascertain that the correct version number is recorded for autocoding.

RX Coding System–Current identifies whether the treatment information was recorded using CoC rules or SEER rules and the version of each applied. The CoC requires that the *FORDS* manual be followed for all cases diagnosed January 1, 2003, or later. For cases diagnosed January 1, 2018 or later, follow the STORE Manual (*RX Coding System–Current* [1460] = 08).

The *ICD-O-3 Conversion Flag* [2116] identifies how conversion from ICD-O-2 to ICD-O-3 was accomplished, and the *ICD-O-2 Conversion Flag* [1980] identifies how conversion from ICD-O-1 to ICD-O-2 was accomplished. Both should be autocoded at the time of conversion. If the results of either conversion were verified by review for some cases, the conversion flag will need to be updated to indicate that the case was reviewed.

Data Submission Type

The NCDB is moving to submission of data via a single data portal rather than the current separate data portals for RQRS and NCDB. The new *RQRS NCDB Submission Flag* [2155] will facilitate identification of the purpose of the data submission at the receiving end.

Section Two: Instructions for Coding

Patient Identification

Accession Number

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
550	9	745-753	See Coding Instructions	All Years	01/04, 01/10

Description

Provides a unique identifier for the patient consisting of the year in which the patient was first seen at the reporting facility and the consecutive order in which the patient was abstracted.

Rationale

This data item protects the identity of the patient and allows cases to be identified on a local, state and national level.

Coding Instructions

- When a patient is deleted from the database, **do not** reuse the accession number for another patient.
- The first four numbers specify the year and the last five numbers are the numeric order in which the patient was entered into the registry database.
- Numeric gaps are allowed in accession numbers.
- A patient's accession number is never reassigned.
- If a patient is first accessioned into the registry, then the registry later changes its reference date and the patient is subsequently accessioned into the registry with a new primary, use the original accession number associated with the patient and code the data item *Sequence Number* [560] appropriately.

Code	Definition
(fill spaces)	Nine-digit number used to identify the year in which the patient was first seen at the reporting facility for the diagnosis and/or treatment of cancer.

Examples

Code	Reason
200300033	Patient enters the hospital in 2003, and is diagnosed with breast cancer. The patient is the thirty-third patient accessioned in 2003.
200300033	A patient with the accession number 200300033 for a breast primary returns to the hospital with a subsequent colon primary in 2004. The accession number will remain the same. *Sequence Number* [560] will distinguish this primary.
200300010	Patient diagnosed in November 2002 at another facility enters the reporting facility in January 2003, and is the tenth case accessioned in 2003.
200300012	Patient diagnosed in staff physician office in December 2002 enters the reporting facility in January 2003, and is the twelfth case accessioned in 2003.

Code	Reason
199100067	Patient enters the hospital in 1991 and is diagnosed with prostate cancer. The registry later sets a new reference date of January 1, 1997. The same patient presents with a diagnosis of lymphoma in 2005. *Sequence Number* [560] will distinguish this primary.
200300001	First patient diagnosed and/or treated and entered into the registry database for 2003.
200300999	Nine hundred ninety-ninth patient diagnosed and/or treated and entered into the registry database for 2003.
200401504	One thousand five hundred fourth patient diagnosed and/or treated and entered into the registry database for 2004.

Sequence Number

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
560	2	754-755	00-88, 99	All Years	06/05, 04/07, 01/10, 01/13

Description

Indicates the sequence of malignant and nonmalignant neoplasms over the lifetime of the patient.

Rationale

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

Coding Instructions

- Codes 00–59 and 99 indicate neoplasms of malignant (*in situ* or invasive) behavior (*Behavior* equals 2 or 3). Codes 60–88 indicate neoplasms of non-malignant behavior (*Behavior* equals 0 or 1).
- Code 00 only if the patient has a single malignant primary. If the patient develops a subsequent invasive or *in situ* primary tumor, change the code for the first tumor from 00 to 01, and number subsequent tumors sequentially.
- Code 60 only if the patient has a single non-malignant primary. If the patient develops a subsequent non-malignant primary, change the code for the first tumor from 60 to 61, and assign codes to subsequent non-malignant primaries sequentially.
- If two or more invasive or *in situ* neoplasms are diagnosed at the same time, assign the lowest sequence number to the diagnosis with the worst prognosis. If no difference in prognosis is evident, the decision is arbitrary.
- Any tumor in the patient's past which is reportable or reportable-by-agreement at the time the current tumor is diagnosed must be taken into account when sequencing subsequently accessioned tumors. However, do not reassign sequence numbers if one of those tumors becomes non-reportable later.
- Sequence numbers should be reassigned if the facility learns later of an unaccessioned tumor that affects the sequence.

Malignant or In Situ Primaries

Code	Definition
00	One malignant or *in situ* primary only in the patient's lifetime
01	First of two or more independent malignant or *in situ* primaries
02	Second of two or more independent or *in situ* primaries
…	(Actual sequence of this malignant or *in situ* primary)

Code	Definition
59	Fifty-ninth of 59 or more independent malignant or *in situ* primaries
99	Unknown number of malignant or *in situ* primaries

Non-Malignant Primaries

Code	Definition
60	One nonmalignant primary only in the patient's lifetime
61	First of two or more independent nonmalignant primaries
62	Second of two or more independent nonmalignant primaries
…	(Actual sequence of this nonmalignant primary)
87	Twenty-seventh of 27 or more independent nonmalignant primaries
88	Unspecified number of independent nonmalignant primaries

Examples

Code	Reason
00	Patient with no previous history of cancer diagnosed with *in situ* breast carcinoma on June 13, 2003.
01	The sequence number is changed when the patient with an *in situ* breast carcinoma diagnosed June 13, 2003, is diagnosed with a subsequent melanoma on August 30, 2003.
02	Sequence number assigned to the melanoma diagnosed on August 30, 2003, following a breast cancer *in situ* diagnosis on June 13, 2003
04	A nursing home patient is admitted to the hospital for first course surgery for a colon adenocarcinoma. The patient has a prior history of three malignant cancers of the type the registry is required to accession, though the patient was not seen for these cancers at the hospital. No sequence numbers 01, 02 or 03 are accessioned for this patient.
60	The sequence number assigned to a benign brain tumor diagnosed on November 1, 2005, following a breast carcinoma diagnosed on June 13, 2003, and a melanoma on August 30, 2003.
63	Myeloproliferative disease (9975/1) is diagnosed by the facility in 2003 and accessioned as Sequence 60. A benign brain tumor was diagnosed and treated elsewhere in 2002; the patient comes to the facility with a second independent benign brain tumor in 2004. Unaccessioned earlier brain tumor is counted as Sequence 61, myeloproliferative disease is resequenced to 62, and second benign brain tumor is Sequence 63.

Medical Record Number

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
2300	11	4315-4325	See Coding Instructions	All Years	01/11

Description

Records the medical record number usually assigned by the reporting facility's health information management (HIM) department.

Rationale

This number identifies the patient within a reporting facility. It can be used to reference a patient record and it helps to identify multiple reports on the same patient.

Coding Instructions

- Record the medical record number.

Code	Definition
——NNNN	If the medical record number is fewer than 11 characters, right justify the characters and allow leading blanks.
—-NNNNRT (Radiology) ——-NNSU (One-day surgery clinic)	Record standard abbreviations for departments that do not use HIM medical record numbers.
———UNK	Unknown

Social Security Number

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
2320	9	4328-4336	See Coding Instructions	All Years	

Description

Records the patient's Social Security number.

Rationale

This data item can be used to identify patients with similar names.

Coding Instructions

- Code the patient's Social Security number.
- A patient's Medicare claim number may not always be identical to the person's Social Security number.
- Code Social Security numbers that end with "B" or "D" as 999999999. The patient receives benefits under the spouse's number and this is the spouse's Social Security number.
- See https://www.ssa.gov/ for more information.

Code	Definition
(fill spaces)	Record the patient's Social Security number without dashes
999999999	Patient does not have a Social Security number; SSN is not available.

Last Name

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
2230	40	4049-4088	See Coding Instructions	All Years	01/04, 01/10

Description

Identifies the last name of the patient.

Rationale

This data item is used by hospitals as a patient identifier.

Coding Instructions

- Truncate name if more than 40 letters long. Blanks spaces, hyphens, and apostrophes are allowed. Do not use other punctuation.
- Do not leave blank; code as UNKNOWN if the patient's last name is unknown.
- This field may be updated if the last name changes.

Examples

Code	Reason
Mc Donald	Recorded with space as Mc Donald
O'Hara	Recorded with apostrophe as O'Hara
Smith-Jones	Janet Smith marries Fred Jones and changes her last name to Smith-Jones
UNKNOWN	Patient's last name is not known, use UNKNOWN

First Name

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
2240	40	4089-4128	See Coding Instructions	All Years	01/10, 01/11

Description

Identifies the first name of the patient.

Rationale

This data item is used by hospitals to differentiate between patients with the same last names.

Coding Instructions

- Truncate name if more than 40 letters long. Blanks spaces, hyphens, and apostrophes are allowed. Do not use other punctuation.
- This field may be updated if the name changes.

Examples

Code	Reason
Michael	Patient's name is Michael David Hogan
(leave blank)	If patient's first name is not known, do not fill in the space.

Middle Name (Middle Initial)

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
2250	40	4129-4168	See Coding Instructions	All Years	01/10, 01/11

Description

Identifies the middle name or middle initial of the patient.

Rationale

This data item helps distinguish between patients with identical first and last names.

Coding Instructions

- Truncate name if more than 40 letters long. Blanks spaces, hyphens, and apostrophes are allowed. Do not use other punctuation.
- This field may be updated if the name changes.

Examples

Code	Reason
David	Patient's name is Michael David Hogan
D	Patient's name is Michael D. Hogan
(leave blank)	If patient's middle name is not known or there is none, do not fill in the space.

Patient Address (Number and Street) at Diagnosis

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
2330	60	4348-4407	See Coding Instructions	All Years	01/10, 01/12

Description

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

Rationale

The address is part of the patient's demographic data and has multiple uses. It indicates referral patterns and allows for the analysis of cancer clusters or environmental studies.

Coding Instructions

- Record the number and street address or the rural mailing address of the patient's usual residence when the tumor was diagnosed.
- The address should be fully spelled out with standardized use of abbreviations and punctuation per U.S. Postal Service postal addressing standards. The USPS Postal Addressing Standards, Pub 28, November 2000 can be found on the Internet at *http://pe.usps.gov/cpim/ftp/pubs/pub28/pub28.pdf*.
- Abbreviations should be limited to those recognized by the Postal Service standard abbreviations. They include, but are not limited to: AVE (avenue), BLVD (boulevard), CIR (circle), CT (court), DR (drive), PLZ (plaza), PARK (park), PKWY (parkway), RD (road), SQ (square), ST (street), APT (apartment), BLDG (building), FL (floor), STE (suite), UNIT (unit), RM (room), DEPT (department), N (north), NE (northeast), NW (northwest), S (south), SE (southeast), SW (southwest), E (east), W (west). A complete list of recognized street abbreviations is provided in Appendix C of USPS Pub 28.
- Punctuation is normally limited to periods (for example, 39.2 RD), slashes for fractional addresses (101 1/2 MAIN ST), and hyphens when a hyphen carries meaning (289-01 MONTGOMERY AVE). Use of the pound sign (#) to designate address units should be avoided whenever possible. The preferred notation is as follows: 102 MAIN ST APT 101. If a pound sign is used, there must be a space between the pound sign and the secondary number (425 FLOWER BLVD #72).
- If the patient has multiple tumors, the address may be different for subsequent primaries.
- Do not update this data item if the patient's address changes.
- See Residency Rules in Section One for further instructions.

Examples

Code	Reason
103 FIRST AVE SW APT 102	The use of capital letters is preferred by the USPS; use recognized USPS standardized abbreviations; do not use punctuation unless absolutely necessary to clarify an address; leave blanks between numbers and words.
UNKNOWN	The patient's street address is unknown.

Patient Address at Diagnosis–Supplemental

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
2335	60	4408-4467	See Coding Instructions	All Years	09/06, 01/10, 01/12

Description

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

Rationale

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

Coding Instructions

- Record the place or facility (for example, a nursing home or name of an apartment complex) of the patient's usual residence when the tumor was diagnosed.
- If the patient has multiple tumors, the address may be different for subsequent primaries.
- Do not use this data item to record the number and street address of the patient.
- Do not update this data item if the patient's address changes.
- See Residency Rules in Section One for further instructions.

Examples

Code	Reason
VALLEYVIEW NURSING HOME	The use of capital letters is preferred by the USPS; use recognized USPS standardized abbreviations; do not use punctuation unless absolutely necessary to clarify an address; leave blanks between numbers and words.
(leave blank)	If this address space is not needed, then leave blank.

City/Town at Diagnosis (City or Town)

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
70	50	74-123	See Coding Instructions	1996+	01/10

Description

Identifies the name of the city or town in which the patient resides at the time the tumor is diagnosed and treated.

Rationale

The city or town is part of the patient's demographic data and has multiple uses. It indicates referral patterns and allows for the analysis of cancer clusters or environmental studies.

Coding Instructions

- If the patient resides in a rural area, record the name of the city or town used in his or her mailing address.
- If the patient has multiple malignancies, the city or town may be different for subsequent primaries.
- Do not update this data item if the patient's city or town of residence changes.
- See Residency Rules in Section One for further instructions.

Examples

Code	Reason
CITY NAME	Do not use punctuation, special characters, or numbers. The use of capital letters is preferred by the USPS; it also guarantees consistent results in queries and reporting. Abbreviate where necessary.
UNKNOWN	If the patient's city or town is unknown.

State at Diagnosis (State)

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
80	2	124-125	See Coding Instructions	1996+	09/06, 01/10, 01/11, 01/12

Description

Identifies the patient's state of residence at the time of diagnosis.

Rationale

The state of residence is part of the patient's demographic data and has multiple uses. It indicates referral patterns and allows for the analysis of cancer clusters or environmental studies.

Coding Instructions

- Use U.S. Postal Service abbreviation for the state, territory, commonwealth, U.S. possession, or Canadian province or territory in which the patient resides at the time the tumor is diagnosed and treated.
- If the patient has multiple tumors, the state of residence may be different for subsequent primaries.
- If the patient is a foreign resident, then code either XX or YY depending on the circumstance.
- Do not update this data item if the patient's state of residence changes.

Code	Label	Code	Label	Code	Label
AL	Alabama	MB	Manitoba	PW	Palau
AK	Alaska	MH	Marshall Islands	PA	Pennsylvania
AB	Alberta	MD	Maryland	PE	Prince Edward Island
AS	American Samoa	MA	Massachusetts	PR	Puerto Rico
AA	APO/FPO Armed Services America	MI	Michigan	QC	Quebec
AE	APO/FPO Armed Services Europe	FM	Micronesia	ZZ	Residence unknown.
AP	APO/FPO Armed Services Pacific	MN	Minnesota	XX	Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country is *known*.

Code	Label	Code	Label	Code	Label
AZ	Arizona	MS	Mississippi	YY	Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country is *unknown*.
AR	Arkansas	MO	Missouri	CD	Resident of Canada and the province is *unknown*.
BC	British Columbia	MT	Montana	US	Resident of the U.S. (including its territories, commonwealths, or possessions) and the state is *unknown*
CA	California	NE	Nebraska	RI	Rhode Island
CD	Canada, province unknown	NV	Nevada	SK	Saskatchewan
CO	Colorado	NB	New Brunswick	SC	South Carolina
CT	Connecticut	NH	New Hampshire	SD	South Dakota
DE	Delaware	NJ	New Jersey	US	United States, state unknown
DC	District of Columbia	NM	New Mexico	TN	Tennessee
FL	Florida	NY	New York	TX	Texas
GA	Georgia	NL	Newfoundland and Labrador	UT	Utah
GU	Guam	NC	North Carolina	VT	Vermont
HI	Hawaii	ND	North Dakota	VI	Virgin Islands
ID	Idaho	NT	Northwest Territories	VA	Virginia
IL	Illinois	NS	Nova Scotia	WA	Washington
IN	Indiana	NU	Nunavut	WV	West Virginia
IA	Iowa	OH	Ohio	WI	Wisconsin
KS	Kansas	OK	Oklahoma	WY	Wyoming
KY	Kentucky	ON	Ontario	YT	Yukon
LA	Louisiana	OR	Oregon		
ME	Maine	UM	Outlying Islands		

Postal Code at Diagnosis (Zip Code)

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
100	9	126-134	See Coding Instructions	All Years	01/04

Description

Identifies the postal code of the patient's address at diagnosis.

Rationale

The postal code is 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.

Coding Instructions

- For U.S. residents, record the patient's nine-digit extended postal code at the time of diagnosis and treatment.
- For Canadian residents, record the six-character postal code.
- When available, record the postal code for other countries.
- If the patient has multiple malignancies, the postal code may be different for subsequent primaries.
- Do not update this data item if the patient's postal code changes.
- See Residency Rules in Section One for further instructions.

Code	Definition
(fill spaces)	The patient's nine-digit U.S. extended postal code. Do not record hyphens.
60611_ _ _ _	When the nine-digit extended U.S. ZIP Code is not available, record the five-digit postal code, left justified, followed by four blanks.
M6G2S8_ _ _	The patient's six-character Canadian postal code left justified, followed by three blanks.
88888_ _ _ _ or 888888888	Permanent address in a country other than Canada, United States, or U.S. possessions and postal code is unknown.
99999_ _ _ _ or 999999999	Permanent address in Canada, United States, or U.S. possession and postal code is unknown.

Address at Dx--Country

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
102	3	464-466	See Coding Instructions	1996+	Added 01/13

Description

Identifies the country of the patient's residence at the time of diagnosis. The codes are based on International Organization for Standardization (ISO) 3166-1 alpha-3 country codes, with some custom codes.

Rationale

The country code is part of the patient's demographic data and has multiple uses. It may be useful for understanding risk factors, assessment of patient prognosis, and chances for survival.

Coding Instructions

- This item corresponds to the other *Addr* at DX items (state, postal code).
- Do not change if the patient moves to another country. Patients with more than one tumor may have different countries at diagnosis, however.
- See Appendix D for a list of country codes and their respective state codes.
- This item was first defined for use in 2013; cases diagnosed before that date should be converted automatically by the registry's software.

Examples

Code	Label
USA	United States
CAN	Canada

County at Diagnosis

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
90	3	135-137	001-997, 998, 999	1996+	09/06, 01/10, 01/15

Description

Identifies the county of the patient's residence at the time the reportable tumor is diagnosed.

Rationale

This data item may be used for epidemiological purposes. For example, to measure the cancer incidence in a particular geographic area.

Coding Instructions

- For U.S. residents, use codes issued by the Federal Information Processing Standards (FIPS) publication *Counties and Equivalent Entities of the United States, Its Possessions, and Associated areas*. This publication is available in a reference library or can be accessed on the Internet through the U.S. EPA's Envirofacts Data Warehouse and Applications Web site at https://www.epa.gov/.
- If the patient has multiple tumors, the county codes may be different for each tumor.
- If the patient is a non-U.S. resident, use code 999.
- Do not update this data item if the patient's county of residence changes.

Code	Label	Definition
001–997	County at diagnosis	Valid FIPS code.
998	Outside state/county code unknown	Known town, city, state, or country of residence, but county code not known and a resident outside of the state of the reporting institution (must meet all criteria).
999	County unknown	The county of the patient is unknown, or the patient is not a United States resident. County is not documented in the patient's medical record.

Patient Address (Number and Street) Current

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
2350	60	4468-4527	See Coding Instructions	All Years	09/04, 01/10, 01/12

Description

Identifies the patient's current address (number and street).

Rationale

This data item provides a current address used for follow-up purposes. It is different from *Patient Address at Diagnosis* (NAACCR #2330).

Coding Instructions

- Record the number and street address or the rural mailing address of the patient's current usual residence.
- The address should be fully spelled out with standardized use of abbreviations and punctuation per U.S. Postal Service postal addressing standards. The USPS Postal Addressing Standards, Pub 28, November 2000 can be found on the Internet at http://pe.usps.gov/cpim/ftp/pubs/pub28/pub28.pdf.
- Abbreviations should be limited to those recognized by the Postal Service standard abbreviations. They include, but are not limited to: AVE (avenue), BLVD (boulevard), CIR (circle), CT (court), DR (drive), PLZ (plaza), PARK (park), PKWY (parkway), RD (road), SQ (square), ST (street), APT (apartment), BLDG (building), FL (floor), STE (suite), UNIT (unit), RM (room), DEPT (department), N (north), NE (northeast), NW (northwest), S (south), SE (southeast), SW (southwest), E (east), W (west). A complete list of recognized street abbreviations is provided in Appendix C of USPS Pub 28.
- Punctuation is normally limited to periods (for example, 39.2 RD), slashes for fractional addresses (101 1/2 MAIN ST), and hyphens when a hyphen carries meaning (289-01 MONTGOMERY AVE). Use of the pound sign (#) to designate address units should be avoided whenever possible. The preferred notation is as follows: 102 MAIN ST APT 101. If a pound sign is used, there must be a space between the pound sign and the secondary number (425 FLOWER BLVD #72).
- Update this data item if the patient's address changes.
- Do not change this item when the patient dies.
- See Residency Rules in Section One for further instructions.

Examples

Code	Reason
103 FIRST AVE SW APT 102	The use of capital letters is preferred by the USPS; use recognized USPS standardized abbreviations; do not use punctuation unless absolutely necessary to clarify an

Code	Reason
	address; leave blanks between numbers and words.
UNKNOWN	The patient's street address is unknown.

Patient Address Current–Supplemental

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
2355	60	4528-4587	See Coding Instructions	All Years	09/06, 01/10, 01/12

Description

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

Rationale

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

Coding Instructions

- Record the place or facility (for example, a nursing home or name of an apartment complex) of the patient's current usual residence.
- If the patient has multiple tumors, the address may be different for subsequent primaries.
- Update this data item if a patient's address changes.
- Do not use this data item to record the number and street address of the patient.
- Do not change this item when the patient dies.
- See Residency Rules in Section One for further instructions.

Examples

Code	Reason
VALLEYVIEW NURSING HOME	The use of capital letters is preferred by the USPS; use recognized USPS standardized abbreviations; do not use punctuation unless absolutely necessary to clarify an address; leave blanks between numbers and words.
(leave blank)	If this address space is not needed, then leave blank.

City/Town–Current

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1810	50	2803-2852	See Coding Instructions	All Years	09/04

Description

Identifies the name of the city or town of the patient's current usual residence.

Rationale

This data item provides a current city or town used for follow-up purposes. It is different from *City/Town at Diagnosis* [70].

Coding Instructions

- If the patient resides in a rural area, record the name of the city or town used in his or her mailing address.
- If the patient has multiple malignancies, the current city or town should be the same for all tumors.
- Update this data item if the patient's city or town of residence changes.
- Do not change this item when the patient dies.
- See Residency Rules in Section One for further instructions.

Examples

Code	Reason
CITY NAME	Do not use punctuation, special characters, or numbers. The use of capital letters is preferred by the USPS; it also guarantees consistent results in queries and reporting. Abbreviate where necessary.
UNKNOWN	If the patient's city or town is unknown.

State–Current

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1820	2	2853-2854	See Coding Instructions	All Years	09/06, 01/11, 01/12

Description

Identifies the patient's current state of residence.

Rationale

This item provides a current state of residence used for follow-up purposes. It is different from *State at Diagnosis* [80].

Coding Instructions

- Use U.S. Postal Service abbreviation for the state, territory, commonwealth, U.S. possession, or Canadian province or territory of the patient's current usual residence.
- If the patient has multiple tumors, the current state of residence should be the same for all tumors.
- If the patient is a foreign resident, then code either XX or YY depending on the circumstance.
- Update this data item if the patient's state of residence changes.
- Do not change this item when the patient dies.
-

Code	Label	Code	Label	Code	Label
AL	Alabama	MB	Manitoba	PW	Palau
AK	Alaska	MH	Marshall Islands	PA	Pennsylvania
AB	Alberta	MD	Maryland	PE	Prince Edward Island
AS	American Samoa	MA	Massachusetts	PR	Puerto Rico
AA	APO/FPO Armed Services America	MI	Michigan	QC	Quebec
AE	APO/FPO Armed Services Europe	FM	Micronesia	ZZ	Residence unknown
AP	APO/FPO Armed Services Pacific	MN	Minnesota	XX	Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country is *known*.

Code	Label	Code	Label	Code	Label
AZ	Arizona	MS	Mississippi	YY	Resident of a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country is *unknown*.
AR	Arkansas	MO	Missouri	CD	Resident of Canada and the province is *unknown*.
BC	British Columbia	MT	Montana	US	Resident of the U.S. (including its territories, commonwealths, or possessions) and the state is *unknown*
CA	California	NE	Nebraska	RI	Rhode Island
CD	Canada, province unknown	NV	Nevada	SK	Saskatchewan
CO	Colorado	NB	New Brunswick	SC	South Carolina
CT	Connecticut	NH	New Hampshire	SD	South Dakota
DE	Delaware	NJ	New Jersey	US	United States, state unknown
DC	District of Columbia	NM	New Mexico	TN	Tennessee
FL	Florida	NY	New York	TX	Texas
GA	Georgia	NL	Newfoundland and Labrador	UT	Utah
GU	Guam	NC	North Carolina	VT	Vermont
HI	Hawaii	ND	North Dakota	VI	Virgin Islands
ID	Idaho	NT	Northwest Territories	VA	Virginia
IL	Illinois	NS	Nova Scotia	WA	Washington
IN	Indiana	NU	Nunavut	WV	West Virginia
IA	Iowa	OH	Ohio	WI	Wisconsin
KS	Kansas	OK	Oklahoma	WY	Wyoming
KY	Kentucky	ON	Ontario	YT	Yukon
LA	Louisiana	OR	Oregon		
ME	Maine	UM	Outlying Islands		

Postal Code–Current (Zip Code)

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1830	9	2855-2863	See Coding Instructions	All Years	01/04

Description

Identifies the postal code of the patient's current address.

Rationale

This data item provides a current postal code for follow-up purposes and should be updated. It is different from *Postal Code at Diagnosis* [100].

Coding Instructions

- For U.S. residents, record the nine-digit extended postal code for the patient's current usual residence.
- For Canadian residents, record the six-character postal code.
- When available, record the postal code for other countries.
- If the patient has multiple tumors, the postal code should be the same.
- Update this data item if the patient's postal code changes.

Examples

Code	Definition
(fill spaces)	The patient's nine-digit U.S. extended postal code. Do not record hyphens.
60611_ _ _ _	When the nine-digit extended U.S. ZIP Code is not available, record the five-digit postal code, left justified, followed by four blanks.
M6G2S8_ _ _	The patient's six-character Canadian postal code left justified, followed by three blanks.
88888_ _ _ _ or 888888888	Permanent address in a country other than Canada, United States, or U.S. possessions and postal code is unknown.
99999_ _ _ _ or 999999999	Permanent address in Canada, United States, or U.S. possession and postal code is unknown.

Address Current—Country

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1832	3	467-469	See Coding Instructions	2013+	Added 01/13

Description

Identifies the country of the patient's current residence. The codes are based on International Organization for Standardization (ISO) 3166-1 alpha-3 country codes, with some custom codes.

Rationale

The country code is part of the patient's demographic data and has multiple uses. It may be useful for understanding risk factors, assessment of patient prognosis, and chances for survival, and is useful for follow-up.

Coding Instructions

- This item corresponds to Address Current—State.
- See Appendix D for a list of country codes and their respective state codes.
- This item was first defined for use in 2013; cases diagnosed before that date should be converted automatically by the registry's software.

Examples

Code	Label
USA	United States
CAN	Canada

Telephone

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
2360	10	4588-4597	See Coding Instructions	All Years	

Description

Records the current telephone number with area code for the patient.

Rationale

This data item may be used by the hospital registry to contact the patient for follow-up.

Coding Instructions

- The telephone number should be the current number with area code of the patient.
- Update this data item if the patient's telephone number changes.

Code	Label
(fill spaces)	Number is entered without dashes.
0000000000	Patient does not have a telephone.
9999999999	Telephone number is unavailable or unknown.

Birthplace—State

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
252	2	470-471	See Coding Instructions	2013+	01/13

Description

Records the patient's state of birth.

Rationale

This data item is used to evaluate medical care delivery to special populations and to identify populations at special risk for certain cancers.

Coding Instructions

- Use the most specific code.
- This item corresponds to Birthplace—Country.
- See Appendix D for a list of state codes and their respective country codes.
- This item was first defined for use in 2013; cases diagnosed before that date should be converted automatically by the registry's software from the former *Place of Birth*.

Examples

Code	Reason
IL	If the state in which the patient was born is Illinois, then use the USPS code for the state of Illinois.
XX	Born in a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country *is known* (code the country in *Birthplace-Country*).
YY	Born in a country other than the U.S. (including its territories, commonwealths, or possessions) or Canada and the country *is unknown*.
US	Born in the U.S. (including its territories, commonwealths, or possessions) and the state is *unknown*
CD	Born in Canada and the province is *unknown*.
ZZ	Place of birth is unknown, not mentioned in patient record.

Birthplace—Country

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
254	3	472-474	See Coding Instructions	2013+	01/13

Description

Identifies the country where the patient was born. The codes are based on International Organization for Standardization (ISO) 3166-1 alpha-3 country codes, with some custom codes.

Rationale

The country code is part of the patient's demographic data and has multiple uses. It may be useful for understanding risk factors, assessment of patient prognosis, and chances for survival.

Coding Instructions

- This item corresponds to Birthplace—State.
- See Appendix D for a list of country codes and their respective state codes.
- This item was first defined for use in 2013; cases diagnosed before that date should be converted automatically by the registry's software.

Examples

Code	Reason
USA	United States
CAN	Canada
ZZU	Place of birth is unknown, not mentioned in patient record.

Date of Birth

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
240	8	226-233	CCYYMMDD	All Years	01/10

Description

Identifies the date of birth of the patient.

Rationale

This data item is useful for patient identification. It is also useful when analyzing tumors according to age cohort.

Coding Instructions

- Record the patient's date of birth as indicated in the patient record. For single-digit day or month, record with a lead 0 (for example, September is 09). Use the full four-digit year for year.
- For *in utero* diagnosis and treatment, record the actual date of birth. It will follow one or both dates for those events.
- If only the patient age is available, calculate the year of birth from age and the year of diagnosis and leave day and month of birth unknown (for example, a 60 year old patient diagnosed in 2010 is calculated to have been born in 1950).
- If month is unknown, the day is coded unknown. If the year cannot be determined, the day and month are both coded unknown.
- If the date of birth cannot be determined at all, record the reason in *Date of Birth Flag* [241]
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about date entry in their own systems. The traditional format for *Date of Birth* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of Birth* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date. The *Date of Birth Flag* [241] is used to explain why *Date of Birth* is not a known date. See Date of Birth Flag for an illustration of the relationships among these items.

Date of Birth Flag

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
241	2	234-235	12, Blank	2010+	01/10

Description

This flag explains why there is no appropriate value in the corresponding date field, Date of Birth [240].

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate nondate information that had previously been transmitted in date fields.

Coding Instructions

- Leave this item blank if Date of Birth [240] has a full or partial date recorded.
- Code 12 if the *Date of Birth* cannot be determined at all.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Label
12	A proper value is applicable but not known (for example, birth date is unknown)
(Blank)	A valid date value is provided in item *Date of Birth* [240]

Age at Diagnosis

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
230	3	223-225	000–120, 999	All Years	09/08

Description

Records the age of the patient at his or her last birthday before diagnosis.

Rationale

This data item is useful for patient identification. It may also be useful when analyzing tumors according to specific patient age.

Coding Instructions

- If the patient has multiple primaries, then the age at diagnosis may be different for subsequent primaries.

Code	Label
000	Less than one year old; diagnosed *in utero*
001	One year old but less than two years old
002	Two years old
...	Actual age in years
120	One hundred twenty years old
999	Unknown age

Race 1

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
160	2	207-208	01–08, 10–17, 20–22, 25–28, 30–32, 96–99	All Years	01/04, 09/08, 01/10, 01/12

Description

Identifies the primary race of the person.

Rationale

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

Coding Instructions

- Additional races reported by the person should be coded in *Race 2*, *Race 3*, *Race 4*, and *Race 5*.
- *Race 1* is the field used to compare with race data on cases diagnosed prior to January 1, 2000.
- "Race" is analyzed with *Spanish/Hispanic Origin* [190]. Both items must be recorded. All tumors for the same patient should have the same race code.
- If the patient is multiracial, then code all races using *Race 2* [161] through *Race 5* [164], and code all remaining *Race* items 88.
- If the person is multiracial and one of the races is white, code the other race(s) first with white in the next race field.
- If the person is multiracial and one of the races is Hawaiian, code Hawaiian as *Race 1*, followed by the other race(s).
- A known race code (other than blank or 99) must not occur more than once. For example, do not code "Black" in *Race 1* for one parent and "Black" in *Race 2* for the other parent.
- If *Race 1* is coded 99, then *Race 2* through *Race 5* must all be coded 99.
- Codes 08–13 became effective with diagnoses on or after January 1, 1988.
- Code 14 became effective with diagnoses on or after January 1, 1994.
- In 2010, code 09 was converted to the new code 15, and codes 16 and 17 were added.
- Codes 20–97 became effective with diagnoses on or after January 1, 1991. SEER participants in San Francisco, San Jose–Monterey, and Los Angeles are permitted to use codes 14 and 20–97 for cases diagnosed after January 1, 1987.
- If *Race Coding System–Current* [170] is less than six (6) for cases diagnosed prior to January 1, 2000, then *Race 2* through *Race 5* must be blank.
- If a patient diagnosed prior to January 1, 2000, develops a subsequent primary after that date, then *Race Coding System–Current* must be seven (7), and data items *Race 2* through *Race 5* that do not have specific race recorded must be coded 88.

Code	Label	Code	Label
01	White	17	Pakistani
02	Black	20	Micronesian, NOS
03	American Indian, Aleutian, or Eskimo (includes all indigenous populations of the Western hemisphere)	21	Chamorro/Chamoru
04	Chinese	22	Guamanian, NOS
05	Japanese	25	Polynesian, NOS
06	Filipino	26	Tahitian
07	Hawaiian	27	Samoan
08	Korean	28	Tongan
10	Vietnamese	30	Melanesian, NOS
11	Laotian	31	Fiji Islander
12	Hmong	32	New Guinean
13	Kampuchean (Cambodian)	96	Other Asian, including Asian, NOS and Oriental, NOS
14	Thai	97	Pacific Islander, NOS
15	Asian Indian or Pakistani, NOS (formerly code 09)	98	Other
16	Asian Indian	99	Unknown

Examples

Code	Reason
01	A patient was born in Mexico of Mexican parentage. Code also *Spanish/Hispanic Origin* [190].
02	A black female patient.
05	A patient has a Japanese father and a Caucasian mother. (Caucasian will be coded in *Race 2*).

Race 2

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
161	2	209-210	01–08, 10–17, 20–22, 25–28, 30–32, 88, 96–99	2000+	01/04, 09/08, 01/10, 01/12

Description

Identifies the patient's race.

Rationale

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

Coding Instructions

- "Race" is analyzed with *Spanish/Hispanic Origin* [190]. Both items must be recorded. All tumors for the same patient should have the same race code.
- If *Race 1* [160] is coded 99, then *Race 2* must be coded 99.
- Codes 08–13 became effective with diagnoses on or after January 1, 1988.
- Code 14 became effective with diagnoses on or after January 1, 1994.
- In 2010, code 09 was converted to the new code 15, and codes 16 and 17 were added.
- Codes 20–97 became effective with diagnoses on or after January 1, 1991. SEER participants in San Francisco, San Jose–Monterey, and Los Angeles are permitted to use codes 14 and 20–97 for cases diagnosed after January 1, 1987.
- See the instructions for Race 1 [160] for coding sequences for entering multiple races.

Code	Label	Code	Label
01	White	20	Micronesian, NOS
02	Black	21	Chamorro/Chamoru
03	American Indian, Aleutian, or Eskimo (includes all indigenous populations of the Western hemisphere)	22	Guamanian, NOS
04	Chinese	25	Polynesian, NOS
05	Japanese	26	Tahitian
06	Filipino	27	Samoan
07	Hawaiian	28	Tongan
08	Korean	30	Melanesian, NOS
10	Vietnamese	31	Fiji Islander
11	Laotian	32	New Guinean

Code	Label	Code	Label
12	Hmong	88	No additional races
13	Kampuchean (Cambodian)	96	Other Asian, including Asian, NOS and Oriental, NOS
14	Thai	97	Pacific Islander, NOS
15	Asian Indian or Pakistani, NOS (formerly code 09)	98	Other
16	Asian Indian	99	Unknown
17	Pakistani		

Race 3

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
162	2	211-212	01–08, 10–17, 20–22, 25–28, 30–32, 88, 96–99	2000+	01/04, 09/08, 01/10, 01/12

Description

Identifies the patient's race.

Rationale

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

Coding Instructions

- "Race" is analyzed with *Spanish/Hispanic Origin* [190]. Both items must be recorded. All tumors for the same patient should have the same race code.
- If *Race 2* [161] is coded 88 or 99, then *Race 3* must be coded with the same value.
- Codes 08–13 became effective with diagnoses on or after January 1, 1988.
- Code 14 became effective with diagnoses on or after January 1, 1994.
- In 2010, code 09 was converted to the new code 15, and codes 16 and 17 were added.
- Codes 20–97 became effective with diagnoses on or after January 1, 1991. SEER participants in San Francisco, San Jose–Monterey, and Los Angeles are permitted to use codes 14 and 20–97 for cases diagnosed after January 1, 1987.
- See the instructions for Race 1 [160] for coding sequences for entering multiple races.

Code	Label	Code	Label
01	White	20	Micronesian, NOS
02	Black	21	Chamorro/Chamoru
03	American Indian, Aleutian, or Eskimo (includes all indigenous populations of the Western hemisphere)	22	Guamanian, NOS
04	Chinese	25	Polynesian, NOS
05	Japanese	26	Tahitian
06	Filipino	27	Samoan
07	Hawaiian	28	Tongan
08	Korean	30	Melanesian, NOS
10	Vietnamese	31	Fiji Islander
11	Laotian	32	New Guinean

Code	Label	Code	Label
12	Hmong	88	No additional races
13	Kampuchean (Cambodian)	96	Other Asian, including Asian, NOS and Oriental, NOS
14	Thai	97	Pacific Islander, NOS
15	Asian Indian or Pakistani, NOS (formerly code 09)	98	Other
16	Asian Indian	99	Unknown
17	Pakistani		

Race 4

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
163	2	213-214	01–08, 10–17, 20–22, 25–28, 30–32, 88, 96–99	2000+	01/04, 09/08, 01/10, 01/12

Description

Identifies the patient's race.

Rationale

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

Coding Instructions

- "Race" is analyzed with *Spanish/Hispanic Origin* [190]. Both items must be recorded. All tumors for the same patient should have the same race code.
- If *Race 3* [161] is coded 88 or 99, then *Race 4* must be coded with the same value.
- Codes 08–13 became effective with diagnoses on or after January 1, 1988.
- Code 14 became effective with diagnoses on or after January 1, 1994.
- In 2010, code 09 was converted to the new code 15, and codes 16 and 17 were added.
- Codes 20–97 became effective with diagnoses on or after January 1, 1991. SEER participants in San Francisco, San Jose–Monterey, and Los Angeles are permitted to use codes 14 and 20–97 for cases diagnosed after January 1, 1987.
- See the instructions for Race 1 [160] for coding sequences for entering multiple races.

Code	Label	Code	Label
01	White	20	Micronesian, NOS
02	Black	21	Chamorro/Chamoru
03	American Indian, Aleutian, or Eskimo (includes all indigenous populations of the Western hemisphere)	22	Guamanian, NOS
04	Chinese	25	Polynesian, NOS
05	Japanese	26	Tahitian
06	Filipino	27	Samoan
07	Hawaiian	28	Tongan
08	Korean	30	Melanesian, NOS
10	Vietnamese	31	Fiji Islander
11	Laotian	32	New Guinean

Code	Label	Code	Label
12	Hmong	88	No additional races
13	Kampuchean (Cambodian)	96	Other Asian, including Asian, NOS and Oriental, NOS
14	Thai	97	Pacific Islander, NOS
15	Asian Indian or Pakistani, NOS (formerly code 09)	98	Other
16	Asian Indian	99	Unknown
17	Pakistani		

Race 5

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
164	2	215-216	01–08, 10–17, 20–22, 25–28, 30–32, 88, 96–99	2000+	01/04, 09/08, 01/10, 01/12

Description

Identifies the patient's race.

Rationale

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

Coding Instructions

- "Race" is analyzed with *Spanish/Hispanic Origin* [190]. Both items must be recorded. All tumors for the same patient should have the same race code.
- If *Race 4* [161] is coded 88 or 99, then *Race 5* must be coded with the same value.
- Codes 08–13 became effective with diagnoses on or after January 1, 1988.
- Code 14 became effective with diagnoses on or after January 1, 1994.
- In 2010, code 09 was converted to the new code 15, and codes 16 and 17 were added.
- Codes 20–97 became effective with diagnoses on or after January 1, 1991. SEER participants in San Francisco, San Jose–Monterey, and Los Angeles are permitted to use codes 14 and 20–97 for cases diagnosed after January 1, 1987.
- See the instructions for Race 1 [160] for coding sequences for entering multiple races.

Code	Label	Code	Label
01	White	20	Micronesian, NOS
02	Black	21	Chamorro/Chamoru
03	American Indian, Aleutian, or Eskimo (includes all indigenous populations of the Western hemisphere)	22	Guamanian, NOS
04	Chinese	25	Polynesian, NOS
05	Japanese	26	Tahitian
06	Filipino	27	Samoan
07	Hawaiian	28	Tongan
08	Korean	30	Melanesian, NOS
10	Vietnamese	31	Fiji Islander
11	Laotian	32	New Guinean

Code	Label	Code	Label
12	Hmong	88	No additional races
13	Kampuchean (Cambodian)	96	Other Asian, including Asian, NOS and Oriental, NOS
14	Thai	97	Pacific Islander, NOS
15	Asian Indian or Pakistani, NOS (formerly code 09)	98	Other
16	Asian Indian	99	Unknown
17	Pakistani		

Spanish Origin–All Sources (Spanish/Hispanic Origin)

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
190	1	219-219	0–7, 9	All Years	09/04

Description

Identifies persons of Spanish or Hispanic origin.

Rationale

This code is used by hospital and central registries to identify whether or not the person should be classified as "Hispanic" for purposes of calculating cancer rates. Hispanic populations have different patterns of occurrence of cancer from other populations that may be included in the 01 (White category) of *Race 1* through *Race 5* [160–164].

Coding Instructions

- Persons of Spanish or Hispanic origin may be of any race, but these categories are generally not used for Native Americans, Filipinos, or others who may have Spanish names.
- Code 0 (Non-Spanish; non-Hispanic) for Portuguese and Brazilian persons.
- If the patient has multiple tumors, all records should have the same code.

Code	Label
0	Non-Spanish; non-Hispanic
1	Mexican (includes Chicano)
2	Puerto Rican
3	Cuban
4	South or Central America (except Brazil)
5	Other specified Spanish/Hispanic origin (includes European; excludes Dominican Republic)
6	Spanish, NOS; Hispanic, NOS; Latino, NOS (There is evidence other than surname or maiden name that the person is Hispanic, but he/she cannot be assigned to any category of 1–5)
7	Spanish surname only (The only evidence of the person's Hispanic origin is surname or maiden name, and there is no contrary evidence that the person is not Hispanic)
8	Dominican Republic (for use with patients who were diagnosed with cancer on January 1, 2005, or later)
9	Unknown whether Spanish or not; not stated in patient record

Sex

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
220	1	222-222	1–6, 9	All Years	01/15, 01/16

Description

Identifies the sex of the patient.

Rationale

This data item is used to compare cancer rates and outcomes by site. The same sex code should appear in each medical record for a patient with multiple tumors.

Coding Instructions

- Record the patient's sex as indicated in the medical record.
- Natality for transsexuals was added for use in 2015, but may be applied for earlier diagnoses.
- The definition of code 3 was updated to "Other (intersex, disorders of sexual development/DSD)" in 2016.

Code	Label
1	Male
2	Female
3	Other (intersex, disorders of sexual development/DSD)
4	Transsexual, NOS
5	Transsexual, natal male
6	Transsexual, natal female
9	Not stated in patient record

Primary Payer at Diagnosis

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
630	2	792-793	01, 02, 10, 20, 21, 31, 35, 60–68, 99	All Years	06/05, 01/10

Description

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

Rationale

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

Coding Instructions

- If the patient is diagnosed at the reporting facility, record the payer at the time of diagnosis.
- If the patient is diagnosed elsewhere or the payer at the time of diagnosis is not known record the payer when the patient is initially admitted for treatment.
- Record the type of insurance reported on the patient's admission page.
- Codes 21 and 65–68 are to be used for patients diagnosed on or after January 1, 2006.
- If more than one payer or insurance carrier is listed on the patient's admission page record the first.
- If the patient's payer or insurance carrier changes, do not change the initially recorded code.

Code	Label	Definition
01	Not insured	Patient has no insurance and is declared a charity write-off.
02	Not insured, self-pay	Patient has no insurance and is declared responsible for charges.
10	Insurance, NOS	Type of insurance unknown or other than the types listed in codes 20, 21, 31, 35, 60–68.
20	Private insurance: Managed Care, HMO, or PPO	An organized system of prepaid care for a group of enrollees usually within a defined geographic area. Generally formed as one of four types: a group model, an independent physician association (IPA), a network, or a staff model. "Gate-keeper model" is another term for describing this type of insurance.
21	Private insurance: Fee-for-Service	An insurance plan that does not have a negotiated fee structure with the participating hospital. Type of insurance plan not coded as 20.

Code	Label	Definition
31	Medicaid	State government administered insurance for persons who are uninsured, below the poverty level, or covered under entitlement programs. Medicaid other than described in code 35.
35	Medicaid administered through a Managed Care plan	Patient is enrolled in Medicaid through a Managed Care program (for example, HMO or PPO). The Managed Care plan pays for all incurred costs.
60	Medicare without supplement, Medicare, NOS	Federal government funded insurance for persons who are 65 years of age or older, or are chronically disabled (Social Security insurance eligible). Not described in codes 61, 62, or 63.
61	Medicare with supplement, NOS	Patient has Medicare and another type of unspecified insurance to pay costs not covered by Medicare.
62	Medicare administered through a Managed Care plan	Patient is enrolled in Medicare through a Managed Care plan (for example, HMO or PPO). The Managed Care plan pays for all incurred costs.
63	Medicare with private supplement	Patient has Medicare and private insurance to pay costs not covered by Medicare.
64	Medicare with Medicaid eligibility	Federal government Medicare insurance with State Medicaid administered supplement.
65	TRICARE	Department of Defense program providing supplementary civilian-sector hospital and medical services beyond a military treatment facility to military dependents, retirees, and their dependents. Formally CHAMPUS (Civilian Health and Medical Program of the Uniformed Services).
66	Military	Military personnel or their dependents who are treated at a military facility.
67	Veterans Affairs	Veterans who are treated in Veterans Affairs facilities.
68	Indian/Public Health Service	Patient who receives care at an Indian Health Service facility or at another facility, and the medical costs are reimbursed by the Indian Health Service. Patient receives care at a Public Health Service facility or at another facility, and medical costs are reimbursed by the Public Health Service.
99	Insurance status unknown	It is unknown from the patient's medical record whether or not the patient is insured.

Examples

Code	Reason
01	An indigent patient is admitted with no insurance coverage.
20	A patient is admitted for treatment and the patient admission page states the primary insurance carrier is an HMO.
62	A 65-year-old male patient is admitted for treatment and the patient admission page states the patient is covered by Medicare with additional insurance coverage from a PPO.

Comorbidities and Complications #1 (Secondary Diagnoses)

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
3110	5	1527-1531	00000, 00100–13980, 24000–99990, E8700–E8799, E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049, Blank	2002-2017	06/05, 01/11, 01/12, 01/13, 01/18

Description

Records the patient's preexisting medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-9-CM codes. All are considered secondary diagnoses.

Rationale

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

Coding Instructions

- Use this item to record ICD-9-CM codes only for patients diagnosed before 2018. Use *Secondary Diagnosis #1* [3780] to record ICD-10-CM codes for patients diagnosed in 2018 and later. During the adoption of ICD-10-CM codes, it is possible both will appear in the same patient record.
- Secondary diagnoses are found on the discharge abstract. Information from the billing department at your facility may be consulted when a discharge abstract is not available.
- Code the secondary diagnoses in the sequence in which they appear on the discharge abstract or are recorded by the billing department at your facility.
- Report the secondary diagnoses for this cancer using the following priority rules:
    - Surgically treated patients:
        - following the most definitive surgery of the primary site
        - following other non-primary site surgeries
    - Non-surgically treated patients:
        - following the first treatment encounter/episode
    - In cases of non-treatment:
        - following the last diagnostic/evaluative encounter
- If the data item *Readmission to the Same Hospital within 30 Days of Surgical Discharge* [3190] is coded 1, 2, or 3, report *Comorbidities and Complications* ICD-9-CM codes appearing on the "readmission" discharge abstract.

- If no ICD-9-CM secondary diagnoses were documented, then code 00000 in this data item, and leave the remaining *Comorbidities and Complications* data items blank.
- If fewer than 10 ICD-9-CM secondary diagnoses are listed, then code the diagnoses listed, and leave the remaining *Comorbidities and Complications* data items blank.

Code	Label
00000	No comorbid conditions or complications documented.
00100–13980, 24000–99990	Comorbid conditions: Omit the decimal point between the third and fourth characters.
E8700–E8799, E9300–E9499	Complications: Omit the decimal point between the fourth and fifth characters.
V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049	Factors affecting health status: Omit the decimal point between the fourth and fifth characters.

Examples

Code	Reason
49600	COPD (ICD-9-CM code 496)
25001	Type 1 diabetes mellitus (ICD-9-CM code 250.01)
E8732	The patient was inadvertently exposed to an overdose of external beam radiation (ICD-9-CM code E873.2)
E9300	During hospitalization the patient has an adverse reaction to Ampicillin, a semisynthetic form of penicillin (ICD-9-CM code E930.0)
V1030	The patient has a personal history of breast cancer (ICD-9-CM code V10.3)

Comorbidities and Complications #2 (Secondary Diagnoses)

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
3120	5	1532-1536	00100–13980, 24000–99990, E8700–E8799, E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049, Blank	2002-2017	06/05, 01/11, 01/12, 01/13, 01/15, 01/18

Description

Records the patient's preexisting medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-9-CM codes. All are considered secondary diagnoses.

Rationale

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

Coding Instructions

- Use this item to record ICD-9-CM codes. Use *Secondary Diagnosis #2* [3782] to record ICD-10-CM codes. During the adoption of ICD-10-CM codes, it is possible both will appear in the same patient record.
- If only one comorbid condition or complication is listed, then leave this data item blank.
- If only two comorbid conditions or complications are listed, then code the diagnoses listed and leave the remaining *Comorbidities and Complications* items blank.
- For further Instructions for Coding, see *Comorbidities and Complications #1* [3110].

Code	Label
00100–13980, 24000–99990	Comorbid conditions: Omit the decimal point between the third and fourth characters.
E8700–E8799, E9300–E9499	Complications: Omit the decimal point between the fourth and fifth characters.
V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049	Factors affecting health status: Omit the decimal point between the fourth and fifth characters.

Comorbidities and Complications #3 (Secondary Diagnoses)

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
3130	5	1537-1541	00100–13980, 24000–99990, E8700–E8799, E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049, Blank	2002-2017	06/05, 01/11, 01/12, 01/13, 01/15, 01/18

Description

Records the patient's preexisting medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-9-CM codes. All are considered secondary diagnoses.

Rationale

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

Coding Instructions

- Use this item to record ICD-9-CM codes. Use *Secondary Diagnosis #3* [3784] to record ICD-10-CM codes. During adoption of ICD-10-CM codes, it is possible both will appear in the same patient record.
- If only two comorbid conditions or complications are listed, then leave this data item blank.
- If only three comorbid conditions or complications are listed, then code the diagnoses listed and leave the remaining *Comorbidities and Complications* items blank.
- For further Instructions for Coding, see *Comorbidities and Complications #1* [3110].

Code	Label
00100–13980, 24000–99990	Comorbid conditions: Omit the decimal point between the third and fourth characters.
E8700–E8799, E9300–E9499	Complications: Omit the decimal point between the fourth and fifth characters.
V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049	Factors affecting health status: Omit the decimal point between the fourth and fifth characters.

Comorbidities and Complications #4 (Secondary Diagnoses)

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
3140	5	1542-1546	00100–13980, 24000–99990, E8700–E8799, E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049, Blank	2002-2017	06/05, 01/11, 01/12, 01/13, 01/15, 01/18

Description

Records the patient's preexisting medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-9-CM codes. All are considered secondary diagnoses.

Rationale

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

Coding Instructions

- Use this item to record ICD-9-CM codes. Use *Secondary Diagnosis #4* [3786] to record ICD-10-CM codes. During adoption of ICD-10-CM codes, it is possible both will appear in the same patient record.
- If only three comorbid conditions or complications are listed, then leave this data item blank.
- If only four comorbid conditions or complications are listed, then code the diagnoses listed and leave the remaining *Comorbidities and Complications* items blank.
- For further Instructions for Coding, see *Comorbidities and Complications #1* [3110].

Code	Label
00100–13980, 24000–99990	Comorbid conditions: Omit the decimal point between the third and fourth characters.
E8700–E8799, E9300–E9499	Complications: Omit the decimal point between the fourth and fifth characters.
V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049	Factors affecting health status: Omit the decimal point between the fourth and fifth characters.

Comorbidities and Complications #5 (Secondary Diagnoses)

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
3150	5	1547-1551	00100–13980, 24000–99990, E8700–E8799, E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049, Blank	2002-2017	06/05, 01/11, 01/12, 01/13, 01/15, 01/18

Description

Records the patient's preexisting medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-9-CM codes. All are considered secondary diagnoses.

Rationale

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

Coding Instructions

- Use this item to record ICD-9-CM codes. Use *Secondary Diagnosis #5* [3788] to record ICD-10-CM codes. During adoption of ICD-10-CM codes, it is possible both will appear in the same patient record.
- If only four comorbid conditions or complications are listed, then leave this data item blank.
- If only five comorbid conditions or complications are listed, then code the diagnoses listed and leave the remaining *Comorbidities and Complications* items blank.
- For further Instructions for Coding, see *Comorbidities and Complications #1* [3110].

Code	Label
00100–13980, 24000–99990	Comorbid conditions: Omit the decimal point between the third and fourth characters.
E8700–E8799, E9300–E9499	Complications: Omit the decimal point between the fourth and fifth characters.
V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049	Factors affecting health status: Omit the decimal point between the fourth and fifth characters.

Comorbidities and Complications #6 (Secondary Diagnoses)

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
3160	5	1552-1556	00100–13980, 24000–99990, E8700–E8799, E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049, Blank	2002-2017	06/05, 01/11, 01/12, 01/13, 01/15, 01/18

Description

Records the patient's preexisting medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-9-CM codes. All are considered secondary diagnoses.

Rationale

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

Coding Instructions

- Use this item to record ICD-9-CM codes. Use *Secondary Diagnosis #6* [3790] to record ICD-10-CM codes. During adoption of ICD-10-CM codes, it is possible both will appear in the same patient record.
- If only five comorbid conditions or complications are listed, then leave this data item blank.
- If only six comorbid conditions or complications are listed, then code the diagnoses listed and leave the remaining *Comorbidities and Complications* items blank.
- For further Instructions for Coding, see *Comorbidities and Complications #1* [3110].

Code	Label
00100–13980, 24000–99990	Comorbid conditions: Omit the decimal point between the third and fourth characters.
E8700–E8799, E9300–E9499	Complications: Omit the decimal point between the fourth and fifth characters.
V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049	Factors affecting health status: Omit the decimal point between the fourth and fifth characters.

Comorbidities and Complications #7 (Secondary Diagnoses)

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
3161	5	1557-1561	00100–13980, 24000–99990, E8700–E8799, E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049, Blank	2006-2017	01/11, 01/12, 01/13, 01/15, 01/18

Description

Records the patient's preexisting medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-9-CM codes. All are considered secondary diagnoses.

Rationale

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

Coding Instructions

- Use this item to record ICD-9-CM codes. Use *Secondary Diagnosis #7* [3792] to record ICD-10-CM codes. During the adoption of ICD-10-CM codes, it is possible both will appear in the same patient record.
- *Comorbidities and Complications #7* is to be used for patients diagnosed on or after January 1, 2006.
- If only six comorbid conditions or complications are listed, then leave this data item blank.
- If only seven comorbid conditions or complications are listed, then code the diagnoses listed and leave the remaining *Comorbidities and Complications* items blank.
- For further Instructions for Coding, see *Comorbidities and Complications #1* [3110].

Code	Label
00100–13980, 24000–99990	Comorbid conditions: Omit the decimal point between the third and fourth characters.
E8700–E8799, E9300–E9499	Complications: Omit the decimal point between the fourth and fifth characters.
V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049	Factors affecting health status: Omit the decimal point between the fourth and fifth characters.

Comorbidities and Complications #8 (Secondary Diagnoses)

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
3162	5	1562-1566	00100–13980, 24000–99990, E8700–E8799, E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049, Blank	2006-2017	01/11, 01/12, 01/13, 01/15, 01/18

Description

Records the patient's preexisting medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-9-CM codes. All are considered secondary diagnoses.

Rationale

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

Coding Instructions

- Use this item to record ICD-9-CM codes. Use *Secondary Diagnosis #8* [3794] to record ICD-10-CM codes. During the adoption of ICD-10-CM codes, it is possible both will appear in the same patient record.
- *Comorbidities and Complications #8* is to be used for patients diagnosed on or after January 1, 2006.
- If only seven comorbid conditions or complications are listed, then leave this data item blank.
- If only eight comorbid conditions or complications are listed, then code the diagnoses listed and leave the remaining *Comorbidities and Complications* items blank.
- For further Instructions for Coding, see *Comorbidities and Complications #1* [3110].

Code	Label
00100–13980, 24000–99990	Comorbid conditions: Omit the decimal point between the third and fourth characters.
E8700–E8799, E9300–E9499	Complications: Omit the decimal point between the fourth and fifth characters.
V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049	Factors affecting health status: Omit the decimal point between the fourth and fifth characters.

Comorbidities and Complications #9 (Secondary Diagnoses)

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
3163	5	1567-1571	00100–13980, 24000–99990, E8700–E8799, E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049, Blank	2006-2017	01/11, 01/12, 01/13, 01/15, 01/18

Description

Records the patient's preexisting medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-9-CM codes. All are considered secondary diagnoses.

Rationale

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

Coding Instructions

- Use this item to record ICD-9-CM codes. Use *Secondary Diagnosis #9* [3796] to record ICD-10-CM codes. During the adoption of ICD-10-CM codes, it is possible both will appear in the same patient record.
- *Comorbidities and Complications #9* is to be used for patients diagnosed on or after January 1, 2006.
- If only eight comorbid conditions or complications are listed, then leave this data item blank.
- If only nine comorbid conditions or complications are listed, then code the diagnoses listed and leave the remaining *Comorbidities and Complications* items blank.
- For further Instructions for Coding, see *Comorbidities and Complications #1* [3110].

Code	Label
00100–13980, 24000–99990	Comorbid conditions: Omit the decimal point between the third and fourth characters.
E8700–E8799, E9300–E9499	Complications: Omit the decimal point between the fourth and fifth characters.
V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049	Factors affecting health status: Omit the decimal point between the fourth and fifth characters.

Comorbidities and Complications #10 (Secondary Diagnoses)

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
3164	5	1572-1576	00100–13980, 24000–99990, E8700–E8799, E9300–E9499, V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049, Blank	2006-2017	01/11, 01/12, 01/13, 01/15, 01/18

Description

Records the patient's preexisting medical conditions, factors influencing health status, and/or complications during the patient's hospital stay for the treatment of this cancer using ICD-9-CM codes. All are considered secondary diagnoses.

Rationale

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

Coding Instructions

- Use this item to record ICD-9-CM codes. Use *Secondary Diagnosis #10* [3796] to record ICD-10-CM codes. During the adoption of ICD-10-CM codes, it is possible both will appear in the same patient record.
- *Comorbidities and Complications #10* is to be used for patients diagnosed on or after January 1, 2006.
- If only nine comorbid conditions or complications are listed, then leave this data item blank.
- For further Instructions for Coding, see *Comorbidities and Complications #1* [3110].

Code	Label
00100–13980, 24000–99990	Comorbid conditions: Omit the decimal point between the third and fourth characters.
E8700–E8799, E9300–E9499	Complications: Omit the decimal point between the fourth and fifth characters.
V0720–V0739, V1000–V1590, V2220–V2310, V2540, V4400–V4589, V5041–V5049	Factors affecting health status: Omit the decimal point between the fourth and fifth characters.

Secondary Diagnosis #1 (Secondary Diagnoses)

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
3780	7	1577-1583	0000000; all values beginning with A-B, E, G-P, R-S; and the following ranges: T36-T50996ZZ, Y62-Y849ZZZ, Z1401-Z229ZZZ, Z681-Z6854ZZ, Z80-Z809ZZZ, Z8500-Z9989ZZ	2015+	01/13

Description

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

Rationale

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

Coding Instructions

- Use this item to record ICD-10-CM codes. Use *Comorbidities and Complications #1* [3110] to record ICD-9-CM codes only for patients diagnosed before 2018. During the adoption of ICD-10-CM codes, it is possible both will appear in the same patient record.
- Note that, while the ICD-9-CM *Comorbidities and Complications* codes were to be followed by zeroes if they did not fill the field, only the actual ICD-10-CM code is to be entered for *Secondary Diagnosis* fields, leaving blanks beyond those characters.
- Omit the decimal points when coding.
- Secondary diagnoses are found on the discharge abstract. Information from the billing department at your facility may be consulted when a discharge abstract is not available.
- Code the secondary diagnoses in the sequence in which they appear on the discharge abstract or are recorded by the billing department at your facility.
- Report the secondary diagnoses for this cancer using the following priority rules:
    - Surgically treated patients:
        - following the most definitive surgery of the primary site
        - following other non-primary site surgeries
    - Non-surgically treated patients:
        - following the first treatment encounter/episode
    - In cases of non-treatment:
        - following the last diagnostic/evaluative encounter

- If the data item *Readmission to the Same Hospital within 30 Days of Surgical Discharge* [3190] is coded 1, 2, or 3, report *Secondary Diagnosis* ICD-10-CM codes appearing on the "readmission" discharge abstract.
- If no ICD-10-CM secondary diagnoses were documented, then code 0000000 in this data item, and leave the remaining *Secondary Diagnosis* data items blank.
- If fewer than 10 ICD-10-CM secondary diagnoses are listed, then code the diagnoses listed, and leave the remaining *Secondary Diagnosis* data items blank.

Examples

Code	Reason
J449	Chronic obstructive pulmonary disease, unspecified (ICD-10-CM code J44.9)
E119	Type 2 diabetes mellitus without complications (ICD-10-CM code E11.9)
Y632	The patient was inadvertently exposed to an overdose of radiation during a medical procedure (ICD-10-CM code E873.2)
T360X5	During hospitalization the patient has an adverse reaction to Ampicillin, a semisynthetic form of penicillin (ICD-10-CM code T36.0X5)
Z853	The patient has a personal history of breast cancer (ICD-10-CM code Z85.3)
0000000	No applicable ICD-10-CM codes are recorded in this patient's record

Secondary Diagnosis #2 (Secondary Diagnoses)

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
3782	7	1584-1590	0000000; all values beginning with A-B, E, G-P, R-S; and the following ranges: T36-T50996ZZ, Y62-Y849ZZZ, Z1401-Z229ZZZ, Z681-Z6854ZZ, Z80-Z809ZZZ, Z8500-Z9989ZZ, Blank	2015+	01/15

Description

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

Rationale

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

Coding Instructions

- Use this item to record ICD-10-CM codes. Use *Comorbidities and Complications #2* [3120] to record ICD-9-CM codes. During the adoption of ICD-10-CM codes, it is possible both will appear in the same patient record.
- Note that, while the ICD-9-CM *Comorbidities and Complications* codes were to be followed by zeroes if they did not fill the field, only the actual ICD-10-CM code is to be entered for *Secondary Diagnosis* fields, leaving blanks beyond those characters.
- Omit the decimal points when coding.
- If fewer than 10 ICD-10-CM secondary diagnoses are listed, then code the diagnoses listed, and leave the remaining *Secondary Diagnosis* data items blank.

Examples

Code	Reason
J449	Chronic obstructive pulmonary disease, unspecified (ICD-10-CM code J44.9)
E119	Type 2 diabetes mellitus without complications (ICD-10-CM code E11.9)
Y632	The patient was inadvertently exposed to an overdose of radiation during a medical procedure (ICD-10-CM code E873.2)
T360X5	During hospitalization the patient has an adverse reaction to Ampicillin, a semisynthetic form of penicillin (ICD-10-CM code T36.0X5)
Z853	The patient has a personal history of breast cancer (ICD-10-CM code Z85.3)

Secondary Diagnosis #3 (Secondary Diagnoses)

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
3784	7	1591-1597	0000000; all values beginning with A-B, E, G-P, R-S; and the following ranges: T36-T50996ZZ, Y62-Y849ZZZ, Z1401-Z229ZZZ, Z681-Z6854ZZ, Z80-Z809ZZZ, Z8500-Z9989ZZ, Blank	2015+	01/15

Description

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

Rationale

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

Coding Instructions

- Use this item to record ICD-10-CM codes. Use *Comorbidities and Complications #3* [3130] to record ICD-9-CM codes. During the adoption of ICD-10-CM codes, it is possible both will appear in the same patient record.
- Note that, while the ICD-9-CM *Comorbidities and Complications* codes were to be followed by zeroes if they did not fill the field, only the actual ICD-10-CM code is to be entered for *Secondary Diagnosis* fields, leaving blanks beyond those characters.
- Omit the decimal points when coding.
- If fewer than 10 ICD-10-CM secondary diagnoses are listed, then code the diagnoses listed, and leave the remaining *Secondary Diagnosis* data items blank.

Examples

Code	Reason
J449	Chronic obstructive pulmonary disease, unspecified (ICD-10-CM code J44.9)
E119	Type 2 diabetes mellitus without complications (ICD-10-CM code E11.9)
Y632	The patient was inadvertently exposed to an overdose of radiation during a medical procedure (ICD-10-CM code E873.2)
T360X5	During hospitalization the patient has an adverse reaction to Ampicillin, a semisynthetic form of penicillin (ICD-10-CM code T36.0X5)
Z853	The patient has a personal history of breast cancer (ICD-10-CM code Z85.3)

Secondary Diagnosis #4 (Secondary Diagnoses)

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
3786	7	1598-1604	0000000; all values beginning with A-B, E, G-P, R-S; and the following ranges: T36-T50996ZZ, Y62-Y849ZZZ, Z1401-Z229ZZZ, Z681-Z6854ZZ, Z80-Z809ZZZ, Z8500-Z9989ZZ, Blank	2015+	01/15

Description

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

Rationale

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

Coding Instructions

- Use this item to record ICD-10-CM codes. Use *Comorbidities and Complications #4* [3140] to record ICD-9-CM codes. During the adoption of ICD-10-CM codes, it is possible both will appear in the same patient record.
- Note that, while the ICD-9-CM *Comorbidities and Complications* codes were to be followed by zeroes if they did not fill the field, only the actual ICD-10-CM code is to be entered for *Secondary Diagnosis* fields, leaving blanks beyond those characters.
- Omit the decimal points when coding.
- If fewer than 10 ICD-10-CM secondary diagnoses are listed, then code the diagnoses listed, and leave the remaining *Secondary Diagnosis* data items blank.

Examples

Code	Reason
J449	Chronic obstructive pulmonary disease, unspecified (ICD-10-CM code J44.9)
E119	Type 2 diabetes mellitus without complications (ICD-10-CM code E11.9)
Y632	The patient was inadvertently exposed to an overdose of radiation during a medical procedure (ICD-10-CM code E873.2)
T360X5	During hospitalization the patient has an adverse reaction to Ampicillin, a semisynthetic form of penicillin (ICD-10-CM code T36.0X5)
Z853	The patient has a personal history of breast cancer (ICD-10-CM code Z85.3)

Secondary Diagnosis #5 (Secondary Diagnoses)

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
3788	7	1605-1611	0000000; all values beginning with A-B, E, G-P, R-S; and the following ranges: T36-T50996ZZ, Y62-Y849ZZZ, Z1401-Z229ZZZ, Z681-Z6854ZZ, Z80-Z809ZZZ, Z8500-Z9989ZZ, Blank	2015+	01/15

Description

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

Rationale

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

Coding Instructions

- Use this item to record ICD-10-CM codes. Use *Comorbidities and Complications #5* [3150] to record ICD-9-CM codes. During the adoption of ICD-10-CM codes, it is possible both will appear in the same patient record.
- Note that, while the ICD-9-CM *Comorbidities and Complications* codes were to be followed by zeroes if they did not fill the field, only the actual ICD-10-CM code is to be entered for *Secondary Diagnosis* fields, leaving blanks beyond those characters.
- Omit the decimal points when coding.
- If fewer than 10 ICD-10-CM secondary diagnoses are listed, then code the diagnoses listed, and leave the remaining *Secondary Diagnosis* data items blank.

Examples

Code	Reason
J449	Chronic obstructive pulmonary disease, unspecified (ICD-10-CM code J44.9)
E119	Type 2 diabetes mellitus without complications (ICD-10-CM code E11.9)
Y632	The patient was inadvertently exposed to an overdose of radiation during a medical procedure (ICD-10-CM code E873.2)
T360X5	During hospitalization the patient has an adverse reaction to Ampicillin, a semisynthetic form of penicillin (ICD-10-CM code T36.0X5)
Z853	The patient has a personal history of breast cancer (ICD-10-CM code Z85.3)

Secondary Diagnosis #6 (Secondary Diagnoses)

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
3790	7	1612-1618	0000000; all values beginning with A-B, E, G-P, R-S; and the following ranges: T36-T50996ZZ, Y62-Y849ZZZ, Z1401-Z229ZZZ, Z681-Z6854ZZ, Z80-Z809ZZZ, Z8500-Z9989ZZ, Blank	2015+	01/15

Description

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

Rationale

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

Coding Instructions

- Use this item to record ICD-10-CM codes. Use *Comorbidities and Complications #6* [3160] to record ICD-9-CM codes. During the adoption of ICD-10-CM codes, it is possible both will appear in the same patient record.
- Note that, while the ICD-9-CM *Comorbidities and Complications* codes were to be followed by zeroes if they did not fill the field, only the actual ICD-10-CM code is to be entered for *Secondary Diagnosis* fields, leaving blanks beyond those characters.
- Omit the decimal points when coding.
- If fewer than 10 ICD-10-CM secondary diagnoses are listed, then code the diagnoses listed, and leave the remaining *Secondary Diagnosis* data items blank.

Examples

Code	Reason
J449	Chronic obstructive pulmonary disease, unspecified (ICD-10-CM code J44.9)
E119	Type 2 diabetes mellitus without complications (ICD-10-CM code E11.9)
Y632	The patient was inadvertently exposed to an overdose of radiation during a medical procedure (ICD-10-CM code E873.2)
T360X5	During hospitalization the patient has an adverse reaction to Ampicillin, a semisynthetic form of penicillin (ICD-10-CM code T36.0X5)
Z853	The patient has a personal history of breast cancer (ICD-10-CM code Z85.3)

Secondary Diagnosis #7 (Secondary Diagnoses)

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
3792	7	1619-1625	0000000; all values beginning with A-B, E, G-P, R-S; and the following ranges: T36-T50996ZZ, Y62-Y849ZZZ, Z1401-Z229ZZZ, Z681-Z6854ZZ, Z80-Z809ZZZ, Z8500-Z9989ZZ, Blank	2015+	01/15

Description

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

Rationale

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

Coding Instructions

- Use this item to record ICD-10-CM codes. Use *Comorbidities and Complications #7* [3161] to record ICD-9-CM codes. During the adoption of ICD-10-CM codes, it is possible both will appear in the same patient record.
- Note that, while the ICD-9-CM *Comorbidities and Complications* codes were to be followed by zeroes if they did not fill the field, only the actual ICD-10-CM code is to be entered for *Secondary Diagnosis* fields, leaving blanks beyond those characters.
- Omit the decimal points when coding.
- If fewer than 10 ICD-10-CM secondary diagnoses are listed, then code the diagnoses listed, and leave the remaining *Secondary Diagnosis* data items blank.

Examples

Code	Reason
J449	Chronic obstructive pulmonary disease, unspecified (ICD-10-CM code J44.9)
E119	Type 2 diabetes mellitus without complications (ICD-10-CM code E11.9)
Y632	The patient was inadvertently exposed to an overdose of radiation during a medical procedure (ICD-10-CM code E873.2)
T360X5	During hospitalization the patient has an adverse reaction to Ampicillin, a semisynthetic form of penicillin (ICD-10-CM code T36.0X5)
Z853	The patient has a personal history of breast cancer (ICD-10-CM code Z85.3)

Secondary Diagnosis #8 (Secondary Diagnoses)

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
3794	7	1626-1632	0000000; all values beginning with A-B, E, G-P, R-S; and the following ranges: T36-T50996ZZ, Y62-Y849ZZZ, Z1401-Z229ZZZ, Z681-Z6854ZZ, Z80-Z809ZZZ, Z8500-Z9989ZZ, Blank	2015+	01/15

Description

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

Rationale

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

Coding Instructions

- Use this item to record ICD-10-CM codes. Use *Comorbidities and Complications #8* [3162] to record ICD-9-CM codes. During the adoption of ICD-10-CM codes, it is possible both will appear in the same patient record.
- Note that, while the ICD-9-CM *Comorbidities and Complications* codes were to be followed by zeroes if they did not fill the field, only the actual ICD-10-CM code is to be entered for *Secondary Diagnosis* fields, leaving blanks beyond those characters.
- Omit the decimal points when coding.
- If fewer than 10 ICD-10-CM secondary diagnoses are listed, then code the diagnoses listed, and leave the remaining *Secondary Diagnosis* data items blank.

Examples

Code	Reason
J449	Chronic obstructive pulmonary disease, unspecified (ICD-10-CM code J44.9)
E119	Type 2 diabetes mellitus without complications (ICD-10-CM code E11.9)
Y632	The patient was inadvertently exposed to an overdose of radiation during a medical procedure (ICD-10-CM code E873.2)
T360X5	During hospitalization the patient has an adverse reaction to Ampicillin, a semisynthetic form of penicillin (ICD-10-CM code T36.0X5)
Z853	The patient has a personal history of breast cancer (ICD-10-CM code Z85.3)

Secondary Diagnosis #9 (Secondary Diagnoses)

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
3796	7	1633-1639	0000000; all values beginning with A-B, E, G-P, R-S; and the following ranges: T36-T50996ZZ, Y62-Y849ZZZ, Z1401-Z229ZZZ, Z681-Z6854ZZ, Z80-Z809ZZZ, Z8500-Z9989ZZ, Blank	2015+	01/15

Description

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

Rationale

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

Coding Instructions

- Use this item to record ICD-10-CM codes. Use *Comorbidities and Complications #9* [3163] to record ICD-9-CM codes. During the adoption of ICD-10-CM codes, it is possible both will appear in the same patient record.
- Note that, while the ICD-9-CM *Comorbidities and Complications* codes were to be followed by zeroes if they did not fill the field, only the actual ICD-10-CM code is to be entered for *Secondary Diagnosis* fields, leaving blanks beyond those characters.
- Omit the decimal points when coding.
- If fewer than 10 ICD-10-CM secondary diagnoses are listed, then code the diagnoses listed, and leave the remaining *Secondary Diagnosis* data items blank.

Examples

Code	Reason
J449	Chronic obstructive pulmonary disease, unspecified (ICD-10-CM code J44.9)
E119	Type 2 diabetes mellitus without complications (ICD-10-CM code E11.9)
Y632	The patient was inadvertently exposed to an overdose of radiation during a medical procedure (ICD-10-CM code E873.2)
T360X5	During hospitalization the patient has an adverse reaction to Ampicillin, a semisynthetic form of penicillin (ICD-10-CM code T36.0X5)
Z853	The patient has a personal history of breast cancer (ICD-10-CM code Z85.3)

Secondary Diagnosis #10 (Secondary Diagnoses)

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
3798	7	1640-1646	0000000; all values beginning with A-B, E, G-P, R-S; and the following ranges: T36-T50996ZZ, Y62-Y849ZZZ, Z1401-Z229ZZZ, Z681-Z6854ZZ, Z80-Z809ZZZ, Z8500-Z9989ZZ, Blank	2015+	01/15

Description

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

Rationale

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

Coding Instructions

- Use this item to record ICD-10-CM codes. Use *Comorbidities and Complications #10* [3164] to record ICD-9-CM codes. During the adoption of ICD-10-CM codes, it is possible both will appear in the same patient record.
- Note that, while the ICD-9-CM *Comorbidities and Complications* codes were to be followed by zeroes if they did not fill the field, only the actual ICD-10-CM code is to be entered for *Secondary Diagnosis* fields, leaving blanks beyond those characters.
- Omit the decimal points when coding.
- If fewer than 10 ICD-10-CM secondary diagnoses are listed, then code the diagnoses listed, and leave the remaining *Secondary Diagnosis* data items blank.

Examples

Code	Reason
J449	Chronic obstructive pulmonary disease, unspecified (ICD-10-CM code J44.9)
E119	Type 2 diabetes mellitus without complications (ICD-10-CM code E11.9)
Y632	The patient was inadvertently exposed to an overdose of radiation during a medical procedure (ICD-10-CM code E873.2)
T360X5	During hospitalization the patient has an adverse reaction to Ampicillin, a semisynthetic form of penicillin (ICD-10-CM code T36.0X5)
Z853	The patient has a personal history of breast cancer (ICD-10-CM code Z85.3)

NPI–Managing Physician

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
2465	10	5015-5024	10 digits, Blank	2008+	04/07, 09/08

Description

Identifies the physician who is responsible for the overall management of the patient during diagnosis and/or treatment of this cancer.

Rationale

The managing physician is responsible for the patient's work-up, plans the treatment, and directs the delivery of patient care in accordance with CoC Standards. In most cases, the managing physician is responsible for AJCC staging.

Coding Instructions

- Record the 10-digit NPI for the physician responsible for managing the patient's care.
- Check with the billing or health information departments to determine the physician's NPI or search at https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do
- NPI should be recorded as available for cases diagnosed during 2007, and is required to be recorded for all cases diagnosed January 1, 2008, and later.
- NPI may be blank for cases diagnosed on or before December 31, 2006.
- Do not update this item. Once the registry has designated a managing physician for the patient, this item should not be changed even if a different managing physician is assigned.

Code	Label
(fill spaces)	10-digit NPI number for the managing physician.
(leave blank)	NPI for the managing physician is unknown or not available.

NPI–Following Physician

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
2475	10	5033-5042	10 digits, Blank	2008+	04/07, 09/08, 01/11

Description

Records the NPI for the physician currently responsible for the patient's medical care.

Rationale

The following physician is the first contact for obtaining information on a patient's status and subsequent treatment. This information may be used for outcomes studies.

Coding Instructions

- Record the 10-digit NPI for the physician currently responsible for the patient's medical care.
- Check with the billing or health information departments to determine the physician's NPI or search at https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.
- Change this data item when patient follow-up becomes the responsibility of another physician.
- NPI should be recorded as available for cases diagnosed during 2007, and is required to be recorded for all cases diagnosed January 1, 2008, and later.
- NPI may be blank for cases diagnosed on or before December 31, 2006.

Code	Label
(fill spaces)	10-digit NPI number for the following physician.
(leave blank)	NPI for the following physician is unknown or not available.

NPI–Primary Surgeon

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
2485	10	5051-5060	10 digits, Blank	2008+	04/07, 09/08, 01/11

Description

Identifies the physician who performed the most definitive surgical procedure.

Rationale

Administrative, physician, and service referral reports are based on this item.

Coding Instructions

- Record the 10-digit NPI for the physician who performed the most definitive surgical procedure.
- Check with the billing or health information departments to determine the physician's NPI or search at https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.
- NPI should be recorded as available for cases diagnosed during 2007, and is required to be recorded for all cases diagnosed January 1, 2008, and later.
- NPI may be blank for cases diagnosed on or before December 31, 2006.
- Do not update this item. 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 surgeon.

Code	Label
(fill spaces)	10-digit NPI number for the primary surgeon.
(leave blank)	The patient did not have surgery. NPI for the primary surgeon is unknown or not available. The physician who performed the surgical procedure was not a surgeon (for example, general practitioner).

NPI–Physician #3 (Radiation Oncologist–CoC Preferred)

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
2495	10	5069-5078	10 digits, Blank	2008+	4/07, 9/08, 1/10, 1/11

Description

Records the NPI for a physician involved in the care of the patient. The Commission on Cancer recommends that this item identify the physician who performed the most definitive radiation therapy.

Rationale

Administrative, physician, and service referral reports are based on this data item. It also can be used for follow-up purposes.

Coding Instructions

- Record the 10-digit NPI for the physician.
- Check with the billing or health information departments to determine the physician's NPI or search at https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.
- Do not update this item. If the registry has designated a primary radiation oncologist for the patient, the information in this data item should not be changed or updated even if the patient receives care from another radiation oncologist.
- NPI should be recorded as available for cases diagnosed during 2007, and is required to be recorded for all cases diagnosed January 1, 2008, and later.
- NPI may be blank for cases diagnosed on or before December 31, 2006.
-

Code	Label
(fill spaces)	10-digit NPI number for the primary radiation oncologist.
(leave blank)	NPI for the primary radiation oncologist is unknown or not available.

NPI–Physician #4 (Medical Oncologist–CoC Preferred)

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
2505	10	5087-5096	10 digits, Blank	2008+	4/07, 9/08, 1/10, 1/11, 1/12

Description

Records the NPI for a physician involved in the care of the patient. The Commission on Cancer recommends that this data item identify the physician who gives the most definitive systemic therapy.

Rationale

Administrative, physician, and service referral reports are based on this data item. It also can be used for follow-up purposes.

Coding Instructions

- Record the 10-digit NPI for the physician.
- Check with the billing or health information departments to determine the physician's NPI or search at https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.
- Do not update this item. If the registry has designated a primary medical oncologist for the patient, the information in this data item should not be changed or updated even if the patient receives care from another medical oncologist.
- NPI should be recorded as available for cases diagnosed during 2007, and is required to be recorded for all cases diagnosed January 1, 2008, and later.
- NPI may be blank for cases diagnosed on or before December 31, 2006.

Code	Label
(fill spaces)	10-digit NPI number for the primary medical oncologist.
(leave blank)	NPI for the primary medical oncologist is unknown or not available.

Cancer Identification

Class of Case

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
610	2	790-791	00, 10-14, 20-22, 30-38, 40-43, 49, 99	All Years	09/08, 01/10, 05/10, 01/11, 01/12, 01/14, 01/15

Description

Class of Case divides cases into two groups. Analytic cases (codes 00–22) are those that are required by CoC to be abstracted because of the program's primary responsibility in managing the cancer. Analytic cases are grouped according to the location of diagnosis and first course of treatment. Nonanalytic cases (codes 30–49 and 99) may be abstracted by the facility to meet central registry requirements or in response to a request by the facility's cancer program. Nonanalytic cases are grouped according to the reason a patient who received care at the facility is nonanalytic, or the reason a patient who never received care at the facility may have been abstracted.

Rationale

Class of Case reflects the facility's role in managing the cancer, whether the cancer is required to be reported by CoC, and whether the case was diagnosed after the program's Reference Date.

Coding Instructions

- Code the *Class of Case* that most precisely describes the patient's relationship to the facility.
- Code 00 applies only when it is known the patient went elsewhere for treatment. If it is not known that the patient actually went somewhere else, code *Class of Case* 10.
- It is possible that information for coding *Class of Case* will change during the patient's first course of care. If that occurs, change the code accordingly.
- Document *NPI–Institution Referred To* [2425] or the applicable physician NPI (NAACCR #s 2585, 2495, 2505) for patients coded 00 to establish that the patient went elsewhere for treatment
- Code 34 or 36 if the diagnosis benign or borderline (*Behavior* 0 or 1) for any site is diagnosed before 2004 or for any site other than meninges (C70._), brain (C71._), spinal cord, cranial nerves, and other parts of central nervous system (C72._), pituitary gland (C75.1), craniopharyngeal duct (C75.2) and pineal gland (C75.3) that was diagnosed in 2004 or later.
- Code 34 or 36 for carcinoma in situ of the cervix (CIS) and intraepithelial neoplasia grade III (8077/2 or 8148/2) of the cervix (CIN III), prostate (PIN III), vulva (VIN III), vagina (VAIN III), and anus (AIN III).
- Physicians who are not employed by the hospital but are under contract with it or have routine admitting privileges there are described in codes 10-12 and 41 as physicians with admitting privileges. Treatment provided in the office of a physician with admitting privileges is provided "elsewhere". That is because care given in the physician's office is not within the hospital's realm of responsibility.

- If the hospital purchases a physician practice, it will be necessary to determine whether the practice is now legally considered part of the hospital (their activity is coded as the hospital's) or not. If the practice is not legally part of the hospital, it will be necessary to determine whether the physicians involved have routine admitting privileges or not, as with any other physician.
- "In-transit" care is care given to a patient who is temporarily away from the patient's usual practitioner for continuity of care. If these cases are abstracted, they are *Class of Case* 31. Monitoring of oral medication started elsewhere is coded *Class of Case* 31. If a patient begins first course radiation or chemotherapy infusion elsewhere and continues at the reporting facility, and the care is not in-transit, then the case is analytic (*Class of Case* 21).

Code	Label
Analytic Classes of Case (Required by CoC to be abstracted by accredited programs)	
Initial diagnosis at reporting facility or in a staff physician's office	
00	Initial diagnosis at the reporting facility AND all treatment or a decision not to treat was done elsewhere
10	Initial diagnosis at the reporting facility or in an office of a physician with admitting privileges AND part or all of first course treatment or a decision not to treat was at the reporting facility, NOS
11	Initial diagnosis in an office of a physician with admitting privileges AND part of first course treatment was done at the reporting facility
12	Initial diagnosis in an office of a physician with admitting privileges AND all first course treatment or a decision not to treat was done at the reporting facility
13	Initial diagnosis at the reporting facility AND part of first course treatment was done at the reporting facility; part of first course treatment was done elsewhere
14	Initial diagnosis at the reporting facility AND all first course treatment or a decision not to treat was done at the reporting facility
Initial diagnosis elsewhere	
20	Initial diagnosis elsewhere AND all or part of first course treatment was done at the reporting facility, NOS
21	Initial diagnosis elsewhere AND part of first course treatment was done at the reporting facility; part of first course treatment was done elsewhere.
22	Initial diagnosis elsewhere AND all first course treatment or a decision not to treat was done at the reporting facility
Classes of Case not required by CoC to be abstracted (May be required by Cancer Committee, state or regional registry, or other entity)	
Patient appears in person at reporting facility	
30	Initial diagnosis and all first course treatment elsewhere AND reporting facility participated in diagnostic workup (for example, consult only, treatment plan only, staging workup after initial diagnosis elsewhere)
31	Initial diagnosis and all first course treatment elsewhere AND reporting facility provided in-transit care; or hospital provided care that facilitated treatment elsewhere (for example, stent placement)

Code	Label
32	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease recurrence or persistence (active disease)
33	Diagnosis AND all first course treatment provided elsewhere AND patient presents at reporting facility with disease history only (disease not active)
34	Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis AND part or all of first course treatment by reporting facility
35	Case diagnosed before program's Reference Date AND initial diagnosis AND all or part of first course treatment by reporting facility
36	Type of case not required by CoC to be accessioned (for example, a benign colon tumor) AND initial diagnosis elsewhere AND all or part of first course treatment by reporting facility
37	Case diagnosed before program's Reference Date AND initial diagnosis elsewhere AND all or part of first course treatment by facility
38	Initial diagnosis established by autopsy at the reporting facility, cancer not suspected prior to death
Patient does not appear in person at reporting facility	
40	Diagnosis AND all first course treatment given at the same staff physician's office
41	Diagnosis and all first course treatment given in two or more different offices of physicians with admitting privileges
42	Nonstaff physician or non-CoC accredited clinic or other facility, not part of reporting facility, accessioned by reporting facility for diagnosis and/or treatment by that entity (for example, hospital abstracts cases from an independent radiation facility)
43	Pathology or other lab specimens only
49	Death certificate only
99	Nonanalytic case of unknown relationship to facility (not for use by CoC accredited cancer programs for analytic cases).

Examples

Code	Reason
00	Leukemia was diagnosed at the facility, and all care was given in an office of a physician with practice privileges. The treatment may be abstracted if the cancer committee desires, but the case is *Class of Case* 00.
13	Breast cancer was diagnosed at the reporting hospital and surgery performed there. Radiation was given at the hospital across the street with which the reporting hospital has an agreement.
10	Reporting hospital found cancer in a biopsy, but was unable to discover whether the homeless patient actually received any treatment elsewhere.
32	After treatment failure, the patient was admitted to the facility for supportive care.
11	Patient was diagnosed by a physician with practice privileges, received neoadjuvant radiation at another facility, then underwent surgical resection at the reporting facility.

Code	Reason
42	Patients from an unaffiliated, free-standing clinic across the street that hospital voluntarily abstracts with its cases because many physicians work both at the clinic and the hospital.
31	Patient received chemotherapy while attending daughter's wedding in the reporting hospital's city, then returned to the originating hospital for subsequent treatments.

NPI–Institution Referred From

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
2415	10	4925-4934	10 digits, Blank	2008+	04/07, 09/08, 01/11

Description

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

Rationale

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

Coding Instructions

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

Code	Label
(fill spaces)	10-digit NPI number for the facility.
(leave blank)	NPI for the referring facility is unknown or not available.
(leave blank)	If the patient was not referred to the reporting facility from another facility.

NPI–Institution Referred To

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
2425	10	4945-4954	10 digits, Blank	2008+	04/07, 09/08, 01/11

Description

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

Rationale

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

Coding Instructions

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

Code	Label
(fill spaces)	10-digit NPI number for the facility.
(leave blank)	NPI for the facility referred to is unknown or not available.
(leave blank)	If the patient was not referred to another facility.

Date of First Contact

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
580	8	759-766	CCYYMMDD	All Years	09/06, 01/04, 01/10, 01/11

Description

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

Rationale

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

Coding Instructions

- Record the date the patient first had contact with the facility as either an inpatient or outpatient for diagnosis and/or first course treatment of a reportable tumor. The date may be the date of an outpatient visit for a biopsy, x-ray, or laboratory test, or the date a pathology specimen was collected at the hospital.
- For analytic cases (*Class of Case* 00-22), the *Date of First Contact* is the date the patient became analytic. For non-analytic cases, it is the date the patient first qualified for the *Class of Case* that causes the case to be abstracted.
- If this is an autopsy-only or death certificate-only case, then use the date of death.
- When a patient is diagnosed in a staff physician's office, the date of first contact is the date the patient was physically first seen at the reporting facility.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date of First Contact* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of First Contact* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date. The D*ate of First Contact Flag* [581] is used to explain why *Date of First Contact* is not a known date. See *Date of First Contact Flag* for an illustration of the relationships among these items.

Examples

Code	Label	Definition
20090914	September 14, 2009	Patient undergoes a biopsy in a staff physician's office on September 8, 2009. The pathology specimen was sent to the reporting facility and was read as malignant melanoma. The patient enters that same reporting facility on September 14, 2009 for wide re-excision.
20101207	December 7, 2010	Patient has an MRI of the brain on December 7, 2010, for symptoms including severe headache and disorientation. The MRI findings are suspicious for astrocytoma. Surgery on December 19 removes all gross tumor.
20110499	April 2011	Information is limited to the description "Spring," 2011.
20110799	July 2011	Information is limited to the description "The middle of the year," 2011.
20111099	October 2011	Information is limited to the description "Fall," 2011.
CCYY1299 or CCYY0199	December or January	If information is limited to the description "Winter," try to determine if this means the beginning or the end of the year.

Date of First Contact Flag

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
581	2	767-768	12, Blank	2010+	01/10

Description

This flag explains why there is no appropriate value in the corresponding date field, *Date of First Contact* [580].

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate nondate information that had previously been transmitted in date fields.

Coding Instructions

- Leave this item blank if *Date of First Contact* [580] has a full or partial date recorded.
- Code 12 if the *Date of First Contact* cannot be determined at all.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software

Code	Label
12	A proper value is applicable but not known (that is, the date of first contact is unknown)
(blank)	A valid date value is provided in item *Date of First Contact* [580]

Date of Initial Diagnosis

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
390	8	544-551	CCYYMMDD	All Years	09/04, 09/08, 1/10, 01/11

Description

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

Rationale

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

Coding Instructions

- Use the first date of diagnosis whether clinically or histologically established.
- If the physician states that in retrospect the patient had cancer at an earlier date, use the earlier date as the date of diagnosis.
- Refer to the list of Ambiguous Terms in Section One for language that represents a diagnosis of cancer.
- Use the date treatment was started as the date of diagnosis if the patient receives a first course of treatment before a diagnosis is documented.
- The date of death is the date of diagnosis for a *Class of Case* [610] 38 (diagnosed at autopsy) or 49 (death certificate only).
- Use the actual date of diagnosis for an *in utero* diagnosis, for cases diagnosed on January 1, 2009, or later.
- If the year of diagnosis cannot be identified, it must be approximated. In that instance, the month and day are unknown.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date of Initial Diagnosis* MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of Initial Diagnosis* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date.

Examples

Code	Label	Definition
20100702	July 2, 2010	Cytology “suspicious” for cancer June 12, 2010; pathology positive July 2, 2010. Do not consider cytology with ambiguous terms to be diagnostic.
20100517	May 17, 2010	Pathology “suspicious” for cancer May 17, 2010; confirmed positive May 22, 2010
20100499	April 2010	Physician’s referral notes dated July 5, 2010, indicate the patient was diagnosed with cancer spring of 2010. Use April for “spring”, July for “summer” or “mid-year”, October for “fall” or “autumn”. In winter, attempt to determine whether the diagnosis was “late in the year” (use December with the applicable year) or “early in year” (use January with the respective year).

Primary Site

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
400	4	554-557	C+3 digits	All Years	01/04, 09/08, 01/10

Description

Identifies the primary site.

Rationale

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

Coding Instructions

- Record the ICD-O-3 topography code for the site of origin.
- Consult the physician advisor to identify the primary site or the most definitive site code if the medical record does not contain that information.
- Topography codes are indicated by a "C" preceding the three-digit code number. Do not record the decimal point.
- Follow the Instructions for Coding in ICD-O-3, pages 20–40 and in the current *SEER Multiple Primary and Histology Coding Rules* to assign site for solid tumors.
- Refer to the instructions for Occult Cervical Lymph Node and Cutaneous Carcinoma of the Head and Neck found in the Overview of Coding Principles section.
- Follow the instructions in *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* and the Hematopoietic and Lymphoid Neoplasms Database (Hematopoietic DB) for assigning site for lymphomas, leukemia and other hematopoietic neoplasms.
- Use subcategory 8 for single tumors that overlap the boundaries of two or more sub-sites and the point of origin is not known.
- Use subcategory 9 for multiple tumors that originate in different subsites of one organ.

Examples

Code	Reason
C108	Overlapping lesion of oropharynx. Code overlapping lesion when a large tumor involves both the lateral wall of the oropharynx (C10.2) and the posterior wall of the oropharynx (C10.3) and the point of origin is not stated.
C678	Overlapping lesion of bladder. Code overlapping lesion of the bladder when a single lesion involves the dome (C67.1) and the lateral wall (C67.2) and the point of origin is not stated.

Code	Reason
C189	Colon, NOS. Familial polyposis with carcinoma and carcinoma in situ throughout the transverse (C18.4) and descending colon (C18.6) would be one primary and coded to colon, NOS (C18.9). For a full explanation see the *SEER 2007 Multiple Primary and Histology Coding Rules*.
C16–	Stomach (sub-site as identified). An extranodal lymphoma of the stomach is coded to C16.– (sub-site as identified).

Laterality

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
410	1	558-558	0-5, 9	All Years	01/10, 05/10, 01/13

Description

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

Rationale

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

Coding Instructions

- Code laterality for all paired sites. (See Section One for additional information.)
- Do not code metastatic sites as bilateral involvement.
- If both lungs have nodules or tumors and the lung of origin is not known, assign code 4.
- Where the right and left sides of paired sites are contiguous (come into contact) and the lesion is at the point of contact of the right and left sides, use code 5, midline. Note that "midline of the right breast" is coded 1, right; midline in this usage indicates the primary site is C50.8 (overlapping sites).
- Non-paired sites may be coded right or left, if appropriate. Otherwise, code non-paired sites 0.

Code	Label
0	Organ is not a paired site.
1	Origin of primary is right.
2	Origin of primary is left.
3	Only one side involved, right or left origin not specified.
4	Bilateral involvement at time of diagnosis, lateral origin unknown for a single primary; or both ovaries involved simultaneously, single histology; bilateral retinoblastomas; bilateral Wilms tumors
5	Paired site: midline tumor
9	Paired site, but no information concerning laterality

Histology

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
522	4	564-567	Four digits	2001+	09/06, 01/10, 03/10

Description

Identifies the microscopic anatomy of cells.

Rationale

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

Coding Instructions

- ICD-O-3 identifies the morphology codes with an "M" preceding the code number. Do not record the "M."
- Record histology using the ICD-O-3 (https://seer.cancer.gov/icd-o-3/) codes in the Numeric Lists/Morphology section (ICD-O-3, pp. 69–104) and in the Alphabetic Index (ICD-O-3, pp. 105–218).
- Follow the coding rules outlined on pages 20 through 40 of ICD-O-3.
- Use the current *Multiple Primary and Histology Coding Rules* (https://seer.cancer.gov/tools/solidtumor/) when coding the histology for all reportable solid tumors. These rules are effective for cases diagnosed January 1, 2007, or later. Do not use these rules to abstract cases diagnosed prior to January 1, 2007.
- Review all pathology reports.
- Code the final pathologic diagnosis for solid tumors.
- For lymphomas, leukemias and other hematopoietic tumors, follow the instructions in *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* and the Hematopoietic and Lymphoid Neoplasms Database (Hematopoietic DB)
- The codes for cancer, NOS (8000) and carcinoma, NOS (8010) are **not** interchangeable. If the physician says that the patient has carcinoma, then code carcinoma, NOS (8010).

Examples

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

Behavior Code

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
523	1	568-568	0–3	>2001	04/04, 01/10, 01/12, 01/13, 01/15

Description

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

Rationale

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

Coding Instructions

- Code 3 if any *malignant* invasion is present, no matter how limited.
- Code 3 if any *malignant* metastasis to nodes or tissue beyond the primary is present.
- If the specimen is from a metastatic site, code the histology of the metastatic site and code 3 for behavior.

Note: The ICD-O-3 behavior code for juvenile astrocytoma (9421/1) is coded as 3 by agreement of North American registry standard-setters. Refer to "Case Eligibility" in Section One for information. **Gastro-intestinal stromal tumors (GIST) and thymomas are frequently non-malignant. However, they must be abstracted and assigned a Behavior Code of 3 if they are noted to have multiple foci, metastasis or positive lymph nodes.**

Code	Label	Definition
0	Benign	Benign
1	Borderline	Uncertain whether benign or malignant
		Borderline malignancy
		Low malignant potential
		Uncertain malignant potential
2	In situ and synonymous with in situ	Adenocarcinoma in an adenomatous polyp with no invasion of stalk
		Bowen disease (not reportable for C44._)
		Clark level 1 for melanoma (limited to epithelium)
		Comedocarcinoma, noninfiltrating (C50.–)
		Confined to epithelium
		Hutchinson melanotic freckle, NOS (C44.–)
		Intracystic, noninfiltrating.(carcinoma)

Code	Label	Definition
		Intraductal.(carcinoma)
		Intraepidermal, NOS (carcinoma)
		Intraepithelial, NOS (carcinoma)
		Involvement up to, but not including the basement membrane
		Lentigo maligna (C44.–)
		Lobular neoplasia (C50.–)
		Lobular, noninfiltrating (C50.–) (carcinoma)
		Noninfiltrating (carcinoma)
		Noninvasive (carcinoma only)
		No stromal invasion or involvement
		Papillary, noninfiltrating or intraductal (carcinoma)
		Precancerous melanosis (C44.–)
		Queyrat erythroplasia (C60.–)
3	Invasive	Invasive or microinvasive.

Examples

Code	Reason
3	Intraductal carcinoma (8500/2) with focal areas of invasion
3	Atypical thymoma (8585/1) with malignant metastasis in one lymph node
1	Atypical meningioma (9539/1) invading bone of skull (the meninges, which line the skull, are capable of invading into the bone without being malignant; do not code as malignant unless it is specifically mentioned)
1	GIST (with no mention whether malignant or benign)
3	Malignant GIST

Grade Clinical

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
3843	1	1286-1286	1-5, 8, 9, A, B, C, D, E, L, H, M, S	2018+	01/18

Description

This data item records the grade of a solid primary tumor before any treatment (surgical resection or initiation of any treatment including neoadjuvant).

For cases diagnosed January 1, 2018 and later, this data item, along with *Grade Pathological* [3844] and *Grade Post-Therapy* [3845], replaces *Grade/Differentiation* [440] as well as SSF's for cancer sites with alternative grading systems (e.g., breast [Bloom-Richardson], prostate [Gleason]).

Rationale

Grade is a measure of the aggressiveness of the tumor. Grade and cell type are important prognostic indicators for many cancers**. For some sites, grade is required to assign the clinical stage group.**

For those cases that are eligible for AJCC staging, the recommended grading system is specified in the AJCC 8th Edition Chapter. The AJCC 8th Edition Chapter-specific grading systems (codes 1-5, L, H, M, S) take priority over the generic grade definitions (codes A-E, 8, 9). For those cases that are not eligible for AJCC staging, if the recommended grading system is not documented, the generic grade definitions would apply.

Coding Instructions

- Please see the following URL for detailed coding instructions and site-specific coding rules: https://www.naaccr.org/SSDI/Grade-Manual.pdf.

Grade Pathological

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
3844	1	1287-1287	1-5, 8, 9, A, B, C, D, E, L, H, M, S	2018+	01/18

Description

This data item records the grade of a solid primary tumor that has been resected and for which no neoadjuvant therapy was administered. If AJCC staging is being assigned, the tumor must have met the surgical resection requirements in the AJCC manual. This may include the grade from the clinical workup. Since all clinical information is used in pathological staging. Record the highest grade documented from any microscopic specimen of the primary site whether from the clinical workup or the surgical resection.

For cases diagnosed January 1, 2018 and later, this data item, along with *Grade Clinical* [3843] and *Grade Post Therapy* [3845], replaces *Grade/Differentiation* [440] as well as SSF's for cancer sites with alternative grading systems (e.g., breast [Bloom-Richardson], prostate [Gleason]).

Rationale

Grade is a measure of the aggressiveness of the tumor. Grade and cell type are important prognostic indicators for many cancers. For some sites, grade is required to assign the pathological stage group.

For those cases that are eligible AJCC staging, the recommended grading system is specified in the AJCC 8th Edition Chapter. The AJCC 8th Edition Chapter-specific grading systems (codes 1-5, L, H, M, S) take priority over the generic grade definitions (codes A-E, 8, 9). For those cases that are not eligible for AJCC staging, if the recommended grading system is not documented, the generic grade definitions would apply.

Coding Instructions

- Please see the following URL for detailed coding instructions and site-specific coding rules: https://www.naaccr.org/SSDI/Grade-Manual.pdf.

Grade Post Therapy

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
3845	1	1288-1288	1-5, 8, 9, A, B, C, D, E, L, H, M, S, Blank	2018+	01/18

Description

This data item records the grade of a solid primary tumor that has been resected following neoadjuvant therapy. If AJCC staging is being assigned, the tumor must have met the surgical resection requirements in the AJCC manual. Record the highest grade documented from the surgical treatment resection specimen of the primary site following neoadjuvant therapy.

For cases diagnosed January 1, 2018 and later, this data item, along with *Grade Clinical* [3843] and *Grade Pathological* [3844], replaces *Grade/Differentiation* [440] as well as SSF's for cancer sites with alternative grading systems (e.g., breast [Bloom-Richardson], prostate [Gleason]).

Rationale

Grade is a measure of the aggressiveness of the tumor. Grade and cell type are important prognostic indicators for many cancers. For some sites, grade is required to assign the post-neoadjuvant stage group.

For those cases that are eligible AJCC staging, the recommended grading system is specified in the AJCC 8th Edition Chapter. The AJCC 8th Edition Chapter-specific grading systems (codes 1-5, L, H, M, S) take priority over the generic grade definitions (codes A-E, 8, 9). For those cases that are not eligible for AJCC staging, if the recommended grading system is not documented, the generic grade definitions would apply.

Coding Instructions

- Please see the following URL for detailed coding instructions and site-specific coding rules: https://www.naaccr.org/SSDI/Grade-Manual.pdf.

Diagnostic Confirmation

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
490	1	576-576	1, 2, 4–9	All Years	01/04, 01/10, 01/11, 01/12, 01/13

Description

Records the best method of diagnostic confirmation of the cancer being reported at any time in the patient's history. The rules for coding differ between solid tumors and hematopoietic and lymphoid neoplasms.

Rationale

This item is an indicator of the precision of diagnosis. The percentage of solid tumors that are clinically diagnosed only is an indication of whether casefinding includes sources beyond pathology reports. Complete casefinding must include both clinically and pathologically confirmed cases.

Coding Instructions – Solid Tumors (all tumors *except* M9590-9992)

- These instructions apply to "Codes for Solid Tumors" below. See the section following this one for "Coding Hematopoietic or Lymphoid Tumors (9590-9992)".
- The codes are in **priority order**; code 1 has the highest priority. Always code the procedure with the lower numeric value when presence of cancer is confirmed with multiple diagnostic methods. This data item must be changed to the lower (higher priority) code if a more definitive method confirms the diagnosis *at any time during* the course of the disease.
- Assign code 1 when the microscopic diagnosis is based on tissue specimens from biopsy, frozen section, surgery, autopsy or D&C or from aspiration of biopsy of bone marrow specimens.
- Assign code 2 when the microscopic diagnosis is based on cytologic examination of *cells* such as sputum smears, bronchial brushings, bronchial washings, prostatic secretions, breast secretions, gastric fluid, spinal fluid, peritoneal fluid, pleural fluid, urinary sediment, cervical smears and vaginal smears, or from paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid. CoC does not require programs to abstract cases that contain ambiguous terminology regarding a cytologic diagnosis.
- Code 5 when the diagnosis of cancer is based on laboratory tests or marker studies which are clinically diagnostic for that specific cancer.
- Code 6 when the diagnosis is based only on the surgeon's operative report from a surgical exploration or endoscopy or from gross autopsy findings in the absence of tissue or cytological findings.
- Assign code 8 when the case was diagnosed by any clinical method not mentioned in preceding codes. A number of hematopoietic and lymphoid neoplasms are diagnosed by tests of exclusion where the tests for the disease are equivocal and the physician makes a clinical diagnosis based on the information from the equivocal tests and the patient's clinical presentation.

Coding Instructions – Hematopoietic or Lymphoid Tumors (M9590-9992)

- These instructions apply to "Codes for Hematopoietic and Lymphoid Neoplasms" below. See the preceding section for instructions "Coding Solid Tumors".
- There is no priority hierarchy for coding *Diagnostic Confirmation* for hematopoietic and lymphoid tumors. Most commonly, the specific histologic type is diagnosed by immunophenotyping or genetic testing See the *Hematopoietic Database* (DB) for information on the definitive diagnostic confirmation for specific types of tumors.
- Code 1 when the microscopic diagnosis is based on tissue specimens from biopsy, frozen section, surgery, or autopsy or bone marrow specimens from aspiration or biopsy.
- For leukemia only, code 1 when the diagnosis is based only on the complete blood count (CBC), white blood count (WBC) or peripheral blood smear. Do not use code 1 if the diagnosis was based on immunophenotyping or genetic testing using tissue, bone marrow, or blood.
- Use code 2 when the microscopic diagnosis is based on cytologic examination of cells (rather than tissue) including but not limited to spinal fluid, peritoneal fluid, pleural fluid, urinary sediment, cervical smears and vaginal smears, or from paraffin block specimens from concentrated spinal, pleural, or peritoneal fluid. These methods are rarely used for hematopoietic or lymphoid tumors.
- Assign code 3 when there is a histology positive for cancer AND positive immunophenotyping and/or positive genetic testing results. Do not use code 3 for neoplasms diagnosed prior to January 1, 2010.
- Assign code 5 when the diagnosis of cancer is based on laboratory tests or marker studies which are clinically diagnostic for that specific cancer, but no positive histologic confirmation.
- Assign code 6 when the diagnosis is based only on the surgeon's report from a surgical exploration or endoscopy or from gross autopsy findings without tissue or cytological findings.
- Assign code 8 when the case was diagnosed by any clinical method not mentioned in preceding codes. A number of hematopoietic and lymphoid neoplasms are diagnosed by tests of exclusion where the tests for the disease are equivocal and the physician makes a clinical diagnosis based on the information from the equivocal tests and the patient's clinical presentation.

Code	Label	Definition
1	Positive histology	Histologic confirmation (tissue microscopically examined).
2	Positive cytology	Cytologic confirmation (no tissue microscopically examined; fluid cells microscopically examined).
3	Positive histology PLUS • Positive immunophenotyping AND/OR • Positive genetic studies	Histology is positive for cancer, and there are also positive immunophenotyping and/or genetic test results. For example, bone marrow examination is positive for acute myeloid leukemia. (9861/3) Genetic testing shows AML with inv(16)(p13.1q22) (9871/3). (Used only for hematopoietic and lymphoid neoplasms M-9590/3-9992/3)

Code	Label	Definition
4	Positive microscopic confirmation, method not specified	Microscopic confirmation is all that is known. It is unknown if the cells were from histology or cytology.
5	Positive laboratory test/marker study	A clinical diagnosis of cancer is based on laboratory tests/marker studies which are clinically diagnostic for cancer.
6	Direct visualization without microscopic confirmation	The tumor was visualized during a surgical or endoscopic procedure only with no tissue resected for microscopic examination.
7	Radiography and other imaging techniques without microscopic confirmation	The malignancy was reported by the physician from an imaging technique report only.
8	Clinical diagnosis only, other than 5, 6 or 7	The malignancy was reported by the physician in the medical record.
9	Unknown whether or not microscopically confirmed	A statement of malignancy was reported in the medical record, but there is no statement of how the cancer was diagnosed (usually nonanalytic).

Stage of Disease at Diagnosis

Date of Surgical Diagnostic and Staging Procedure

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1280	8	2214-2221	CCYYMMDD	All Years	01/10, 01/11

Description

Records the date on which the surgical diagnostic and/or staging procedure was performed.

Rationale

This data item is used to track the use of surgical procedure resources that are not considered treatment.

Coding Instructions

- Record the date on which the surgical diagnostic and/or staging procedure described in *Surgical Diagnostic and Staging Procedure* [1350] was performed at this or any facility.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this modification does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date of Surgical Diagnostic and Staging Procedure* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of Surgical Diagnostic and Staging Procedure* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *RX Date-DX/Stg Proc Flag* [1281] is used to explain why *Date of Surgical Diagnostic and Staging Procedure* is not a known date. See *RX Date-DX/Stg Proc Flag* for an illustration of the relationships among these items.

Rx Date–Dx/Stg Proc Flag

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1281	2	2222-2223	10–12, Blank	2010+	01/12

Description

This flag explains why there is no appropriate value in the corresponding date data item, *Date of Surgical Diagnostic and Staging Procedure* [1280].

Rationale

As part of an initiative to standardize date data items, date flag data items were introduced to accommodate non-date information that had previously been transmitted in date data items.

Coding Instructions

- Leave this item blank if *Date of Surgical Diagnostic and Staging Procedure* [1280] has a full or partial date recorded.
- Code 10 if it is unknown whether a surgical diagnostic or staging procedure was performed.
- Code 11 if no surgical diagnostic or staging procedure was performed.
- Code 12 if the *Date of Surgical Diagnostic and Staging Procedure* cannot be determined, but a surgical diagnostic or staging procedure was performed for the patient.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Label
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any diagnostic or staging procedure performed).
11	No proper value is applicable in this context (for example, no diagnostic or staging procedure performed; autopsy only case).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (for example, diagnostic or staging procedure performed but date is unknown).
(blank)	A valid date value is provided in item *Date of Surgical Diagnostic and Staging Procedure* (NAACCR Item #1280). Case was diagnosed prior to January 1, 2007.

Surgical Diagnostic and Staging Procedure

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1350	2	2235-2236	00–07, 09	All Years	09/06, 09/08, 01/12, 01/15

Description

Identifies the positive surgical procedure(s) performed to diagnose and/or stage disease.

Rationale

This data item is used to track the use of surgical procedure resources that are not considered treatment.

Coding Instructions

- Record the type of procedure performed as part of the initial diagnosis and workup, whether this is done at your institution or another facility.
- Only record positive procedures. For benign and borderline reportable tumors, report the biopsies positive for those conditions. For malignant tumors, report procedures if they were positive for malignancy.
- If both an incisional biopsy of the primary site and an incisional biopsy of a metastatic site are done, use code 02 (Incisional biopsy of primary site).
- If a lymph node is biopsied or removed to diagnose or stage *lymphoma*, and that node is NOT the only node involved with lymphoma, use code 02. If there is only a single lymph node involved with lymphoma, use the data item *Surgical Procedure of Primary Site* [1290] to code these procedures.
- Do not code surgical procedures which aspirate, biopsy, or remove *regional lymph nodes* in an effort to diagnose and/or stage disease in this data item. Use the data item *Scope of Regional Lymph Node Surgery* [1292] to code these procedures. Do not record the date of surgical procedures which aspirate, biopsy, or remove regional lymph nodes in the data item *Date of Surgical Diagnostic and Staging Procedure* [1280]. See instructions for *Scope of Regional Lymph Node Surgery* [1292].
- Code brushings, washings, cell aspiration, and hematologic findings (peripheral blood smears) as positive cytologic diagnostic confirmation in the data item *Diagnostic Confirmation* [490]. These are not considered surgical procedures and should not be coded in this item.
- Do not code excisional biopsies with clear or microscopic margins in this data item. Use the data item *Surgical Procedure of Primary Site* [1290] to code these procedures.
- If a needle biopsy precedes an excisional biopsy or more extensive surgery, and upon the excisional biopsy or more extensive surgery the surgical margins are clear (i.e., no tumor remains), DO NOT consider the needle biopsy to be an excisional biopsy. The needle biopsy should be recorded as such in the *Surgical Diagnostic and Staging Procedure* [1350] data item and the excisional biopsy or more extensive surgery in the *Surgical Procedure of the Primary Site* data item [1290].

- Do not code palliative surgical procedures in this data item. Use the data item *Palliative Procedure* [3270] to code these procedures.

Code	Label
00	No surgical diagnostic or staging procedure was performed.
01	A biopsy (incisional, needle, or aspiration) was done to a site other than the primary site. No exploratory procedure was done.
02	A biopsy (incisional, needle, or aspiration) was done to the primary site; or biopsy or removal of a lymph node to diagnose or stage lymphoma.
03	A surgical exploration only. The patient was not biopsied or treated.
04	A surgical procedure with a bypass was performed, but no biopsy was done.
05	An exploratory procedure was performed, and a biopsy of either the primary site or another site was done.
06	A bypass procedure was performed, and a biopsy of either the primary site or another site was done.
07	A procedure was done, but the type of procedure is unknown.
09	No information of whether a diagnostic or staging procedure was performed.

Examples

Code	Reason
00	A lung cancer primary was diagnosed by CT scan. The patient expired. No surgical diagnostic or staging surgical procedure was performed.
00	A sputum sample is examined cytologically to confirm a diagnosis of suspected lung cancer. The procedure is not surgical.
01	A needle biopsy of a liver metastasis in a patient with suspected widespread colon cancer was done. Gross residual tumor is left at the biopsy site.
03	During abdominal exploratory surgery, a gastric lesion and suspicious retroperitoneal lymph nodes were observed. No biopsy or treatment was done.
04	An abdominal exploration of a patient revealed pancreatic carcinoma with extension into surrounding organs and arteries. No attempt to treat. A bypass was performed to alleviate symptoms.
05	An exploratory procedure was performed for primary colon carcinoma with biopsy of suspicious liver lesions.
06	Esophagogastrostomy was performed for infiltrating gastric tumor following a biopsy of the primary site.
07	Stage III lung carcinoma was diagnosed and staged prior to admission.
09	A patient expires in the emergency room with recently diagnosed metastatic melanoma. It is unknown whether a diagnostic or staging procedure was done.

Surgical Diagnostic and Staging Procedure at This Facility

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
740	2	809-810	00–07, 09	All Years	01/04, 09/08, 01/12

Description

Identifies the positive surgical procedure(s) performed to diagnose and/or stage disease.

Rationale

This data item is used to track the use of surgical procedure resources that are not considered treatment.

Coding Instructions

- Record the type of procedure performed as part of the initial diagnosis and workup at this facility.
- Only record positive procedures. For benign and borderline reportable tumors, report the biopsies positive for those conditions. For malignant tumors, report procedures if they were positive for malignancy.
- If both an incisional biopsy of the primary site and an incisional biopsy of a metastatic site are done, use code 02 (Incisional biopsy of primary site).
- If a lymph node is biopsied or removed to diagnose or stage *lymphoma*, and that node is NOT the only node involved with lymphoma, use code 02. If there is only a single lymph node involved with lymphoma, use the data item *Surgical Procedure of Primary Site at This Facility* [670] to code these procedures.
- Do not code surgical procedures which aspirate, biopsy, or remove *regional lymph nodes* in an effort to diagnose and/or stage disease in this data item. Use the data item *Scope of Regional Lymph Node Surgery at This Facility* [672] to code these procedures. Do not record the date of surgical procedures which aspirate, biopsy, or remove regional lymph nodes in the data item *Date of Surgical Diagnostic and Staging Procedure* [1280]. See instructions for *Scope of Regional Lymph Node Surgery at This Facility* [672].
- Code brushings, washings, cell aspiration, and hematologic findings (peripheral blood smears) as positive cytologic diagnostic confirmation in the data item *Diagnostic Confirmation* [490]. These are not considered surgical procedures and should not be coded in this item.
- Do not code excisional biopsies with clear or microscopic margins in this data item. Use the data item *Surgical Procedure of Primary Site at This Facility* [670] to code these procedures.
- If a needle biopsy precedes an excisional biopsy or more extensive surgery, and upon the excisional biopsy or more extensive surgery the surgical margins are clear (i.e., no tumor remains), DO NOT consider the needle biopsy to be an excisional biopsy. The needle biopsy should be recorded as such in the *Surgical Diagnostic and Staging Procedure at this Facility* [740] data item and the excisional biopsy or more extensive surgery in the *Surgical Procedure of the Primary Site at this Facility* data item [670].

- Do not code palliative surgical procedures in this data item. Use the data item *Palliative Procedure at This Facility* [3280] to code these procedures.

Code	Label
00	No surgical diagnostic or staging procedure was performed.
01	A biopsy (incisional, needle, or aspiration) was done to a site other than the primary site. No exploratory procedure was done.
02	A biopsy (incisional, needle, or aspiration) was done to the primary site; or biopsy or removal of a lymph node to diagnose or stage lymphoma.
03	A surgical exploration only. The patient was not biopsied or treated.
04	A surgical procedure with a bypass was performed, but no biopsy was done.
05	An exploratory procedure was performed, and a biopsy of either the primary site or another site was done.
06	A bypass procedure was performed, and a biopsy of either the primary site or another site was done.
07	A procedure was done, but the type of procedure is unknown.
09	No information of whether a diagnostic or staging procedure was performed.

Lymphovascular Invasion

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1182	1	1297-1297	0-1, 8-9	2010+	01/11, 01/18

Description

Indicates the presence or absence of tumor cells in lymphatic channels (not lymph nodes) or blood vessels within the primary tumor as noted microscopically by the pathologist.

Rationale

Lymphovascular invasion is an indicator of prognosis.

Coding Instructions

- This coding convention has been developed and implemented for use in the *AJCC Cancer Staging Manual, Seventh Edition*, and updated with new codes in the AJCC 8th Edition staging manual for appropriate disease sites.
- Revised CAP Protocols and 8th Edition chapters will indicate which chapters will use the new codes (2, 3, and 4) and which will only use the existing codes (0, 1, 8, 9), as there are some disease sites where distinguishing between L and V is not medically appropriate.
- Code 8, Not Applicable for benign/borderline brain and CNS tumors.
- For cases diagnosed January 1, 2018 and later, new codes indicating lymphatic, small vessel, and/or large vessel invasion were added.

1. **Code from pathology report(s)**. Code the absence or presence of Lymphovascular invasion as described in the medical record.
    a. The primary sources of information about lymphovascular invasion are the pathology check lists (synoptic reports) developed by the College of American Pathologists. If the case does not have a checklist or synoptic report, code from the pathology report or a physician's statement, in that order.
    b. Do not code perineural invasion in this field.
    c. Information to code this field can be taken from any specimen from the primary tumor (biopsy or resection.)
    d. If lymphovascular invasion is identified in any specimen, it should be coded as present/identified.
    e. For cases with benign or borderline behavior, code the lymphovascular invasion documented (negative or positive) and, if not documented, code unknown.
    f. For cases treated with neoadjuvant therapy, refer to table below in order to code this field. However, if documentation in the medical record indicates information that conflicts with this table, code lymphovascular invasion with the documentation in the medical record.

LVI on pathology report PRIOR to neoadjuvant therapy	LVI on pathology report AFTER neoadjuvant therapy	***Code LVI to:***
0 - Not present/Not identified	0 - Not present/Not identified	*0 - Not present/Not identified*
0 - Not present/Not identified	1 - Present/Identified	*1 - Present/Identified*
0 - Not present/Not identified	9 - Unknown/Indeterminate	*9 - Unknown/Indeterminate*
1 - Present/Identified	0 - Not present/Not identified	*1 - Present/Identified*
1 - Present/Identified	1 - Present/Identified	*1 - Present/Identified*
1 - Present/Identified	9 - Unknown/Indeterminate	*1 - Present/Identified*
9 - Unknown/Indeterminate	0 - Not present/Not identified	*9 - Unknown/Indeterminate*
9 - Unknown/Indeterminate	1 - Present/Identified	*1 - Present/Identified*
9 - Unknown/Indeterminate	9 - Unknown/Indeterminate	*9 - Unknown/Indeterminate*

2. Use of codes.

   a. Use code 0 when the pathology report indicates that there is no lymphovascular invasion. This includes cases of purely in situ carcinoma, which biologically have no access to lymphatic or vascular channels below the basement9 - Unknown/Indeterminate membrane.

   b. Use code 1 when the pathology report or a physician's statement indicates that lymphovascular invasion (or one of its synonyms) is present in the specimen.

   c. Lymphovascular invasion must be coded 0, 1, 2, 3, 4, or 9 for the Schema IDs in the following list:

00071	Lip
00072	Tongue Anterior
00073	Gum
00074	Floor of Mouth
00075	Palate Hard
00076	Buccal Mucosa
00077	Mouth Other
00080	Major Salivary Glands
00100	Oropharynx (p16+)
00111	Oropharynx (p16-)
00112	Hypopharynx
00121	Maxillary Sinus
00122	Nasal Cavity and Ethmoid Sinus
00130	Larynx Other
00131	Larynx Supraglottic
00132	Larynx Glottic
00133	Larynx Subglottic
00161	Esophagus (incl GE Junction) Squamous
00169	Esophagus (incl GE Junction) (excl Squamous)
00170	Stomach
00180	Small Intestine
00190	Appendix
00200	Colon and Rectum
00230	Bile Ducts Intrahepatic

00250	Bile Ducts Perihilar
00260	Bile Ducts Distal
00270	Ampulla Vater
00280	Pancreas
00290	NET Stomach
00301	NET Duodenum
00302	NET Ampulla of Vater
00320	NET Appendix
00330	NET Colon and Rectum
00340	NET Pancreas
00350	Thymus
00360	Lung
00460	Merkel Cell Skin
00470	Melanoma Skin
00500	Vulva
00510	Vagina
00520	Cervix
00530	Corpus Carcinoma
00541	Corpus Sarcoma
00542	Corpus Adenosarcoma
00560	Placenta
00570	Penis
00590	Testis
00620	Bladder
00730	Thyroid
00740	Thyroid Medullary

d. Lymphovascular invasion must be coded 0, 1, 2, 3, 4, 8, or 9 for the Schema IDs in the following list:

00210	Anus
00220	Liver
00241	Gallbladder
00242	Cystic Duct
00381	Bone Appendicular Skeleton
00382	Bone Spine
00383	Bone Pelvis
00400	Soft Tissue Head and Neck
00410	Soft Tissue Trunk and Extremities
00421	Soft Tissue Abdomen and Thorax
00422	Heart, Mediastinum, and Pleura
00440	Retroperitoneum
00450	Soft Tissue Other
00480	Breast (Invasive)
00580	Prostate
00600	Kidney Parenchyma
00610	Kidney Renal Pelvis
00631	Urethra
00632	Urethra-Prostatic
00640	Skin Eyelid
00660	Melanoma Conjunctiva
00671	Melanoma Iris

00672	Melanoma Choroid and Ciliary Body
00700	Orbital Sarcoma
00750	Parathyroid

e. Lymphovascular invasion must be coded 8 (not applicable) for all other Schema IDs:

00060	Cervical Lymph Nodes, Occult Head and Neck
00118	Pharynx Other
00119	Middle Ear
00128	Sinus Other
00140	Melanoma Head and Neck
00150	Cutaneous Carcinoma Head and Neck
00278	Biliary Other
00288	Digestive Other
00358	Trachea
00370	Pleural Mesothelioma
00378	Respiratory Other
00458	Kaposi Sarcoma
00478	Skin Other
00551	Ovary
00552	Primary Peritoneal Carcinoma
00553	Fallopian Tube
00558	Adnexa Uterine Other
00559	Genital Female Other
00598	Genital Male Other
00638	Urinary Other
00650	Conjunctiva
00680	Retinoblastoma
00690	Lacrimal Gland
00698	Lacrimal Sac
00710	Lymphoma Ocular Adnexa
00718	Eye Other
00721	Brain
00722	CNS Other
00723	Intracranial Gland
00770	NET Adrenal Gland
00778	Endocrine Other
00790	Lymphoma
00795	Lymphoma (CLL/SLL)
00811	Mycosis Fungoides
00812	Primary Cutaneous Lymphoma non MF
00821	Plasma Cell Myeloma
00822	Plasma Cell Disorders
00830	Heme/Retic
99999	Ill-Defined Other

f. Use code 9 when

   i. there is no microscopic examination of a primary tissue specimen

   ii. the primary site specimen is cytology only or a fine needle aspiration

   iii. the biopsy is only a very small tissue sample

iv. it is not possible to determine whether lymphovascular invasion is present

v. the pathologist indicates the specimen is insufficient to determine lymphovascular invasion

vi. lymphovascular invasion is not mentioned in the pathology report

vii. primary site is unknown

g. Clarification between codes 8 and 9:

i. Code 8 should only be used in the following situations: 1. Standard-setter does not require this item and you are not collecting it. 2. Those schemas noted above described in code 8 for which LVI is always not applicable.

ii. For those cases where there is no information/documentation from the pathology report or other sources, use code 9.

Code	**Label**
0	Lymphovascular Invasion stated as Not Present
1	Lymphovascular Invasion Present/Identified
2	Lymphatic and small vessel invasion only (L)
3	Venous (large vessel) invasion only (V)
4	BOTH lymphatic and small vessel AND venous (large vessel) invasion
8	Not Applicable
9	Unknown/Indeterminate/not mentioned in path report

Sentinel and Regional Lymph Nodes

Date of Sentinel Lymph Node Biopsy

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
832	8	1016-1023	CCYYMMDD, Blank	2018+	01/18

Description

Records the date of the sentinel lymph node(s) biopsy procedure. This data item is required for CoC-accredited facilities for cases diagnosed 01/01/2018 and later. **This data item is required for breast and cutaneous melanoma cases only.**

Rationale

It is a known fact that sentinel lymph node biopsies have been under-reported. Additionally, the timing and results of sentinel lymph node biopsy procedures are used in quality of care measures. This data item can be used to more accurately assess the date of the sentinel lymph node biopsy procedure separate from the date of a subsequent regional node dissection procedure, if performed.

Coding Instructions

- Record the date of the sentinel lymph node biopsy procedure documented in the *Sentinel Lymph Node Examined* [834].
- This data items documents the date of sentinel node biopsy; do not record the date of lymph node aspiration, fine needle aspiration, fine needle aspiration biopsy, core needle biopsy, or core biopsy.
- Sentinel node procedures are common for other sites, but data is only collected in these fields for breast and cutaneous melanoma. Use the AJCC N suffix to designate sentinel node procedures for ALL sites.
- If the sentinel lymph node biopsy is the first or only surgical procedure performed, record the date documented in this data item in the *Date First Surgical Procedure* [1200].
- If separate sentinel node biopsy procedure and subsequent regional node dissection procedure are performed, record the date of the sentinel lymph node biopsy in this data item, and record the date the subsequent regional node dissection was performed in the *Date Regional Lymph Node Dissection* [682].
- If a sentinel lymph node biopsy is performed in the same procedure as the regional node dissection, record the date of the procedure in both this data item and in the *Date of Regional Lymph Node Dissection* [682] (i.e., the dates should be equal).
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for Date of Sentinel Lymph Node Biopsy is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of Sentinel Lymph Node Biopsy* transmits in CCYYMMDD form, where blank spaces are used for unknown

trailing portions of the date or where a date is not applicable. The *Date of Sentinel Lymph Node Biopsy Flag* [833] is used to explain why *Date of Sentinel Lymph Node Biopsy* is not a known date. See *Date of Sentinel Lymph Node Biopsy Flag* [833] for an illustration of the relationship among these items.

Date of Sentinel Lymph Node Biopsy Flag

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
833	2	1024-1025	10-12, Blank	2018+	01/18

Description

This flag explains why there is no appropriate value in the corresponding *Date of Sentinel Lymph Node Biopsy* [832]. This data item is required for CoC-accredited facilities as of cases diagnosed 01/01/2018 and later. **This data item is required for breast and cutaneous melanoma cases only.**

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

- Leave this item blank if *Date of Sentinel Lymph Node Biopsy* [832] has a full or partial date recorded.
- Code 10 if it is unknown whether sentinel lymph nodes were biopsied.
- Code 11 if no sentinel lymph node biopsy was performed.
- Code 12 if the *Date of Sentinel Lymph Node Biopsy* [832] cannot be determined, but a sentinel lymph node biopsy was performed.
- Registrars should enter this date item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Label
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any sentinel lymph node biopsy was performed)
11	No proper value is applicable in this context (for example, no sentinel lymph node biopsy performed; autopsy only cases)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (for example, sentinel lymph node biopsy performed but date is unknown)
(blank)	A valid date value is provided in item *Date of Sentinel Lymph Node Biopsy* [832]. Case was diagnosed prior to January 1, 2018

Sentinel Lymph Nodes Examined

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
834	2	1014-1015	00-90, 95, 98, 99, Blank	2018+	01/18

Description

Records the total number of lymph nodes sampled during the sentinel node biopsy and examined by the pathologist. This data item is required for CoC-accredited facilities as of cases diagnosed 01/01/2018 and later. **This data item is required for breast and cutaneous melanoma cases only.**

Rationale

It is a known fact that sentinel lymph node biopsies have been under-reported. Additionally, the timing and results of sentinel lymph node biopsy procedures are used in quality of care measures. This data item can be used to more accurately assess the number of lymph nodes biopsied during the sentinel node biopsy procedure separate from the number of lymph nodes dissected during additional subsequent regional node procedures.

Coding Instructions

- If, during a sentinel node biopsy procedure, a few non-sentinel nodes happen to be sampled, document the **total number of nodes sampled during the sentinel node procedure** in this data item. I.e., record the total number of nodes from the sentinel node biopsy procedure regardless of sentinel node status.
- If a sentinel node biopsy procedure and then a subsequent, separate regional node dissection procedure are performed, record the total number of nodes biopsied during the sentinel node procedure in this data item, and record the total number of regional lymph nodes biopsied/dissected (**which includes the number of nodes documented in this data item**) in *Regional Lymph Nodes Examined* [830].
- If a sentinel lymph node biopsy is performed during the same procedure as the regional node dissection, record the total number of nodes biopsied during the sentinel node procedure in this data item, and record the total number of regional lymph nodes biopsied/dissected (**which includes the number of nodes documented in this data item**) in *Regional Lymph Nodes Examined* [830].
- If aspiration of sentinel lymph node(s) AND a sentinel node biopsy procedure were performed for same patient, record the results for the sentinel node biopsy.
- The number of sentinel lymph nodes examined will typically be found in the pathology report; radiology reports, or documented by the physician. Determination of the exact number of sentinel lymph nodes examined may require assistance from the managing physician for consistent coding.
- Sentinel node procedures are common for other sites, but data is only collected in these fields for breast and cutaneous melanoma. Use the AJCC N suffix to designate sentinel node procedures for ALL sites.

- The number of sentinel nodes should be equal to or less than the number of regional nodes examined recorded in the *Regional Lymph Nodes Examined* [830] data item.

Code	Label
00	No sentinel nodes were examined
01-90	Sentinel nodes were examined (code the exact number of sentinel lymph nodes examined)
95	No sentinel nodes were removed, but aspiration of sentinel node(s) was performed
98	Sentinel lymph nodes were biopsied, but the number is unknown
99	It is unknown whether sentinel nodes were examined; not applicable or negative; not stated in patient record

Sentinel Lymph Nodes Positive

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
835	2	1012-1013	00-90, 95, 97-99, Blank	2018+	01/18

Description

Records the exact number of sentinel lymph nodes biopsied by the pathologist and found to contain metastases. This data item is required for CoC-accredited facilities as of cases diagnosed 01/01/2018 and later. **This data item is required for breast and cutaneous melanoma cases only.**

Rationale

It is a known fact that sentinel lymph node biopsies have been under-reported. Additionally, the timing and results of sentinel lymph node biopsy procedures are used in quality of care measures. This data item can be used to more accurately assess the number of positive sentinel lymph nodes biopsied separate from the number of positive lymph nodes identified during additional subsequent regional node dissection procedures, if performed.

Coding Instructions

- If, during a sentinel node biopsy procedure, a few non-sentinel nodes happen to be sampled and are positive, document the **total number of positive nodes identified during the sentinel node procedure** in this data item. I.e., record the total number of positive nodes from the sentinel node biopsy procedure regardless of whether the nodes contain dye or colloidal material (tracer or radiotracer).
- If both a sentinel node biopsy procedure and then a subsequent, separate regional node dissection procedure are performed, record the total number of **positive sentinel nodes** identified during the sentinel node procedure in this data item, and record the total number of positive regional lymph nodes biopsied/dissected (**which includes the number of sentinel nodes documented in this data item**) in *Regional Lymph Nodes Positive* [820].
- If a positive aspiration of sentinel lymph node(s) AND a positive sentinel node biopsy procedure were performed for same patient, record the results for the positive sentinel node biopsy procedure.
- Sentinel node procedures are common for other sites, but data is only collected in these fields for breast and cutaneous melanoma. Use the AJCC N suffix to designate sentinel node procedures for ALL sites.
- **FOR BREAST ONLY**: If a sentinel lymph node biopsy is performed **during the same procedure** as the regional node dissection, use code 97 in this data item, and record the total number of positive regional lymph nodes biopsied/dissected (both sentinel and regional) in *Regional Lymph Nodes Positive* [820].
- The CAP Protocol for Breast is designed to capture information from the resection (there is no diagnostic protocol for breast). As a result, when the sentinel lymph node biopsy is performed during the same procedure as the regional node dissection, only the overall total number of positive regional nodes (both sentinel and regional) is recorded; the number of positive sentinel nodes is not captured.

- **FOR MELANOMA ONLY:** If a sentinel lymph node biopsy is performed **during the same procedure** as the regional node dissection, record the total number of **positive sentinel nodes** identified in this data item, and record the total number of positive regional lymph nodes identified (**which includes the number of positive sentinel nodes documented in this data item**) in *Regional Lymph Nodes Positive* [820].
- When the sentinel lymph node biopsy is performed during the same procedure as the regional node dissection the CAP Protocol for Melanoma captures both the number of positive sentinel nodes as well as the number of positive regional nodes (i.e., the number of positive sentinel nodes is captured).
- The number of sentinel lymph nodes biopsied and found positive will typically be found in the pathology report; radiology reports, or documented by the physician. Determination of the exact number of sentinel lymph nodes positive may require assistance from the managing physician for consistent coding.
- The number of sentinel nodes positive should be less than or equal to than the total number of *Regional Nodes Positive* [820].
- For carcinoma of the breast, if only positive Isolated Tumor Cells (ITC) are identified the sentinel lymph nodes are considered **negative**.
- For melanoma, if only positive Isolated Tumor Cells (ITC) are identified the sentinel lymph nodes are considered **positive**.
- mi (microscopic or micro mets) sentinel lymph nodes are considered positive.

Code	Label
00	All sentinel nodes examined are negative
01-90	Sentinel nodes are positive (code exact number of nodes positive)
95	Positive aspiration of sentinel lymph node(s) was performed
97	Positive sentinel nodes are documented, but the number is unspecified; For breast ONLY: SLN and RLND occurred during the same procedure
98	No sentinel nodes were biopsied
99	It is unknown whether sentinel nodes are positive; not applicable; not stated in patient record

Date Regional Lymph Node Dissection

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
682	8	1002-1009	CCYYMMDD, Blank	2018+	01/18

Description

Records the date non-sentinel regional node dissection was performed. This data item is required for CoC-accredited facilities as of cases diagnosed 01/01/2018 and later.

Rationale

It is a known fact that sentinel lymph node biopsies have been under-reported. Additionally, the timing and results of sentinel lymph node biopsy procedures are used in quality of care measures. This data item can be used to more accurately assess the date of regional node dissection separate from the date of sentinel lymph node biopsy if performed.

Coding Instructions

- Record the date of regional lymph node dissection documented in the *Regional Lymph Nodes Examined* [830].
- Sentinel node procedures are common for other sites, but data is only collected in these fields for breast and cutaneous melanoma. Use the AJCC N suffix to designate sentinel node procedures for ALL sites.
- **For Breast and Melanoma cases**, if both a sentinel node biopsy procedure and then a subsequent, separate regional node dissection procedure are performed, record the date of the regional lymph node dissection in this data item and record the date of the sentinel node biopsy procedure in the *Date of Sentinel Lymph Node Biopsy* [832].
    - If a sentinel lymph node biopsy is **performed in the same procedure** as the regional node dissection, record the date of the procedure in both this data item and in the *Date of Sentinel Lymph Node Biopsy* [832] data item (i.e., the dates should be equal).
- **For all other cases**, record the date of the regional lymph node dissection in this data item.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The interoperable form of *Date Regional Lymph Node Dissection* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *Date Regional Lymph Node Dissection Flag* [683] is used to explain why *Date of Regional Lymph Node Dissection* is not a known date. See *Date Regional Lymph Node Dissection Flag* [683] for an illustration of the relationship among these items.

Date Regional Lymph Node Dissection Flag

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
683	2	1010-1011	10-12, Blank	2018+	01/18

Description

This flag explains why there is no appropriate value in the corresponding date data item, *Date of Regional Lymph Node Dissection* [682]. This data item is required for CoC-accredited facilities as of cases diagnosed 01/01/2018 and later.

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

- Leave this item blank if *Date of Regional Lymph Node Dissection* [682] has a full or partial date recorded.
- Code 10 if it is unknown whether Regional Lymph Nodes were dissected.
- Code 11 if no Regional Lymph Nodes were dissected.
- Code 12 if the *Date of the Regional Lymph Node Dissection* [682] cannot be determined, but regional lymph nodes were dissected.
- Registrars should enter this date item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Label
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any regional lymph node dissection was performed)
11	No proper value is applicable in this context (for example, no regional lymph node dissection was performed; autopsy only cases)
12	A proper value is applicable but not known. This event occurred, but the date is unknown (for example, regional lymph node dissection was performed but date is unknown)
(blank)	A valid date value is provided in item *Date of Regional Lymph Node Dissection* [682]; Case was diagnosed prior to January 1, 2018

Regional Lymph Nodes Examined

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
830	2	1000-1001	00–90, 95–99	All Years	09/06, 01/10

Description

Records the total number of regional lymph nodes that were removed and examined by the pathologist. Beginning with cases diagnosed on or after January 1, 2004, this item became a component of the Collaborative Staging System (CS). In 2016, use of CS was discontinued, however this data item continued to be required.

Rationale

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

Coding Instructions

- **Regional lymph nodes only.** Record information about only regional lymph nodes in this field. Distant lymph node information should not be coded in this field.
- This field is **based on pathologic information only**. This field is to be recorded regardless of whether the patient received preoperative treatment.
- **Use of Code 00.** Code 00 may be used in several situations.
    - When the assessment of lymph nodes is clinical.
    - When no lymph nodes are removed and examined.
    - When a "dissection" of a lymph node drainage area is found to contain no lymph nodes at the time of pathologic examination.
    - If Regional Nodes Examined is coded 00, Regional Nodes Positive is coded as 98.
- **Cumulative nodes removed and examined.** Record the total number of regional lymph nodes removed and examined by the pathologist.
    - The number of regional lymph nodes examined is cumulative from all procedures that removed lymph nodes through the completion of surgeries in the first course of treatment with the exception of aspiration or core biopsies coded to 95.
    - Do not count a positive aspiration or core biopsy of a lymph node in the same lymph node chain removed at surgery as an additional node in Regional Nodes Examined.
    - If the positive aspiration or core biopsy is from a node in a different node region, include the node in the count of Regional Nodes Examined.
    - If the location of the lymph node that is aspirated or core-biopsied is not known, assume it is part of the lymph node chain surgically removed, and do not include it in the count of Regional Nodes Examined.
    - When neither the type of lymph node removal procedure nor the number of lymph nodes examined is known, use code 98.

- **Priority of lymph node counts.** If there is a discrepancy regarding the number of lymph nodes examined, use information in the following priority: final diagnosis, synoptic report (also known as CAP protocol or pathology report checklist), microscopic, gross.
- **Use of code 95.** Use code 95 when the only procedure for regional lymph nodes is a needle aspiration (cytology) or core biopsy (tissue).
- **Lymph node biopsy.** If a lymph node biopsy was performed, code the number of nodes removed, if known. If the number of nodes removed by biopsy is not known, use code 96.
- **Definition of "sampling" (code 96).** A lymph node "sampling" is removal of a limited number of lymph nodes. Other terms for removal of a limited number of nodes include lymph node biopsy, berry picking, sentinel lymph node procedure, sentinel node biopsy, selective dissection. Use code 96 when a limited number of nodes are removed but the number is unknown.
- **Definition of "dissection" (code 97).** A lymph node "dissection" is removal of most or all of the nodes in the lymph node chain(s) that drain the area around the primary tumor. Other terms include lymphadenectomy, radical node dissection, lymph node stripping. Use code 97 when more than a limited number of lymph nodes are removed and the number is unknown.
- **Multiple lymph node procedures.** If both a lymph node sampling and a lymph node dissection are performed and the total number of lymph nodes examined is unknown, use code 97.
- **Use of Code 99.** If it is unknown whether nodes were removed or examined, code as 99.
- **Primary sites always coded 99.** For the following schemas, the Regional Nodes Examined field is always coded as 99.

  Placenta
  Brain and Cerebral Meninges
  Other Parts of Central Nervous System
  Intracranial Gland
  Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms
  Hodgkin and non-Hodgkin Lymphoma
  Myeloma and PlasmaCell Disorders
  Other and Ill-Defined Primary Sites
  Unknown Primary Site
- When definition of regional nodes differs between the AJCC Cancer Staging Manual and the SEER Program Coding and Staging Manual, use the AJCC definition.

Code	Label
00	No nodes were examined
01-89	1-89 nodes were examined (code the exact number of regional lymph nodes examined)
90	90 or more nodes were examined
95	No regional nodes were removed, but aspiration of regional nodes was performed
96	Regional lymph node removal was documented as a sampling, and the number of nodes is unknown/not stated
97	Regional lymph node removal was documented as a dissection, and the number of

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

Regional Lymph Nodes Positive

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
820	2	998-999	00–99	All Years	09/06, 01/10

Description

Records the exact number of regional lymph nodes examined by the pathologist and found to contain metastases. Beginning with cases diagnosed on or after January 1, 2004, this item became a component of the Collaborative Staging System (CS). In 2016, use of CS was discontinued, however this data item continued to be required.

Rationale

This data item is necessary for pathological staging, and it serves as a quality measure for pathology reports and the extent of the surgical evaluation and treatment of the patient.

Coding Instructions

- **Regional lymph nodes only.** Record information about only regional lymph nodes in this field. Involved distant lymph nodes should not be coded in this field.
- This field is **based** on pathologic information only. This field is to be recorded regardless of whether the patient received preoperative treatment.
- **Cumulative nodes positive.** Record the total number of regional lymph nodes removed and found to be positive by pathologic examination.
    - The number of regional lymph nodes positive is cumulative from all procedures that remove lymph nodes through the completion of surgeries in the first course of treatment.
    - Do not count a positive aspiration or core biopsy of a lymph node in the same lymph node chain removed at surgery as an additional node in Regional Nodes Positive when there are positive nodes in the resection. In other words, if there are positive regional lymph nodes in a lymph node dissection, do not count the core needle biopsy or the fine needle aspiration if it is in the same chain. See also Use of Code 95 below.
    - If the positive aspiration or core biopsy is from a node in a different node region, include the node in the count of Regional Nodes Positive.
    - If the location of the lymph node that is core-biopsied or aspirated is not known, assume it is part of the lymph node chain surgically removed, and do not include it in the count of Regional Nodes Positive.
- **Priority of lymph node counts.** If there is a discrepancy regarding the number of positive lymph nodes, use information in the following priority: final diagnosis, synoptic report (also known as CAP protocol or pathology report checklist), microscopic, gross.
- **Positive Nodes in Multiple Primaries in Same Organ.** If there are multiple primary cancers with different histologic types in the same organ and the pathology report just states the number of nodes positive, the registrar should first try to determine the histology of the metastases in the

nodes and code the nodes as positive for the primary with that histology. If no further information is available, code the nodes as positive for all primaries.

- **Isolated tumor cells (ITCs) in lymph nodes.** For all primary sites except cutaneous melanoma and Merkel cell carcinoma of skin, count only lymph nodes that contain micrometastases or larger (metastases greater than 0.2 millimeters in size). Do not include in the count of lymph nodes positive any nodes that are identified as containing isolated tumor cells (ITCs). If the path report indicates that nodes are positive but the size of metastasis is not stated, assume the metastases are larger than 0.2 mm and count the lymph node(s) as positive.
    - **For cutaneous melanoma and Merkel cell carcinoma**, count nodes with ITCs as positive lymph nodes.
- **Use of Code 95.** Use code 95 when the only procedure for regional lymph nodes is a needle aspiration (cytology) or core biopsy (tissue).
    - Use code 95 when a positive lymph node is aspirated and there are no surgically resected lymph nodes.
    - Use code 95 when a positive lymph node is aspirated and surgically resected lymph nodes are negative.
- **Definition of Code 97.** Use code 97 for any combination of positive aspirated, biopsied, sampled or dissected lymph nodes if the number of involved nodes cannot be determined on the basis of cytology or histology. Code 97 includes positive lymph nodes diagnosed by either cytology or histology.
    - Note: If the aspirated node is the only one that is microscopically positive, use code 95.
- **Use of Code 98.** Code 98 may be used in several situations.
    - When the assessment of lymph nodes is clinical only.
    - When no lymph nodes are removed and examined.
    - When a “dissection” of a lymph node drainage area is found to contain no lymph nodes at the time of pathologic examination.
    - If Regional Nodes Positive is coded as 98, Regional Nodes Examined is usually coded 00.
- **Use of code 99.** Use code 99 if it is unknown whether regional lymph nodes are positive.
- **Primary sites always coded 99.** For the following primary sites and histologies, the Regional Nodes Positive field is always coded as 99.

  Placenta
  Brain and Cerebral Meninges
  Other Parts of Central Nervous System
  Intracranial Gland
  Hodgkin and non-Hodgkin Lymphoma
  Hematopoietic, Reticuloendothelial, Immunoproliferative and Myeloproliferative Neoplasms
  Myeloma and PlasmaCell Disorders
  Other and Ill-Defined Primary Sites
  Unknown Primary Site

- When definition of regional nodes differs between the AJCC Cancer Staging Manual and the SEER Program Coding and Staging Manual use the AJCC definition.

Code	Label
00	All nodes examined are negative
01-89	1-89 nodes are positive (code exact number of nodes positive)
90	90 or more nodes are positive
95	Positive aspiration of lymph node(s) was performed
97	Positive nodes are documented, but the number is unspecified
98	No nodes were examined
99	It is unknown whether nodes are positive; not applicable; not stated in patient record

Tumor Size and Mets

Tumor Size Summary

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
756	3	882-884	000-990, 998, 999	2016+	01/16

Description

This data item records the most accurate measurement of a solid primary tumor, usually measured on the surgical resection specimen.

Rationale

Tumor size is one indication of the extent of disease. As such, it is used by both clinicians and researchers. Tumor size that is independent of stage is also useful for quality assurance efforts.

Coding Instructions

Note: All measurements should be in millimeters (mm).

Record size in specified order:

1. Size measured on the surgical resection specimen, when surgery is administered as the first definitive treatment, i.e., no pre-surgical treatment administered.
    a. If there is a discrepancy among tumor size measurements in the various sections of the pathology report, code the size from the synoptic report (also known as CAP protocol or pathology report checklist). If only a text report is available, use: final diagnosis, microscopic, or gross examination, in that order.

    Example: Chest x-ray shows 3.5 cm mass; the pathology report from the surgery states that the same mass is malignant and measures 2.8 cm. Record tumor size as 028 (28 mm).

    Example: Pathology report states lung carcinoma is 2.1 cm x 3.2 cm x 1.4 cm. Record tumor size as 032 (32 mm).

2. If neoadjuvant therapy followed by surgery, do not record the size from the pathologic specimen. Code the largest size of tumor prior to neoadjuvant treatment; if unknown code size as 999.

    Example: Patient has a 2.2 cm mass in the oropharynx; find needle aspiration of mass confirms squamous cell carcinoma. Patient receives a course of neoadjuvant combination chemotherapy. Pathologic size after total resection is 2.8 cm. Record tumor size as 022 (22mm).

3. If no surgical resection, then largest measurement of the tumor from physical exam, imaging, or other diagnostic procedures prior to any other form of treatment (See Coding Rules below).
4. If 1, 2, and 3 do not apply, the largest size from all information available within four months of the date of diagnosis, in the absence of disease progression.

Coding Rules

1. Tumor size is the **diameter** of the tumor, **not the depth or thickness** of the tumor.
2. Recording less than/greater than Tumor Size:
    a. If tumor size is reported as less than x mm or less than x cm, the reported tumor size should be 1 mm less; for example if size is <10 mm, code size as 009. Often these are given in cm such as < 1 cm which is coded as 009, < 2 cm is coded as 019, < 3 cm is coded as 029, < 4 cm is coded as 039, < 5 cm is coded as 049. If stated as less than 1 mm, use code 001.
    b. If tumor size is reported as more than x mm or more than x cm, code size as 1 mm more; for example if size is >10 mm, size should be coded as 011. Often these are given in cm such as > 1 cm, which is coded as 011, > 2 cm is coded as 021, > 3 cm is coded as 031, > 4 cm is coded as 041, > 5 cm is coded as 051. If described as anything greater than 989 mm (98.9 cm) code as 989.
    c. If tumor size is reported to be between two sizes, record tumor size as the midpoint between the two: i.e., add the two sizes together and then divide by two ("between 2 and 3 cm" is coded as 025).
3. **Rounding**: Round the tumor size only if it is described in fractions of millimeters. If the largest dimension of a tumor is less than 1 millimeter (between 0.1 and 0.9 mm), record size as 001 (do not round down to 000). If tumor size is greater than 1 millimeter, round tenths of millimeters in the 1-4 range down to the nearest whole millimeter, and round tenths of millimeters in the 5-9 range up to the nearest whole millimeter. Do not round tumor size expressed in centimeters to the nearest whole centimeter (rather, move the decimal point one space to the right, converting the measurement to millimeters). For breast cancer, please follow the AJCC 8th Edition, Breast Chapter.

    Examples:

    Breast cancer described as 6.5 millimeters in size. Round up *Tumor Size as 007*.

    Cancer in polyp described as 2.3 millimeters in size. Round down *Tumor Size as 002*.

    Focus of cancer described as 1.4 mm in size. *Round down as 001*.

    5.2 mm breast cancer. *Round down to 5 mm and code as 005*.
4. **Priority of imaging/radiographic techniques**: Information on size from imaging/radiographic techniques can be used to code size when there is no more specific size information from a pathology or operative report, but it should be taken as low priority, over a physical exam.
5. **Tumor size discrepancies among imaging and radiographic reports**: If there is a difference in reported tumor size among imaging and radiographic techniques, unless the physician specifies which imaging is most accurate, record the largest size in the record, regardless of which imaging technique reports it.
6. **Always code the size of the primary tumor, not the size of the polyp, ulcer, cyst, or distant metastasis**. However, if the tumor is described as a "cystic mass," and only the size of the entire mass is given, code the size of the entire mass, since the cysts are part of the tumor itself.
7. Record the size of the invasive component, if given.

a. If both an in situ and an invasive component are present and the invasive component is measured, record the size of the invasive component even if it is smaller.

Example: Tumor is mixed in situ and invasive adenocarcinoma, total 3.7 cm in size, of which 1.4 cm is invasive. Record tumor size as 014 (14 mm)

b. If the size of the invasive component is not given, record the size of the entire tumor from the surgical report, pathology report, radiology report or clinical examination.

Example: A breast tumor with infiltrating duct carcinoma with extensive in situ component; total size 2.3 cm. Record tumor size as 023 (23 mm).

Example: Duct carcinoma in situ measuring 1.9 cm with an area of invasive ductal carcinoma. Record tumor size as 019 (19 mm).

8. Record the largest dimension or diameter of tumor, whether it is from an excisional biopsy specimen or the complete resection of the primary tumor.

   Example: Tumor is described as 2.4 x 5.1 x 1.8 cm in size. Record tumor size as 051 (51 mm).

9. Record the size as stated for purely in situ lesions.
10. **Disregard microscopic residual or positive surgical margins when coding tumor size**. Microscopic residual tumor does not affect overall tumor size. The status of primary tumor margins may be recorded in a separate data item.
11. **Do not add the size of pieces or chips together to create a whole**; they may not be from the same location, or they may represent only a very small portion of a large tumor. However, if the pathologist states an aggregate or composite size (determined by fitting the tumor pieces together and measuring the total size), record that size. If the only measurement describes pieces or chips, record tumor size as 999.
12. **Multifocal/multicentric tumors**: If the tumor is multi-focal or if multiple tumors are reported as a single primary, code the size of the largest invasive tumor or if all of the tumors are in situ, code the size of the largest in situ tumor.
13. **Tumor size code 999 is used when size is unknown or not applicable**. Sites/morphologies where tumor size is not applicable are listed here.

    Hematopoietic, Reticuloendothelial, and Myeloproliferative neoplasms: histology codes 9590-9992
    Kaposi Sarcoma
    Melanoma Choroid
    Melanoma Ciliary Body
    Melanoma Iris
14. Document the information to support coded tumor size in the appropriate text data item of the abstract.

Code	Label
000	No mass/tumor found
001	1 mm or described as less than 1 mm
002-988	Exact size in millimeters (2 mm to 988 mm)

Code	Label
989	989 millimeters or larger
990	Microscopic focus or foci only and no size of focus is given
998	SITE-SPECIFIC CODES Alternate descriptions of tumor size for specific sites: Familial/multiple polyposis: Rectosigmoid and rectum (C19.9, C20.9) Colon (C18.0, C18.2-C18.9) If no size is documented: Circumferential: Esophagus (C15.0-C15.5, C15.8-C15.9) Diffuse; widespread: 3/4s or more; linitis plastica: Stomach and Esophagus GE Junction (C16.0-C16.6, C16.8-C16.9) Diffuse, entire lung or NOS: Lung and main stem bronchus (C34.0-C34.3, C34.8-C34.9) Diffuse: Breast (C50.0-C50.6, C50.8-C50.9)
999	Unknown; size not stated Not documented in patient record Size of tumor cannot be assessed Not applicable

Mets at Diagnosis – Bone

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1112	1	870-870	0, 1, 8, 9	2016+	01/16

Description

This data item identifies whether bone is an involved metastatic site. The six Mets at Dx-Metastatic Sites data items provide information on specific metastatic sites for data analysis.

Rationale

Information on site of metastatic disease at diagnosis has prognostic implications to survival among patients with initial late stage disease. Capturing data on where the patient's metastatic lesions (including the number of locations) will be an important variable to include when looking at survival. Survival among metastatic patients is becoming increasingly important for cancer survivors. CoC requires this data item be recorded in its accredited program cancer registries beginning with cases diagnosed January 1, 2016.

Coding Instructions

1. **Code information about bone metastases only** (discontinuous or distant metastases to bone) identified at the time of diagnosis. This data item should not be coded for bone marrow involvement.
    a. Bone involvement may be single or multiple
    b. Information about bone involvement may be clinical or pathological
    c. Code this data item for bone metastases even if the patient had any preoperative systemic therapy
    d. This data item should be coded for all solid tumors, Kaposi sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary Sites
2. **Use of codes**. Assign the code that best describes whether the case has bone metastases at diagnosis.
    a. Use code 0 when the medical record
        i. indicates that there are no distant (discontinuous) metastases at all
        ii. includes a clinical or pathologic statement that there are no bone metastases
        iii. includes imaging reports that are negative for bone metastases
        iv. indicates that the patient has distant (discontinuous) metastases but bone is not mentioned as an involved site

    Example: use code 0 when the patient has lung and liver metastases but not bone

    b. Use code 1 when the medical record
        i. indicates that the patient has distant (discontinuous) metastases and bone is mentioned as an involved site

ii. indicates that bone is the primary site and there are metastases in a different bone or bones

1) do not assign code 1 for a bone primary with multifocal bone involvement of the same bone

iii. indicates that the patient is diagnosed as an unknown primary (C80.9) and bone is mentioned as a distant metastatic site

c. Use code 8 (Not applicable) for the following site/histology combinations for which a code for distant metastasis is not clinically relevant.

ICD-O-3 Site	ICD-O-3 Histology	
C000-C809	9740-9809, 9840-9992	Mast cell, histiocytosis, immunoproliferative, leukemias coded to any site
C420, C421, C424	9811-9818, 9823, 9827, 9837	Specific leukemia/lymphoma histologies coded to blood, bone marrow, hematopoietic
C000-C440, C442-C689, C691-C694, C698-C809	9820, 9826, 9831-9834	Mostly lymphoid leukemias coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS
C000-C440, C442-C689, C691-C694, C698-C809	9731, 9732, 9734	Plasma cell tumors coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS

d. Use code 9 when it cannot be determined from the medical record whether the patient specifically has bone metastases; for example, when there is documentation of carcinomatosis but bone is not specifically mentioned as a metastatic site. In other words, use code 9 when there are known distant metastases but it is not known whether the distant metastases include bone.

Code	Label
0	None; no bone metastases
1	Yes; distant bone metastases
8	Not applicable
9	Unknown whether bone is an involved metastatic site Not documented in patient record

Mets at Diagnosis – Brain

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1113	1	871-871	0, 1, 8, 9	2016+	01/16

Description

This data item identifies whether brain is an involved metastatic site. The six Mets at Dx-Metastatic Sites data items provide information on specific metastatic sites for data analysis.

Rationale

Information on site of metastatic disease at diagnosis has prognostic implications to survival among patients with initial late stage disease. Capturing data on where the patient's metastatic lesions (including the number of locations) will be an important variable to include when looking at survival. Survival among metastatic patients is becoming increasingly important for cancer survivors. CoC requires this data item be recorded in its accredited program cancer registries beginning with cases diagnosed January 1, 2016.

Coding Instructions

1. **Code information about brain metastases only** (discontinuous or distant metastases to brain) identified at the time of diagnosis. This data item should not be coded for involvement of spinal cord or other parts of the central nervous system.
    a. Brain involvement may be single or multiple
    b. Information about brain involvement may be clinical or pathological
    c. Code this data item whether or not the patient had any preoperative systemic therapy
    d. This data item should be coded for all solid tumors, Kaposi sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary Sites
2. **Use of codes**. Assign the code that best describes whether the case has brain metastases at diagnosis.
    a. Use code 0 when the medical record
        i. indicates that there are no distant (discontinuous) metastases at all
        ii. includes a clinical or pathologic statement that there are no brain metastases
        iii. includes imaging reports that are negative for brain metastases
        iv. indicates that the patient has distant (discontinuous) metastases but brain is not mentioned as an involved site

    Example: use code 0 when the patient has lung and liver metastases but not brain

    b. Use code 1 when the medical record
        i. indicates that the patient has distant (discontinuous) metastases and brain is mentioned as an involved site

ii. indicates that the patient is diagnosed as an unknown primary (C80.9) and brain is mentioned as a distant metastatic site

c. Use code 8 (Not applicable) for the following site/histology combinations for which a code for distant metastasis is not clinically relevant.

ICD-O-3 Site	ICD-O-3 Histology	
C000-C809	9740-9809, 9840-9992	Mast cell, histiocytosis, immunoproliferative, leukemias coded to any site
C420, C421, C424	9811-9818, 9823, 9827, 9837	Specific leukemia/lymphoma histologies coded to blood, bone marrow, hematopoietic
C000-C440, C442-C689, C691-C694, C698-C809	9820, 9826, 9831-9834	Mostly lymphoid leukemias coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS
C000-C440, C442-C689, C691-C694, C698-C809	9731, 9732, 9734	Plasma cell tumors coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS

d. Use code 9 when it cannot be determined from the medical record whether the patient specifically has brain metastases; for example, when there is documentation of carcinomatosis but brain is not specifically mentioned as a metastatic site. In other words, use code 9 when there are known distant metastases but it is not known whether the distant metastases include brain.

Code	Label
0	None; no brain metastases
1	Yes; distant brain metastases
8	Not applicable
9	Unknown whether brain is involved metastatic site Not documented in patient record

Mets at Diagnosis – Distant Lymph Nodes

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1114	1	872-872	0, 1, 8, 9	2016+	01/16

Description

This data item identifies whether distant lymph node(s) are an involved metastatic site. The six Mets at Dx-Metastatic Sites data items provide information on specific metastatic sites for data analysis.

Rationale

Information on site of metastatic disease at diagnosis has prognostic implications to survival among patients with initial late stage disease. Capturing data on where the patient's metastatic lesions (including the number of locations) will be an important variable to include when looking at survival. Survival among metastatic patients is becoming increasingly important for cancer survivors. CoC requires this data item be recorded in its accredited program cancer registries beginning with cases diagnosed January 1, 2016.

Coding Instructions

1. **Code information about distant lymph node(s) metastases only** (metastases to distant lymph nodes) identified at the time of diagnosis.
    a. Distant lymph node involvement may be single or multiple
    b. Information about distant lymph node involvement may be clinical or pathological
    c. Code this data item whether or not the patient had any preoperative systemic therapy
    d. This data item should not be coded for regional lymph node involvement with the exception of lymph nodes for placenta which are in the M1 category
    e. This data item should be coded for all solid tumors, Kaposi sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary Sites.
2. **Use of codes**. Assign the code that best describes whether the case has distant lymph node metastases at diagnosis.
    a. Use code 0 when the medical record
        i. indicates that there are no distant (discontinuous) metastases at all
        ii. includes a clinical or pathologic statement that there are no distant lymph node metastases
        iii. includes imaging reports that are negative for distant lymph node metastases
        iv. indicates that the patient has distant (discontinuous) metastases but distant lymph node(s) are not mentioned as an involved site

    Example: use code 0 when the patient has lung and liver metastases but not distant lymph node(s)

    b. Use code 1 when the medical record

i. indicates that the patient has distant (discontinuous) metastases and distant lymph node(s) are mentioned as an involved site

ii. indicates that the patient is diagnosed as an unknown primary (C80.9) and distant lymph node(s) are mentioned as a metastatic site

c. Use code 8 (Not applicable) for the following site/histology combinations for which a code for distant metastasis is not clinically relevant.

ICD-O-3 Site	ICD-O-3 Histology	
C000-C809	9740-9809, 9840-9992	Mast cell, histiocytosis, immunoproliferative, leukemias coded to any site
C420, C421, C424	9811-9818, 9823, 9827, 9837	Specific leukemia/lymphoma histologies coded to blood, bone marrow, hematopoietic
C000-C440, C442-C689, C691-C694, C698-C809	9820, 9826, 9831-9834	Mostly lymphoid leukemias coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS
C000-C440, C442-C689, C691-C694, C698-C809	9731, 9732, 9734	Plasma cell tumors coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS

d. Use code 9 when it cannot be determined from the medical record whether the patient specifically has distant lymph node metastases; for example, when there is documentation of carcinomatosis but distant lymph node(s) are not specifically mentioned as a metastatic site. In other words, use code 9 when there are known distant metastases but it is not known whether the distant metastases include distant lymph node(s).

Code	Label
0	None; no distant lymph node metastases
1	Yes; distant lymph node metastases
8	Not applicable
9	Unknown whether distant lymph node(s) are involved metastatic site Not documented in patient record

Mets at Diagnosis – Liver

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1115	1	873-873	0, 1, 8, 9	2016+	01/16

Description

This data item identifies whether liver is an involved metastatic site. The six Mets at Dx-Metastatic Sites data items provide information on specific metastatic sites for data analysis.

Rationale

Information on site of metastatic disease at diagnosis has prognostic implications to survival among patients with initial late stage disease. Capturing data on where the patient's metastatic lesions (including the number of locations) will be an important variable to include when looking at survival. Survival among metastatic patients is becoming increasingly important for cancer survivors. CoC requires this data item be recorded in its accredited program cancer registries beginning with cases diagnosed January 1, 2016.

Coding Instructions

1. **Code information about liver metastases only** (discontinuous or distant metastases to liver) identified at the time of diagnosis.
    a. Liver involvement may be single or multiple
    b. Information about liver involvement may be clinical or pathological
    c. Code this data item whether or not the patient had any preoperative systemic therapy
    d. This data item should be coded for all solid tumors, Kaposi sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary Sites
2. **Use of codes.** Assign the code that best describes whether the case has liver metastases at diagnosis.
    a. Use code 0 when the medical record
        i. indicates that there are no distant (discontinuous) metastases at all
        ii. includes a clinical or pathologic statement that there are no liver metastases
        iii. includes imaging reports that are negative for liver metastases
        iv. indicates that the patient has distant (discontinuous) metastases but liver is not mentioned as an involved site

    Example: use code 0 when the patient has lung and brain metastases but not liver

    b. Use code 1 when the medical record
        i. indicates that the patient has distant (discontinuous) metastases and liver is mentioned as an involved site
        ii. indicates that the patient is diagnosed as an unknown primary (C80.9) and liver is mentioned as a distant metastatic site

c. Use code 8 (Not applicable) for the following site/histology/combinations for which a code for distant metastasis is not clinically relevant.

ICD-O-3 Site	ICD-O-3 Histology	
C000-C809	9740-9809, 9840-9992	Mast cell, histiocytosis, immunoproliferative, leukemias coded to any site
C420, C421, C424	9811-9818, 9823, 9827, 9837	Specific leukemia/lymphoma histologies coded to blood, bone marrow, hematopoietic
C000-C440, C442-C689, C691-C694, C698-C809	9820, 9826, 9831-9834	Mostly lymphoid leukemias coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS
C000-C440, C442-C689, C691-C694, C698-C809	9731, 9732, 9734	Plasma cell tumors coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS

d. Use code 9 when it cannot be determined from the medical record whether the patient specifically has liver metastases; for example, when there is documentation of carcinomatosis but liver is not specifically mentioned as a metastatic site. In other words, use code 9 when there are known distant metastases but it is not known whether the distant metastases include liver.

Code	Label
0	None; no liver metastases
1	Yes; distant liver metastases
8	Not applicable
9	Unknown whether liver is involved metastatic site Not documented in patient record

Mets at Diagnosis – Lung

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1116	1	874-874	0, 1, 8, 9	2016+	01/16

Description

This data item identifies whether lung is an involved metastatic site. The six Mets at Dx-Metastatic Sites data items provide information on specific metastatic sites for data analysis.

Rationale

Information on site of metastatic disease at diagnosis has prognostic implications to survival among patients with initial late stage disease. Capturing data on where the patient's metastatic lesions (including the number of locations) will be an important variable to include when looking at survival. Survival among metastatic patients is becoming increasingly important for cancer survivors. CoC requires this data item be recorded in its accredited program cancer registries beginning with cases diagnosed January 1, 2016.

Coding Instructions

1. **Code information about lung metastases only** (discontinuous or distant metastases to lung) identified at the time of diagnosis. This data item should not be coded for pleural or pleural fluid involvement.
    a. Lung involvement may be single or multiple
    b. Information about lung involvement may be clinical or pathological
    c. Code this data item whether or not the patient had any preoperative systemic therapy
    d. This data item should be coded for all solid tumors, Kaposi sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary Sites
2. **Use of codes.** Assign the code that best describes whether the case has lung metastases at diagnosis.
    a. Use code 0 when the medical record
        i. indicates that there are no distant (discontinuous) metastases at all
        ii. includes a clinical or pathologic statement that there are no lung metastases
        iii. includes imaging reports that are negative for lung metastases
        iv. indicates that the patient has distant (discontinuous) metastases but lung is not mentioned as an involved site.

    Example: use code 0 when the patient has liver and brain metastases but not lung

    b. Use code 1 when the medical record
        i. indicates that the patient has distant (discontinuous) metastases and lung is mentioned as an involved site

ii. indicates that lung is the primary site and there are metastases in the contralateral lung

1) do not assign code 1 for a lung primary with multifocal involvement of the same lung

iii. indicates that the patient is diagnosed as an unknown primary (C80.9) and lung is mentioned as a distant metastatic site

c. Use code 8 (Not applicable) for the following site/histology combinations for which a code for distant metastasis is not clinically relevant.

ICD-O-3 Site	ICD-O-3 Histology	
C000-C809	9740-9809, 9840-9992	Mast cell, histiocytosis, immunoproliferative, leukemias coded to any site
C420, C421, C424	9811-9818, 9823, 9827, 9837	Specific leukemia/lymphoma histologies coded to blood, bone marrow, hematopoietic
C000-C440, C442-C689, C691-C694, C698-C809	9820, 9826, 9831-9834	Mostly lymphoid leukemias coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS
C000-C440, C442-C689, C691-C694, C698-C809	9731, 9732, 9734	Plasma cell tumors coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS

d. Use code 9 when it cannot be determined from the medical record whether the patient specifically has lung metastases; for example, when there is documentation of carcinomatosis but lung is not specifically mentioned as a metastatic site. In other words, use code 9 when there are known distant metastases but it is not known whether the distant metastases include lung.

Code	Label
0	None; no lung metastases
1	Yes; distant lung metastases
8	Not applicable
9	Unknown whether lung is involved metastatic site Not documented in patient record

Mets at Diagnosis – Other

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1117	1	875-875	0, 1, 2, 8, 9	2016+	01/16, 01/18

Description

The six Mets at Dx-Metastatic Sites fields provide information on metastases for data analysis. This data item identifies any type of distant involvement not captured in the **Mets at Diagnosis – Bone, Mets at Diagnosis – Brain, Mets at Diagnosis – Liver, Mets at Diagnosis – Lung, and Mets at Diagnosis – Distant Lymph Nodes fields. It includes involvement of other specific sites and more generalized metastases such as carcinomatosis.** Some examples include but are not limited to the adrenal gland, bone marrow, pleura, malignant pleural effusion, peritoneum, and skin.

Rationale

Information on site of metastatic disease at diagnosis has prognostic implications to survival among patients with initial late stage disease. Capturing data on where the patient's metastatic lesions (including the number of locations) will be an important variable to include when looking at survival. Survival among metastatic patients is becoming increasingly important for cancer survivors. CoC requires this data item be recorded in its accredited program cancer registries beginning with cases diagnosed January 1, 2016.

Coding Instructions

1. **Code information about other metastases only** (discontinuous or distant metastases) identified at the time of diagnosis. This data item should not be coded for bone, brain, liver, lung or distant lymph node metastases.
    a. Other involvement may be single or multiple
    b. Information about other involvement may be clinical or pathological.
    c. Code this data item whether or not the patient had any preoperative (neoadjuvant) systemic therapy
    d. This data item should be coded for all solid tumors, Kaposi sarcoma, Unknown Primary Site, and Other and Ill-Defined Primary Sites.
2. **Use of codes.** Assign the code that best describes whether the case has other metastases at diagnosis.
    a. Use code 0 when the medical record
        i. indicates that there are no distant (discontinuous) metastases at all
        ii. includes a clinical or pathologic statement that there are no other metastases
        iii. includes imaging reports that are negative for other metastases
        iv. indicates that the patient has distant (discontinuous) metastases but other sites are not mentioned as involved

    Example: use code 0 when the patient has lung and liver metastases only

b. Use code 1 when the medical record

   i. indicates that the patient has distant (discontinuous) metastases in any site(s) other than bone, brain, liver, lung or distant lymph node(s)

   ii. includes but not limited to the adrenal gland, bone marrow, pleura, malignant pleural effusion, peritoneum and skin

c. Use code 8 (Not applicable) for the following site/histology combination for which a code for distant metastasis is not clinically relevant.

ICD-O-3 Site	ICD-O-3 Histology	
C000-C809	9740-9809, 9840-9992	Mast cell, histiocytosis, immunoproliferative, leukemias coded to any site
C420, C421, C424	9811-9818, 9823, 9827, 9837	Specific leukemia/lymphoma histologies coded to blood, bone marrow, hematopoietic
C000-C440, C442-C689, C691-C694, C698-C809	9820, 9826, 9831-9834	Mostly lymphoid leukemias coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS
C000-C440, C442-C689, C691-C694, C698-C809	9731, 9732, 9734	Plasma cell tumors coded to any site except eyelid, conjunctiva, lacrimal gland, orbit, and eye overlapping and NOS

d. Use code 9 when it cannot be determined from the medical record whether the patient has metastases other than bone, brain, liver, lung and distant lymph node(s). In other words, use code 9 when there are known distant metastases but it is not known specifically what they are.

Code	Label
0	None; no other metastases
1	Yes; distant metastases in known site(s) other than bone, brain, liver, lung or distant lymph nodes
2	Generalized metastases such as carcinomatosis
8	Not applicable
9	Unknown whether any other metastatic site Not documented in patient record

Summary Stage 2018

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
764	1	987-987	0-5, 7, 8, 9, Blank	2018+	01/18

Description

This item stores the directly coded Summary Stage 2018. Effective for cases diagnosed 1/1/2018+. Code summary stage at the initial diagnosis or treatment of the reportable tumor. Summary stage should include all information available through completion of surgery(ies) in the first course of treatment or within 4 months of diagnosis in the absence of disease progression, whichever is longer.

Rationale

The SEER program has collected staging information on cases since its inception in 1973. Summary Stage groups cases into broad categories of in situ, local, regional, and distant. Summary Stage can be used to evaluate disease spread at diagnosis, treatment patterns and outcomes over time.

Stage information is important when evaluating the effects of cancer control programs. It is crucial in understanding whether changes over time in incidence rates or outcomes are due to earlier detection of the cancers. In addition, cancer treatment cannot be studied without knowing the stage at diagnosis.

From 2004 through 2015, CoC relied on the item *Derived SS2000* [3020] for the value of *SEER Summary Stage 2000* [759] as generated by the collaborative Staging algorithm. For cases diagnosed in 2016 and 2017, the CoC required that directly-coded *SEER Summary Stage 2000* [759] be recorded in its accredited program cancer registries. Effective with cases diagnosed January 1, 2018 the CoC requires that directly-coded *SEER Summary Stage 2018* [764] be recorded in its accredited program cancer registries.

Coding Instructions

- Refer to the site and histology-specific definitions of categories and coding instructions in the SEER Summary Staging Manual 2018.
- Use Code 8 for benign and borderline brain/CNS cases.
- Note: For Summary Stage 2018, code 5 for “Regional, NOS” can no longer be coded.

Code	Label
0	In situ
1	Localized only
2	Regional by direct extension only
3	Regional lymph nodes only
4	Regional by BOTH direct extension AND lymph node involvement
7	Distant site(s)/node(s) involved
8	Benign/borderline*

Code	Label
9	Unknown if extension or metastasis (unstaged, unknown, or unspecified)

*Applicable for the following SS2018 chapters: Brain, CNS Other, Intracranial Gland.

AJCC 8th Edition TNM Stage

AJCC TNM Clin T

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1001	15	1082-1096	Alphanumeric, Blank	2018+	01/18

Description

Evaluates the primary tumor (T) and reflects the tumor size and/or extension of the tumor known ***prior*** to the start of any therapy. Detailed site-specific values for the clinical T category as defined by the current AJCC edition.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2018, the CoC requires use of the AJCC 8th Edition Staging System in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

With the implementation of the 8th Edition storage codes are no longer utilized. Codes and Labels for the different categories are exact matches to what is listed in the 8th Edition Manual (except for code 88). The new categories will be used for cases diagnosed in 2018 and later.

Coding Instructions

- The clinical T category staging data item must be recorded for *Class of Case* 10-22.
- It is strongly recommended that the clinical T category staging data item be recorded for *Class of Case* 00 cases if the patient's workup at the facility allows assigning of clinical T.
- Assign clinical T category as documented by the first treating physician or the managing physician in the medical record.
- If the managing physician has not recorded clinical T, registrars *will* assign this item based on the best available information, without necessarily requiring additional contact with the physician.
- Code 88 for clinical and pathological or post therapy T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
- If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
- Refer to the current AJCC Cancer Staging Manual, Eighth Edition for detailed staging rules.
- The valid codes and labels for the *AJCC Cancer Staging Manual, Eighth Edition* have been expanded and are now consistent for clarity. They are provided herein with permission from the American College of Surgeons (ACS) to support the data collection efforts of the CoC and NCDB. These codes and labels cannot be distributed, published, or incorporated into any software (including any electronic record systems), product, or publication without a written license agreement with ACS. The codes and labels cannot be modified, changed, or updated without

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Code	Label
(blank)	Not recorded
cTX	cTX
cT0	cT0
cTa	cTa
cTis	cTis
cTis(DCIS)	cTis(DCIS)
cTis(LAMN)	cTis(LAMN)
cTis(Paget)	cTis(Paget)
cT1	cT1
cT1mi	cT1mi
cT1a	cT1a
cT1a1	cT1a1
cT1a2	cT1a2
cT1b	cT1b
cT1b1	cT1b1
cT1b2	cT1b2
cT1c	cT1c
cT1c1	cT1c1
cT1c2	cT1c2
cT1c3	cT1c3
cT1d	cT1d

Code	Label
cT2	cT2
cT2a	cT2a
cT2a1	cT2a1
cT2a2	cT2a2
cT2b	cT2b
cT2c	cT2c
cT2d	cT2d
cT3	cT3
cT3a	cT3a
cT3b	cT3b
cT3c	cT3c
cT3d	cT3d
cT3e	cT3e
cT4	cT4
cT4a	cT4a
cT4b	cT4b
cT4c	cT4c
cT4d	cT4d
cT4e	cT4e
88	Not applicable

AJCC TNM Clin T Suffix

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1031	4	1097-1100	(m), (s), Blank	2018+	01/18

Description

Identifies the AJCC TNM clinical T category suffix for the tumor ***prior*** to the start of any therapy. Stage suffices identify special cases that need separate analysis. Suffices are adjuncts to and do not change the stage group.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2018 the CoC requires use of the AJCC 8th Edition Staging System in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

With the implementation of the 8th Edition storage codes are no longer utilized. Codes and Labels for the different categories are exact matches to what is listed in the 8th Edition Manual (except for code 88). The new categories will be used for cases diagnosed in 2018 and later.

Coding Instructions

- Record the clinical T category suffix as documented by the first treating physician or the managing physician in the medical record.
- If the managing physician has not recorded the suffix when applicable, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
- If the tumor is not staged according to the AJCC manual, leave this data item blank.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.

Code	Label
(blank)	No information available; not recorded
(m)	Multiple synchronous tumors OR Multifocal tumor (differentiated and anaplastic thyroid only)
(s)	Solitary tumor (differentiated and anaplastic thyroid only)

AJCC TNM Clin N

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1002	15	1101-1115	Alphanumeric, Blank	2018+	01/18

Description

Identifies the absence or presence of regional lymph node (N) metastasis and describes the extent of regional lymph node metastasis of the tumor known ***prior*** to the start of any therapy. Detailed site-specific values for the clinical N category as defined by the current AJCC edition.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2018 the CoC requires use of the AJCC 8th Edition Staging System in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

With the implementation of the 8th Edition storage codes are no longer utilized. Codes and Labels for the different categories are exact matches to what is listed in the 8th Edition Manual (except for code 88). The new categories will be used for cases diagnosed in 2018 and later.

Coding Instructions

- The clinical N category staging data item must be assigned for *Class of Case* 10-22.
- It is strongly recommended that the clinical N category staging data item be recorded for *Class of Case* 00 cases if the patient's workup at the facility allows assigned of clinical N category.
- Record clinical N category as documented by the first treating physician or the managing physician in the medical record.
- If the managing physician has not recorded clinical N, registrars *will* assign this item based on the best available information, without necessarily requiring additional contact with the physician.
- Code 88 for clinical and pathological or post therapy T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
- If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.
- The valid codes and labels for the *AJCC Cancer Staging Manual, Eighth Edition* have been expanded and are now consistent for clarity. They are provided herein with permission from the American College of Surgeons (ACS) to support the data collection efforts of the CoC and NCDB. These codes and labels cannot be distributed, published, or incorporated into any software (including any electronic record systems), product, or publication without a written license agreement with ACS. The codes and labels cannot be modified, changed, or updated without

the express written permission of ACS. Contact ajcc@facs.org for permission. Refer to the most current list of valid codes and labels: https://cancerstaging.org/Pages/Vendors.aspx.

Code	Label
(blank)	Not recorded
cNX	cNX
cN0	cN0
cN0a	cN0a
cN0b	cN0b
cN0(i+)	cN0(i+)
cN1	cN1
cN1mi	cN1mi
cN1a	cN1a
cN1b	cN1b
cN1c	cN1c

Code	Label
cN2	cN2
cN2mi	cN2mi
cN2a	cN2a
cN2b	cN2b
cN2c	cN2c
cN3	cN3
cN3a	cN3a
cN3b	cN3b
cN3c	cN3c
88	Not applicable

AJCC TNM Clin N Suffix

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1034	4	1116-1119	(sn), (f), Blank	2018+	01/18

Description

Identifies the AJCC TNM clinical N category suffix for the tumor ***prior*** to the start of any therapy. Stage suffices identify special cases that need separate analysis. Suffices are adjuncts to and do not change the stage group.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2018 the CoC requires use of the AJCC 8th Edition Staging System in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

With the implementation of the 8th Edition storage codes are no longer utilized. Values and Labels for the different categories are exact matches to what is listed in the 8th Edition Manual (except for code 88). The new categories will be used for cases diagnosed in 2018 and later.

Coding Instructions

- Record the clinical N category suffix as documented by the first treating physician or the managing physician in the medical record.
- If the managing physician has not recorded the suffix when applicable, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
- If the tumor is not staged according to the AJCC manual, leave this data item blank.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.

Code	Label
(blank)	No information available; not recorded
(sn)	Sentinel node procedure with or without FNA or core needle biopsy
(f)	FNA or core needle biopsy only

AJCC TNM Clin M

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1003	15	1120-1134	Alphanumeric, Blank	2018+	01/18

Description

Identifies the presence or absence of distant metastasis (M) of the tumor known ***prior*** to the start of any therapy. Detailed site-specific values for the clinical T category suffix as defined by the current AJCC edition.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2018 the CoC requires use of the AJCC 8th Edition Staging System in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

With the implementation of the 8th Edition storage codes are no longer utilized. Values and Labels for the different categories are exact matches to what is listed in the 8th Edition Manual (except for code 88). The new categories will be used for cases diagnosed in 2018 and later.

Coding Instructions

- The clinical M category staging data item must be assigned for *Class of Case* 10-22.
- It is strongly recommended that the clinical M category staging data item be recorded for *Class of Case* 00 cases if the patient's workup at the facility allows assigning of clinical M.
- Record clinical M category as documented by the first treating physician or managing physician in the medical record.
- If the managing physician has not recorded clinical M category, registrars *will* assign this item based on the best available information, without necessarily requiring additional contact with the physician.
- Code 88 for clinical and pathological or post therapy T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
- If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
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Code	Label
(blank)	Not recorded
cM0	cM0
cM0(i+)	cM0(i+)
cM1	cM1
cM1a	cM1a
cM1a(0)	cM1a(0)
cM1a(1)	cM1a(1)
cM1b	cM1b
cM1b(0)	cM1b(0)
cM1b(1)	cM1b(1)
cM1c	cM1c
cM1c(0)	cM1c(0)
cM1c(1)	cM1c(1)
cM1d	cM1d
cM1d(0)	cM1d(0)
cM1d(1)	cM1d(1)

Code	Label
pM1	pM1
pM1a	pM1a
pM1a(0)	pM1a(0)
pM1a(1)	pM1a(1)
pM1b	pM1b
pM1b(0)	pM1b(0)
pM1b(1)	pM1b(1)
pM1c	pM1c
pM1c(0)	pM1c(0)
pM1c(1)	pM1c(1)
pM1d	pM1d
pM1d(0)	pM1d(0)
pM1d(1)	pM1d(1)
88	Not applicable

AJCC TNM Clin Stage Group

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1004	15	1135-1149	Alphanumeric, Blank	2018+	01/18

Description

Identifies the anatomic extent of disease based on the T, N, and M category data items known ***prior*** to the start of any therapy. Detailed site-specific values for the clinical stage group as defined by the current AJCC edition.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2018 the CoC requires use of the AJCC 8th Edition Staging System in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

With the implementation of the 8th Edition storage codes are still utilized for the stage groups only due to the decision to maintain Arabic numerals in the stage groups. New groups will be used for cases diagnosed in 2018 and later.

Coding Instructions

- Record the clinical stage group as documented by the first treating physician or the managing physician in the medical record.
- If the managing physician has not recorded the clinical stage, registrars *will* assign this item based on the best available information, without necessarily requiring additional contact with the physician.
- Code 88 for clinical and pathological or post therapy T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
- If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
- Convert all Roman numerals to Arabic numerals and use upper-case (capital letters) only.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.
- The valid codes and labels for the *AJCC Cancer Staging Manual, Eighth Edition* have been expanded and are now consistent for clarity. They are provided herein with permission from the American College of Surgeons (ACS) to support the data collection efforts of the CoC and NCDB. These codes and labels cannot be distributed, published, or incorporated into any software (including any electronic record systems), product, or publication without a written license agreement with ACS. The codes and labels cannot be modified, changed, or updated without the express written permission of ACS. Contact ajcc@facs.org for permission. Refer to the most current list of valid codes and labels: https://cancerstaging.org/Pages/Vendors.aspx.

Code	Label
(blank)	Not recorded
Occultcarcinoma	Occult carcinoma
0	0
0a	0a
0is	0is
1	I
1A	IA
1A1	IA1
1A2	IA2
1A3	IA3
1B	IB
1B1	IB1
1B2	IB2
1C	IC
1E	IE
1S	IS
1:0	I:0
1:1	I:1
1:2	I:2
1:3	I:3
1:4	I:4
1:5	I:5
1:6	I:6
1:7	I:7
1:8	I:8
1:9	I:9
1:10	I:10
1:11	I:11
1:12	I:12
1:13	I:13
1:14	I:14
1:15	I:15
1:16	I:16
1:17	I:17
1:18	I:18
1:19	I:19
1:20	I:20
1:21	I:21
1:22	I:22
1:23	I:23
1:24	I:24
1:25	I:25

Code	Label
2	II
2A	IIA
2A1	IIA1
2A2	IIA2
2B	IIB
2C	IIC
2E	IIE
2bulky	II bulky
2:0	II:0
2:1	II:1
2:2	II:2
2:3	II:3
2:4	II:4
2:5	II:5
2:6	II:6
2:7	II:7
2:8	II:8
2:9	II:9
2:10	II:10
2:11	II:11
2:12	II:12
2:13	II:13
2:14	II:14
2:15	II:15
2:16	II:16
2:17	II:17
2:18	II:18
2:19	II:19
2:20	II:20
2:21	II:21
2:22	II:22
2:23	II:23
2:24	II:24
2:25	II:25
3	III
3A	IIIA
3A1	IIIA1
3A2	IIIA2
3B	IIIB
3C	IIIC
3C1	IIIC1
3C2	IIIC2

Code	Label
3:0	III:0
3:1	III:1
3:2	III:2
3:3	III:3
3:4	III:4
3:5	III:5
3:6	III:6
3:7	III:7
3:8	III:8
3:9	III:9
3:10	III:10
3:11	III:11
3:12	III:12
3:13	III:13
3:14	III:14
3:15	III:15
3:16	III:16
3:17	III:17
3:18	III:18
3:19	III:19
3:20	III:20
3:21	III:21
3:22	III:22
3:23	III:23
3:24	III:24
3:25	III:25
4	IV
4A	IVA
4A1	IVA1
4A2	IVA2

Code	Label
4B	IVB
4C	IVC
4:0	IV:0
4:1	IV:1
4:2	IV:2
4:3	IV:3
4:4	IV:4
4:5	IV:5
4:6	IV:6
4:7	IV:7
4:8	IV:8
4:9	IV:9
4:10	IV:10
4:11	IV:11
4:12	IV:12
4:13	IV:13
4:14	IV:14
4:15	IV:15
4:16	IV:16
4:17	IV:17
4:18	IV:18
4:19	IV:19
4:20	IV:20
4:21	IV:21
4:22	IV:22
4:23	IV:23
4:24	IV:24
4:25	IV:25
88	Not applicable
99	Unknown

AJCC TNM Path T

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1011	15	1150-1164	Alphanumeric, Blank	2018+	01/18

Description

Evaluates the primary tumor (T) and reflects the tumor size and/or extension of the tumor known ***following*** the completion of surgical therapy. Detailed site-specific values for the pathological tumor (T) as defined by the current AJCC edition.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2018 the CoC requires use of the AJCC 8th Edition Staging System in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

With the implementation of the 8th Edition storage codes are no longer utilized. Values and Labels for the different categories are exact matches to what is listed in the 8th Edition Manual (except for code 88). The new categories will be used for cases diagnosed in 2018 and later.

Coding Instructions

- The pathological T category staging data item must be assigned for *Class of Case* 10-22.
- Assign pathological T as documented by the treating physician(s) or the managing physician in the medical record.
- If the managing physician has not recorded pathological T category, registrars *will* assign this item based on the best available information, without necessarily requiring additional contact with the physician.
- Code 88 for clinical and pathological or post therapy T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
- For lung, occult carcinoma is assigned TX.
- If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
- The valid codes and labels for the *AJCC Cancer Staging Manual, Eighth Edition* have been expanded and are now consistent for clarity. They are provided herein with permission from the American College of Surgeons (ACS) to support the data collection efforts of the CoC and NCDB. These codes and labels cannot be distributed, published, or incorporated into any software (including any electronic record systems), product, or publication without a written license agreement with ACS. The codes and labels cannot be modified, changed, or updated without the express written permission of ACS. Contact ajcc@facs.org for permission. Refer to the most current list of valid codes and labels: https://cancerstaging.org/Pages/Vendors.aspx.

Code	Label
(blank)	Not recorded
pTX	pTX
pT0	pT0
pTa	pTa
pTis	pTis
pTis(DCIS)	pTis(DCIS)
pTis(LAMN)	pTis(LAMN)
pTis(Paget)	pTis(Paget)
pT1	pT1
pT1mi	pT1mi
pT1a	pT1a
pT1a1	pT1a1
pT1a2	pT1a2
pT1b	pT1b
pT1b1	pT1b1
pT1b2	pT1b2
pT1c	pT1c
pT1c1	pT1c1
pT1c2	pT1c2
pT1c3	pT1c3
pT1d	pT1d
pT2	pT2
pT2a	pT2a
pT2a1	pT2a1
pT2a2	pT2a2
pT2b	pT2b
pT2c	pT2c
pT2d	pT2d
pT3	pT3
pT3a	pT3a
pT3b	pT3b
pT3c	pT3c
pT3d	pT3d
pT4	pT4
pT4a	pT4a
pT4b	pT4b
pT4c	pT4c
pT4d	pT4d
pT4e	pT4e

Code	Label
cTX	cTX
cT0	cT0
cTa	cTa
cTis	cTis
cTis(DCIS)	cTis(DCIS)
cTis(LAMN)	cTis(LAMN)
cTis(Paget)	cTis(Paget)
cT1	cT1
cT1mi	cT1mi
cT1a	cT1a
cT1a1	cT1a1
cT1a2	cT1a2
cT1b	cT1b
cT1b1	cT1b1
cT1b2	cT1b2
cT1c	cT1c
cT1c1	cT1c1
cT1c2	cT1c2
cT1c3	cT1c3
cT1d	cT1d
cT2	cT2
cT2a	cT2a
cT2a1	cT2a1
cT2a2	cT2a2
cT2b	cT2b
cT2c	cT2c
cT2d	cT2d
cT3	cT3
cT3a	cT3a
cT3b	cT3b
cT3c	cT3c
cT3d	cT3d
cT3e	cT3e
cT4	cT4
cT4a	cT4a
cT4b	cT4b
cT4c	cT4c
cT4d	cT4d
cT4e	cT4e

88	Not applicable

AJCC TNM Path T Suffix

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1032	4	1165-1168	(m), (s), Blank	2018+	01/18

Description

Identifies the AJCC TMN pathological T category suffix for the tumor ***following*** the completion of surgical therapy. Stage suffices identify special cases that need separate analysis. Suffices are adjuncts to and do not change the stage group.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2008 the CoC requires that AJCC clinical TNM staging be recorded in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

- Record the pathological stage T category suffix as documented by the first treating physician or the managing physician in the medical record.
- If the managing physician has not recorded the descriptor, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
- If the tumor is not staged according to the AJCC manual, leave this data item blank.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.

Code	Label
(blank)	No information available; not recorded
(m)	Multiple synchronous tumors OR Multifocal tumor (differentiated and anaplastic thyroid only)
(s)	Solitary tumor (differentiated and anaplastic thyroid only)

AJCC TNM Path N

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1012	15	1169-1183	Alphanumeric, Blank	2018+	01/18

Description

Identifies the absence or presence of regional lymph node (N) metastasis and describes the extent of regional lymph node metastasis of the tumor known ***following*** the completion of surgical therapy.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2018 the CoC requires use of the AJCC 8th Edition Staging System in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

With the implementation of the 8th Edition storage codes are no longer utilized. Values and Labels for the different categories are exact matches to what is listed in the 8th Edition Manual (except for code 88). The new categories will be used for cases diagnosed in 2018 and later.

Coding Instructions

- The pathological N category staging data item must be assigned for *Class of Case* 10-22.
- Assign pathological N category as documented by the treating physician(s) or managing physician in the medical record.
- If the managing physician has not recorded pathological N category, registrars *will* assign this item based on the best available information, without necessarily requiring additional contact with the physician.
- Code 88 for clinical and pathological or post therapy T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
- If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.
- The valid codes and labels for the *AJCC Cancer Staging Manual, Eighth Edition* have been expanded and are now consistent for clarity. They are provided herein with permission from the American College of Surgeons (ACS) to support the data collection efforts of the CoC and NCDB. These codes and labels cannot be distributed, published, or incorporated into any software (including any electronic record systems), product, or publication without a written license agreement with ACS. The codes and labels cannot be modified, changed, or updated without the express written permission of ACS. Contact ajcc@facs.org for permission. Refer to the most current list of valid codes and labels: https://cancerstaging.org/Pages/Vendors.aspx.

Code	Label
(blank)	Not recorded
pNX	pNX
pN0	pN0
pN0(i+)	pN0(i+)
pN0(mol+)	pN0(mol+)
pN0a	pN0a
pN1	pN1
pN1mi	pN1mi
pN1a(sn)	pN1a(sn)
pN1a	pN1a
pN1b	pN1b
pN1c	pN1c
pN2	pN2
pN2mi	pN2mi
pN2a	pN2a
pN2b	pN2b
pN2c	pN2c
pN3	pN3
pN3a	pN3a
pN3b	pN3b
pN3c	pN3c

Code	Label
cNX	cNX
cN0	cN0
cN0a	cN0a
cN0b	cN0b
cN0(i+)	cN0(i+)
cN1	cN1
cN1mi	cN1mi
cN1a	cN1a
cN1b	cN1b
cN1c	cN1c
cN2	cN2
cN2mi	cN2mi
cN2a	cN2a
cN2b	cN2b
cN2c	cN2c
cN3	cN3
cN3a	cN3a
cN3b	cN3b
cN3c	cN3c
88	Not applicable

AJCC TNM Path N Suffix

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1035	4	1184-1187	(sn), (f), Blank	2018+	01/18

Description

Identifies the AJCC TNM pathological N suffix for the tumor ***following*** the completion of surgical therapy. Stage suffices identify special cases that need separate analysis. Suffices are adjuncts to and do not change the stage group.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2008 the CoC requires that AJCC pathological TNM staging be recorded in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

- Record the pathological N category suffix as documented by the first treating physician or the managing physician in the medical record.
- If the managing physician has not recorded the descriptor, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
- If the tumor is not staged according to the AJCC manual, leave this data item blank.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.

Code	Label
(blank)	No information available; not recorded
(sn)	Sentinel node procedure with or without FNA or core needle biopsy
(f)	FNA or core needle biopsy only

AJCC TNM Path M

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1013	15	1188- 1202	Alphanumeric, Blank	2018+	01/18

Description

Identifies the presence or absence of distant metastasis (M) of the tumor known ***following*** the completion of surgical therapy.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2018 the CoC requires use of the AJCC 8th Edition Staging System in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

With the implementation of the 8th Edition storage codes are no longer utilized. Values and Labels for the different categories are exact matches to what is listed in the 8th Edition Manual (except for code 88). The new categories will be used for cases diagnosed in 2018 and later.

Coding Instructions

- The pathological M category staging data item must be assigned for *Class of Case* 10-22.
- Assign pathological M category as documented by the treating physician(s) or the managing physician in the medical record.
- If the managing physician has not recorded pathological M category, registrars *will* assign this item based on the best available information, without necessarily requiring additional contact with the physician.
- Code 88 for clinical and pathological or post therapy T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
- If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.
- The valid codes and labels for the *AJCC Cancer Staging Manual, Eighth Edition* have been expanded and are now consistent for clarity. They are provided herein with permission from the American College of Surgeons (ACS) to support the data collection efforts of the CoC and NCDB. These codes and labels cannot be distributed, published, or incorporated into any software (including any electronic record systems), product, or publication without a written license agreement with ACS. The codes and labels cannot be modified, changed, or updated without the express written permission of ACS. Contact ajcc@facs.org for permission. Refer to the most current list of valid codes and labels: https://cancerstaging.org/Pages/Vendors.aspx.

Code	Label
(blank)	Not recorded
cM0	cM0
cM0(i+)	cM0(i+)
cM1	cM1
cM1a	cM1a
cM1a(0)	cM1a(0)
cM1a(1)	cM1a(1)
cM1b	cM1b
cM1b(0)	cM1b(0)
cM1b(1)	cM1b(1)
cM1c	cM1c
cM1c(0)	cM1c(0)
cM1c(1)	cM1c(1)
cM1d	cM1d
cM1d(0)	cM1d(0)
cM1d(1)	cM1d(1)

Code	Label
pM1	pM1
pM1a	pM1a
pM1a(0)	pM1a(0)
pM1a(1)	pM1a(1)
pM1b	pM1b
pM1b(0)	pM1b(0)
pM1b(1)	pM1b(1)
pM1c	pM1c
pM1c(0)	pM1c(0)
pM1c(1)	pM1c(1)
pM1d	pM1d
pM1d(0)	pM1d(0)
pM1d(1)	pM1d(1)
88	Not applicable

AJCC TNM Path Stage Group

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1014	15	1203-1217	Alphanumeric, Blank	2018+	01/18

Description

Identifies the anatomic extent of disease based on the T, N, and M category data items known ***following*** the completion of surgical therapy.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2015 the CoC requires that AJCC pathological TNM staging be recorded in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

- Record the pathological stage group as documented by the treating physician(s) or the managing physician in the medical record.
- If the managing physician has not recorded the pathological stage, registrars *will* assign this item based on the best available information, without necessarily requiring additional contact with the physician(s).
- Code 88 for clinical and pathological or post therapy T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
- If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
- Convert all Roman numerals to Arabic numerals and use upper-case (capital letters) only.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.
- The valid codes and labels for the *AJCC Cancer Staging Manual, Eighth Edition* have been expanded and are now consistent for clarity. They are provided herein with permission from the American College of Surgeons (ACS) to support the data collection efforts of the CoC and NCDB. These codes and labels cannot be distributed, published, or incorporated into any software (including any electronic record systems), product, or publication without a written license agreement with ACS. The codes and labels cannot be modified, changed, or updated without the express written permission of ACS. Contact ajcc@facs.org for permission. Refer to the most current list of valid codes and labels: https://cancerstaging.org/Pages/Vendors.aspx.

Code	Label
(blank)	Not recorded
OccultCarcinoma	Occult carcinoma
0	0

Code	Label
0is	0is
0a	0a
1	I

Code	Label
1A	IA
1A1	IA1
1A2	IA2
1A3	IA3
1B	IB
1B1	IB1
1B2	IB2
1C	IC
1E	IE
1S	IS
1:0	I:0
1:1	I:1
1:2	I:2
1:3	I:3
1:4	I:4
1:5	I:5
1:6	I:6
1:7	I:7
1:8	I:8
1:9	I:9
1:10	I:10
1:11	I:11
1:12	I:12
1:13	I:13
1:14	I:14
1:15	I:15
1:16	I:16
1:17	I:17
1:18	I:18
1:19	I:19
1:20	I:20
1:21	I:21
1:22	I:22
1:23	I:23
1:24	I:24
1:25	I:25
2	II
2A	IIA
2A1	IIA1
2A2	IIA2
2B	IIB
2C	IIC

Code	Label
2E	IIE
2bulky	II bulky
2:0	II:0
2:1	II:1
2:2	II:2
2:3	II:3
2:4	II:4
2:5	II:5
2:6	II:6
2:7	II:7
2:8	II:8
2:9	II:9
2:10	II:10
2:11	II:11
2:12	II:12
2:13	II:13
2:14	II:14
2:15	II:15
2:16	II:16
2:17	II:17
2:18	II:18
2:19	II:19
2:20	II:20
2:21	II:21
2:22	II:22
2:23	II:23
2:24	II:24
2:25	II:25
3	III
3A	IIIA
3A1	IIIA1
3A2	IIIA2
3B	IIIB
3C	IIIC
3C1	IIIC1
3C2	IIIC2
3D	IIID
3:0	III:0
3:1	III:1
3:2	III:2
3:3	III:3
3:4	III:4

Code	Label
3:5	III:5
3:6	III:6
3:7	III:7
3:8	III:8
3:9	III:9
3:10	III:10
3:11	III:11
3:12	III:12
3:13	III:13
3:14	III:14
3:15	III:15
3:16	III:16
3:17	III:17
3:18	III:18
3:19	III:19
3:20	III:20
3:21	III:21
3:22	III:22
3:23	III:23
3:24	III:24
3:25	III:25
4	IV
4A	IVA
4B	IVB
4C	IVC
4:0	IV:0
4:1	IV:1

Code	Label
4:2	IV:2
4:3	IV:3
4:4	IV:4
4:5	IV:5
4:6	IV:6
4:7	IV:7
4:8	IV:8
4:9	IV:9
4:10	IV:10
4:11	IV:11
4:12	IV:12
4:13	IV:13
4:14	IV:14
4:15	IV:15
4:16	IV:16
4:17	IV:17
4:18	IV:18
4:19	IV:19
4:20	IV:20
4:21	IV:21
4:22	IV:22
4:23	IV:23
4:24	IV:24
4:25	IV:25
88	Not applicable
99	Unknown

AJCC TNM Post Therapy T

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1021	15	1218-1232	Alphanumeric, Blank	2018+	01/18

Description

Evaluates the primary tumor (T) and reflects the tumor size and/or extension of the tumor known following the completion of **neoadjuvant** therapy (satisfying the definition for that disease site) and planned **post-neoadjuvant therapy surgical resection**.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2018 the CoC requires use of the AJCC 8th Edition Staging System in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

With the implementation of the 8th Edition storage codes are no longer utilized. Values and Labels for the different categories are exact matches to what is listed in the 8th Edition Manual (except for code 88). The new categories will be used for cases diagnosed in 2018 and later.

Coding Instructions

- The post therapy T category staging data item must be assigned for *Class of Case* 10-22.
- Assign post therapy T category as documented by the treating physician(s) or the managing physician in the medical record.
- If the managing physician has not recorded post therapy T category, registrars *will* assign this item based on the best available information, without necessarily requiring additional contact with the physician.
- Code 88 for clinical and pathological or post therapy T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
- For lung, occult carcinoma is assigned TX.
- If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.
- The valid codes and labels for the *AJCC Cancer Staging Manual, Eighth Edition* have been expanded and are now consistent for clarity. They are provided herein with permission from the American College of Surgeons (ACS) to support the data collection efforts of the CoC and NCDB. These codes and labels cannot be distributed, published, or incorporated into any software (including any electronic record systems), product, or publication without a written license agreement with ACS. The codes and labels cannot be modified, changed, or updated without

the express written permission of ACS. Contact ajcc@facs.org for permission. Refer to the most current list of valid codes and labels: https://cancerstaging.org/Pages/Vendors.aspx.

Code	Label
(blank)	Not recorded
ypTX	ypTX
ypT0	ypT0
ypTa	ypTa
ypTis	ypTis
ypTis(DCIS)	ypTis(DCIS)
ypTis(LAMN)	ypTis(LAMN)
ypTis(Paget)	ypTis(Paget)
ypT1	ypT1
ypT1mi	ypT1mi
ypT1a	ypT1a
ypT1a1	ypT1a1
ypT1a2	ypT1a2
ypT1b	ypT1b
ypT1b1	ypT1b1
ypT1b2	ypT1b2
ypT1c	ypT1c
ypT1c1	ypT1c1
ypT1c2	ypT1c2
ypT1c3	ypT1c3

Code	Label
ypT1d	ypT1d
ypT2	ypT2
ypT2a	ypT2a
ypT2a1	ypT2a1
ypT2a2	ypT2a2
ypT2b	ypT2b
ypT2c	ypT2c
ypT2d	ypT2d
ypT3	ypT3
ypT3a	ypT3a
ypT3b	ypT3b
ypT3c	ypT3c
ypT3d	ypT3d
ypT4	ypT4
ypT4a	ypT4a
ypT4b	ypT4b
ypT4c	ypT4c
ypT4d	ypT4d
ypT4e	ypT4e
88	Not applicable

AJCC TNM Post Therapy T Suffix

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1033	4	1233-1236	(m), (s), Blank	2018+	01/18

Description

Identifies the AJCC TNM post therapy T category suffix for the known following the completion of **neoadjuvant** therapy (satisfying the definition for that disease site) and planned **post-neoadjuvant therapy surgical resection**. Stage suffices identify special cases that need separate analysis. Suffices are adjuncts to and do not change the stage group.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2008 the CoC requires that AJCC clinical TNM staging be recorded in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

- Record the post therapy T category suffix as documented by the first treating physician or the managing physician in the medical record.
- If the managing physician has not recorded the post therapy T category suffix, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
- If the tumor is not staged according to the AJCC manual, leave this data item blank.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.

Code	Label
(blank)	No information available; not recorded
(m)	Multiple synchronous tumors OR Multifocal tumor (differentiated and anaplastic thyroid only)
(s)	Solitary tumor (differentiated and anaplastic thyroid only)

AJCC TNM Post Therapy N

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1022	15	1237-1251	Alphanumeric, Blank	2018+	01/18

Description

Identifies the absence or presence of regional lymph node (N) metastasis and describes the extent of lymph node metastasis of the tumor known following the completion of **neoadjuvant** therapy (satisfying the definition for that disease site) and planned **post-neoadjuvant therapy surgical resection**.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2018 the CoC requires use of the AJCC 8th Edition Staging System in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

With the implementation of the 8th Edition storage codes are no longer utilized. Values and Labels for the different categories are exact matches to what is listed in the 8th Edition Manual (except for code 88). The new categories will be used for cases diagnosed in 2018 and later.

Coding Instructions

- The post therapy N category staging data item must be assigned for *Class of Case* 10-22.
- Assign post therapy N category as documented by the treating physician(s) or managing physician in the medical record.
- If the managing physician has not recorded post therapy N category, registrars *will* assign this item based on the best available information, without necessarily requiring additional contact with the physician.
- Code 88 for clinical and pathological or post therapy T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
- If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.
- The valid codes and labels for the *AJCC Cancer Staging Manual, Eighth Edition* have been expanded and are now consistent for clarity. They are provided herein with permission from the American College of Surgeons (ACS) to support the data collection efforts of the CoC and NCDB. These codes and labels cannot be distributed, published, or incorporated into any software (including any electronic record systems), product, or publication without a written license agreement with ACS. The codes and labels cannot be modified, changed, or updated without the express written permission of ACS. Contact ajcc@facs.org for permission. Refer to the most current list of valid codes and labels: https://cancerstaging.org/Pages/Vendors.aspx.

Code	Label
(blank)	Not recorded
ypNX	ypNX
ypN0	ypN0
ypN0(i+)	ypN0(i+)
ypN0(mol+)	ypN0(mol+)
ypN0a	ypN0a
ypN1	ypN1
ypN1mi	ypN1mi
ypN1a(sn)	ypN1a(sn)
ypN1a	ypN1a
ypN1b	ypN1b

Code	Label
ypN1c	ypN1c
ypN2	ypN2
ypN2mi	ypN2mi
ypN2a	ypN2a
ypN2b	ypN2b
ypN2c	ypN2c
ypN3	ypN3
ypN3a	ypN3a
ypN3b	ypN3b
ypN3c	ypN3c
88	Not applicable

AJCC TNM Post Therapy N Suffix

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1036	4	1252-1255	(sn), (f), Blank	2018+	01/18

Description

Identifies the AJCC TNM post therapy N suffix for the tumor known following the completion of **neoadjuvant** therapy (satisfying the definition for that disease site) and planned **post-neoadjuvant therapy surgical resection**. Stage suffices identify special cases that need separate analysis. Suffices are adjuncts to and do not change the stage group.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2008 the CoC requires that AJCC clinical TNM staging be recorded in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

- Record the post therapy N category suffix as documented by the first treating physician or the managing physician in the medical record.
- If the managing physician has not recorded the post therapy N category suffix, registrars will assign this item based on the best available information, without necessarily requiring additional contact with the physician.
- If the tumor is not staged according to the AJCC manual, leave this data item blank.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.

Code	Label
(blank)	No information available; not recorded
(sn)	Sentinel node procedure with or without FNA or core needle biopsy
(f)	FNA or core needle biopsy only

AJCC TNM Post Therapy M

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1023	15	1256-1270	Alphanumeric, Blank	2018+	01/18

Description

Identifies the presence or absence of distant metastasis (M) of the tumor known following the completion of **neoadjuvant** therapy (satisfying the definition for that disease site) and planned **post-neoadjuvant therapy surgical resection**.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2018 the CoC requires use of the AJCC 8th Edition Staging System in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

With the implementation of the 8th Edition storage codes are no longer utilized. Values and Labels for the different categories are exact matches to what is listed in the 8th Edition Manual (except for code 88). The new categories will be used for cases diagnosed in 2018 and later.

Coding Instructions

- The post therapy M category staging data item must be assigned for *Class of Case* 10-22.
- Assign post therapy M category as documented by the treating physician(s) or the managing physician in the medical record.
- If the managing physician has not recorded post therapy M category, registrars *will* assign this item based on the best available information, without necessarily requiring additional contact with the physician.
- Code 88 for clinical and pathological or post therapy T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
- If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.
- The valid codes and labels for the *AJCC Cancer Staging Manual, Eighth Edition* have been expanded and are now consistent for clarity. They are provided herein with permission from the American College of Surgeons (ACS) to support the data collection efforts of the CoC and NCDB. These codes and labels cannot be distributed, published, or incorporated into any software (including any electronic record systems), product, or publication without a written license agreement with ACS. The codes and labels cannot be modified, changed, or updated without the express written permission of ACS. Contact ajcc@facs.org for permission. Refer to the most current list of valid codes and labels: https://cancerstaging.org/Pages/Vendors.aspx.

Code	Label
(blank)	Not recorded
cM0	cM0
cM0(i+)	cM0(i+)
cM1	cM1
cM1a	cM1a
cM1a(0)	cM1a(0)
cM1a(1)	cM1a(1)
cM1b	cM1b
cM1b(0)	cM1b(0)
cM1b(1)	cM1b(1)
cM1c	cM1c
cM1c(0)	cM1c(0)
cM1c(1)	cM1c(1)
cM1d	cM1d
cM1d(0)	cM1d(0)
cM1d(1)	cM1d(1)

Code	Label
pM1	pM1
pM1a	pM1a
pM1a(0)	pM1a(0)
pM1a(1)	pM1a(1)
pM1b	pM1b
pM1b(0)	pM1b(0)
pM1b(1)	pM1b(1)
pM1c	pM1c
pM1c(0)	pM1c(0)
pM1c(1)	pM1c(1)
pM1d	pM1d
pM1d(0)	pM1d(0)
pM1d(1)	pM1d(1)
88	Not applicable

AJCC TNM Post Therapy Stage Group

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1024	15	1271-1285	Alphanumeric, Blank	2018+	01/18

Description

Identifies the anatomic extent of disease based on the T, N, and M category data items of the tumor known following the completion of **neoadjuvant** therapy (satisfying the definition for that disease site) and planned **post-neoadjuvant therapy surgical resection**.

Rationale

The CoC requires that AJCC TNM staging be used in its accredited cancer programs. Effective January 1, 2015 the CoC requires that AJCC pathological TNM staging be recorded in its accredited program cancer registries. The AJCC developed this staging system for evaluating trends in the treatment and control of cancer. This staging system is used by physicians to estimate prognosis, plan treatment, evaluate new types of therapy, analyze outcomes, design follow-up strategies, and to assess early detection results.

Coding Instructions

- Record the post therapy stage group as documented by the treating physician(s) or the managing physician in the medical record.
- If the managing physician has not recorded the post therapy stage, registrars *will* assign this item based on the best available information, without necessarily requiring additional contact with the physician(s).
- Code 88 for clinical and pathological or post therapy T, N, and M as well as stage group if a site/histology combination is not defined in the current AJCC edition and for in situ tumors that are not staged according to the current AJCC edition.
- If the value does not fill all 15 characters, then record the value to the left and leave the remaining spaces blank.
- Convert all Roman numerals to Arabic numerals and use upper-case (capital letters) only.
- Refer to the current *AJCC Cancer Staging Manual* for staging rules.
- The valid codes and labels for the *AJCC Cancer Staging Manual, Eighth Edition* have been expanded and are now consistent for clarity. They are provided herein with permission from the American College of Surgeons (ACS) to support the data collection efforts of the CoC and NCDB. These codes and labels cannot be distributed, published, or incorporated into any software (including any electronic record systems), product, or publication without a written license agreement with ACS. The codes and labels cannot be modified, changed, or updated without the express written permission of ACS. Contact ajcc@facs.org for permission. Refer to the most current list of valid codes and labels: https://cancerstaging.org/Pages/Vendors.aspx.

Code	Label
(blank)	Not recorded
Occultcarcinoma	Occult carcinoma
0	0
0is	0is
0a	0a
1	I
1A	IA
1A1	IA1
1A2	IA2
1A3	IA3
1B	IB
1B1	IB1
1B2	IB2
1C	IC
1S	IS
1:0	I:0
1:1	I:1
1:2	I:2
1:3	I:3
1:4	I:4
1:5	I:5
1:6	I:6
1:7	I:7
1:8	I:8
1:9	I:9
1:10	I:10
1:11	I:11
1:12	I:12
1:13	I:13
1:14	I:14
1:15	I:15
1:16	I:16
1:17	I:17
1:18	I:18
1:19	I:19
1:20	I:20
1:21	I:21
1:22	I:22
1:23	I:23
1:24	I:24
1:25	I:25
2	II

Code	Label
2A	IIA
2A1	IIA1
2A2	IIA2
2B	IIB
2C	IIC
2:0	II:0
2:1	II:1
2:2	II:2
2:3	II:3
2:4	II:4
2:5	II:5
2:6	II:6
2:7	II:7
2:8	II:8
2:9	II:9
2:10	II:10
2:11	II:11
2:12	II:12
2:13	II:13
2:14	II:14
2:15	II:15
2:16	II:16
2:17	II:17
2:18	II:18
2:19	II:19
2:20	II:20
2:21	II:21
2:22	II:22
2:23	II:23
2:24	II:24
2:25	II:25
3	III
3A	IIIA
3A1	IIIA1
3A2	IIIA2
3B	IIIB
3C	IIIC
3C1	IIIC1
3C2	IIIC2
3D	IIID
3:0	III:0
3:1	III:1

Code	Label
3:2	III:2
3:3	III:3
3:4	III:4
3:5	III:5
3:6	III:6
3:7	III:7
3:8	III:8
3:9	III:9
3:10	III:10
3:11	III:11
3:12	III:12
3:13	III:13
3:14	III:14
3:15	III:15
3:16	III:16
3:17	III:17
3:18	III:18
3:19	III:19
3:20	III:20
3:21	III:21
3:22	III:22
3:23	III:23
3:24	III:24
3:25	III:25
4	IV
4A	IVA
4B	IVB
4C	IVC

Code	Label
4:0	IV:0
4:1	IV:1
4:2	IV:2
4:3	IV:3
4:4	IV:4
4:5	IV:5
4:6	IV:6
4:7	IV:7
4:8	IV:8
4:9	IV:9
4:10	IV:10
4:11	IV:11
4:12	IV:12
4:13	IV:13
4:14	IV:14
4:15	IV:15
4:16	IV:16
4:17	IV:17
4:18	IV:18
4:19	IV:19
4:20	IV:20
4:21	IV:21
4:22	IV:22
4:23	IV:23
4:24	IV:24
4:25	IV:25
88	Not applicable
99	Unknown

Site-Specific Data Items

For cases diagnosed on January 1, 2018 and later, use of the Collaborative Stage (CS) Site-Specific Factors (SSF's) is discontinued, and Site-Specific Data Items (SSDIs) are used for collection of site-specific information.

For cases diagnosed on January 1, 2018 and later, the Site-Specific Data Items in the below table are required by CoC. Data items are listed by their respective NAACCR Data Item Number and Name.

- Please see the SSDI Manual at the following URL for detailed descriptions, rationales, coding instructions and site-specific coding rules: https://www.naaccr.org/SSDI/SSDI-Manual.pdf.

Item #	Site-Specific Data Item
3803	Adenoid Cystic Basaloid Pattern
3804	Adenopathy
3805	AFP Post-Orchiectomy Lab Value
3806	AFP Post-Orchiectomy Range
3807	AFP Pre-Orchiectomy Lab Value
3808	AFP Pre-Orchiectomy Range
3809	AFP Pretreatment Interpretation
3810	AFP Pretreatment Lab Value
3811	Anemia
3812	B symptoms
3813	Bilirubin Pretreatment Total Lab Value
3814	Bilirubin Pretreatment Unit of Measure
3815	Bone Invasion
3817	Breslow Tumor Thickness
3818	CA-125 Pretreatment Interpretation
3819	CEA Pretreatment Interpretation
3820	CEA Pretreatment Lab Value
3821	Chromosome 3 Status
3822	Chromosome 8q Status
3823	Circumferential Resection Margin (CRM)
3824	Creatinine Pretreatment Lab Value
3825	Creatinine Pretreatment Unit of Measure
3826	Estrogen Receptor Percent Positive or Range
3827	Estrogen Receptor Summary
3828	Estrogen Receptor Total Allred Score
3829	Esophagus and EGJ Tumor Epicenter
3830	Extranodal Extension Clin (non-Head and Neck)
3831	Extranodal Extension Head and Neck Clinical
3832	Extranodal Extension Head and Neck Pathological
3833	Extranodal Extension Path (non-Head and Neck)
3834	Extravascular Matrix Patterns
3835	Fibrosis Score

Item #	Site-Specific Data Item
3836	FIGO Stage
3837	Gestational Trophoblastic Prognostic Scoring Index
3838	Gleason Patterns Clinical
3839	Gleason Patterns Pathological
3840	Gleason Score Clinical
3841	Gleason Score Pathological
3842	Gleason Tertiary Pattern
3843	Grade Clinical
3844	Grade Pathological
3845	Grade Post Therapy
3846	hCG Post-Orchiectomy Lab Value
3847	hCG Post-Orchiectomy Range
3848	hCG Pre-Orchiectomy Lab Value
3849	hCG Pre-Orchiectomy Range
3850	HER2 IHC Summary
3851	HER2 ISH Dual Probe Copy Number
3852	HER2 ISH Dual Probe Ratio
3853	HER2 ISH Single Probe Copy Number
3854	HER2 ISH Summary
3855	HER2 Overall Summary
3856	Heritable Trait
3857	High Risk Cytogenetics
3858	High Risk Histologic Features
3859	HIV Status
3860	International Normalized Ratio Prothrombin Time
3861	Ipsilateral Adrenal Gland Involvement
3862	JAK2
3863	Ki-67
3864	Invasion Beyond Capsule
3865	KIT Gene Immunohistochemistry
3866	KRAS
3867	LDH Post-Orchiectomy Range
3868	LDH Pre-Orchiectomy Range
3869	LDH Pretreatment Level
3870	LDH Upper Limits of Normal
3871	LN Assessment Method Femoral-Inguinal
3872	LN Assessment Method Para-Aortic

Item #	Site-Specific Data Item
3873	LN Assessment Method Pelvic
3874	LN Distant Assessment Method
3875	LN Distant: Mediastinal, Scalene
3876	LN Head and Neck Levels I-III
3877	LN Head and Neck Levels IV-V
3878	LN Head and Neck Levels VI-VII
3879	LN Head and Neck Other
3880	LN Isolated Tumor Cells (ITC)
3881	LN Laterality
3882	LN Positive Axillary Level I-II
3883	LN Size
3884	LN Status Femoral-Inguinal, Para-Aortic, Pelvic
3885	Lymphocytosis
3886	Major Vein Involvement
3887	Measured Basal Diameter
3888	Measured Thickness
3889	Methylation of O6-Methylguanine-Methyltransferase
3890	Microsatellite Instability (MSI)
3891	Microvascular Density
3892	Mitotic Count Uveal Melanoma
3893	Mitotic Rate Melanoma
3894	Multigene Signature Method
3895	Multigene Signature Results
3896	NCCN International Prognostic Index (IPI)
3897	Number of Cores Examined
3898	Number of Cores Positive
3899	Number of Examined Para-Aortic Nodes
3900	Number of Examined Pelvic Nodes
3901	Number of Positive Para-Aortic Nodes
3902	Number of Positive Pelvic Nodes
3903	Oncotype Dx Recurrence Score-DCIS
3904	Oncotype Dx Recurrence Score-Invasive
3905	Oncotype Dx Risk Level-DCIS

Item #	Site-Specific Data Item
3906	Oncotype Dx Risk Level-Invasive
3907	Organomegaly
3908	Percent Necrosis Post Neoadjuvant
3909	Perineural Invasion
3910	Peripheral Blood Involvement
3911	Peritoneal Cytology
3913	Pleural Effusion
3914	Progesterone Receptor Percent Positive or Range
3915	Progesterone Receptor Summary
3916	Progesterone Receptor Total Allred Score
3917	Primary Sclerosing Cholangitis
3918	Profound Immune Suppression
3919	Prostate Pathological Extension
3920	PSA (Prostatic Specific Antigen) Lab Value
3921	Residual Tumor Volume Post Cytoreduction
3922	Response to Neoadjuvant Therapy
3923	S Category Clinical
3924	S Category Pathological
3925	Sarcomatoid Features
3926	Schema Discriminator 1
3927	Schema Discriminator 2
3928	Schema Discriminator 3
3929	Separate Tumor Nodules
3930	Serum Albumin Pretreatment Level
3931	Serum Beta-2 Microglobulin Pretreatment Level
3932	LDH Pretreatment Lab Value
3933	Thrombocytopenia
3934	Tumor Deposits
3935	Tumor Growth Pattern
3936	Ulceration
3937	Visceral and Parietal Pleural Invasion

First Course of Treatment

Date of First Course of Treatment

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1270	8	2104-2111	CCYYMMDD, Blank	2003+	01/10, 01/11

Description

Records the date on which treatment (surgery, radiation, systemic, or other therapy) of the patient began at any facility.

Rationale

It is important to be able to measure the delay between diagnosis and the onset of treatment. A secondary use for this date is as a starting point for survival statistics (rather than using the diagnosis date). This date cannot be calculated from the respective first course treatment modality dates if no treatment was given. Therefore, providing the date on which active surveillance is chosen, a physician decides not to treat a patient, or a patient's family or guardian declines treatment is important.

Coding Instructions

- Record the earliest of the following dates: Date of First Surgical Procedure [1200], Date Radiation Started [1210], Date Systemic Therapy Started [3230], or Date Other Treatment Started [1250].
- If active surveillance or watchful waiting is selected as the first course of treatment (*RX Summ–Treatment Status* [1285] = 2) record the date this decision is made.
- In cases of non-treatment (*RX Summ–Treatment Status* [1285] = 0), in which a physician decides not to treat a patient or a patient's family or guardian declines all treatment, the date of first course of treatment is the date this decision was made.
- Leave this item blank if the cancer was diagnosed at autopsy and not suspected prior to that.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date of First Course of Treatment* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of First Course of Treatment* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *Date 1st Crs Rx Flag* [1271] is used to explain why *Date of First Course of Treatment* is not a known date. See Date 1st Crs Rx Flag for an illustration of the relationships among these items.

Examples

Code	Reason
20040214	A patient has a core biopsy on February 12, 2004, and subsequently undergoes an excisional biopsy on February 14, 2004.
20050421	A patient begins receiving preoperative radiation therapy elsewhere on April 21, 2005, and subsequent surgical therapy at this facility on June 2, 2005.

Date 1st Crs Rx Flag

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1271	2	2112-2113	10-12, Blank	2010+	01/12, 01/15

Description

This flag explains why there is no appropriate value in the corresponding date field, *Date of First Course of Treatment* [1270].

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

- Leave this item blank if *Date of First Course of Treatment* [1270] has a full or partial date recorded.
- Code 12 if the *Date of First Course of Treatment* cannot be determined at all, but the patient did receive first course treatment.
- Code 12 if a decision not to treat was made, but the date is totally unknown.
- Code 12 if a decision to use active surveillance was made, but the date is totally unknown.
- Code 10 if it is unknown whether any treatment was administered.
- Code 11 if the initial diagnosis was at autopsy.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Definition
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any treatment was given).
11	No proper value is applicable in this context (that is, autopsy only).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (for example, treatment was given but the date is unknown).
(blank)	A valid date value is provided in item *Date of First Course of Treatment* [1270].

Rx Summ – Treatment Status

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1285	1	2224-2224	0-2, 9	2010+	01/11

Description

This data item summarizes whether the patient received any treatment or the tumor was under active surveillance.

Rationale

This item documents active surveillance (watchful waiting) and eliminates searching each treatment modality to determine whether treatment was given. It is used in conjunction with *Date of First Course of Treatment* [1270] to document whether treatment was or was not given, it is unknown if treatment was given, or treatment was given on an unknown date.

Coding Instructions

- This item may be left blank for cases diagnosed prior to 2010.
- Treatment given after a period of active surveillance is considered subsequent treatment, and it is not coded in this item.
- Use code 0 when treatment is refused or the physician decides not to treat for any reason such as the presence of comorbidities.

Code	Label
0	No treatment given
1	Treatment given
2	Active surveillance (watchful waiting)
9	Unknown if treatment was given

Examples

Code	Reason
0	An elderly patient with pancreatic cancer requested no treatment.
0	Patient is expected to receive radiation, but it has not occurred yet (*Reason for No Radiation* [1430] = 8)
2	Treatment plan for a lymphoma patient is active surveillance.

Surgery Data Items

Date of First Surgical Procedure

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1200	8	2114-2121	CCYYMMDD	<1996, 2002+	01/10, 01/11

Description

Records the earliest date on which any first course surgical procedure was performed. Formerly called "Date of Cancer-Directed Surgery."

Rationale

This item can be used to sequence multiple treatment modalities and to evaluate the time intervals between treatments.

Coding Instructions

- Record the date of the first surgical procedure of the types coded as *Surgical Procedure of Primary Site* [1290], *Scope of Regional Lymph Node Surgery* [1292] or *Surgical Procedure/Other Site* [1294] performed at this or any facility.
- The date in this item may be the same as that in *Date of Most Definitive Surgical Resection of the Primary Site* [3170], if the patient received only one surgical procedure and it was a resection of the primary site.
- If surgery is the first or only treatment administered to the patient, then the date of surgery should be the same as the date entered into the item *Date of First Course Treatment* [1270].
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date of First Surgical Procedure* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of First Surgical Procedure* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *Rx Date–Surgery Flag* [1201] is used to explain why *Date of First Surgical Procedure* is not a known date. See *Rx Date–Surgery Flag* for an illustration of the relationships among these items.

Examples

Code	Reason
20080323	A melanoma patient had an excisional biopsy on March 23, 2008, then a wide excision on March 28, 2008.
20091116	The patient had a small (0.5 cm) lump removed from her breast on November 16, 2009.
20070327	The patient's primary tumor was treated with radiation beginning on April 16, 2007, after a distant metastasis was removed surgically on March 27, 2007.

Rx Date–Surgery Flag

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1201	2	2122-2123	10-12, Blank	2010+	01/10

Description

This flag explains why there is no appropriate value in the corresponding date field, *Date of First Surgical Procedure* [1200].

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

- Leave this item blank if *Date of First Surgical Procedure* [1200] has a full or partial date recorded.
- Code 12 if the *Date of First Surgical Procedure* cannot be determined, but the patient did receive first course surgery.
- Code 10 if it is unknown whether any surgery was performed.
- Code 11 if no surgical procedure was performed.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Label
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any surgery performed).
11	No proper value is applicable in this context (for example, no surgery performed).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, surgery was performed but the date is unknown).
(blank)	A valid date value is provided in item *Date of First Surgical Procedure* [1200].

Date of Most Definitive Surgical Resection of the Primary Site

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
3170	8	2124-2131	CCYYMMDD	2003+	09/08, 01/10, 01/11

Description

Records the date of the most definitive surgical procedure of the primary site performed as part of the first course of treatment.

Rationale

This item is used to measure the lag time between diagnosis and the most definitive surgery of the primary site. It is also used in conjunction with *Date of Surgical Discharge* [3180] to calculate the duration of hospitalization following the most definitive primary site surgical procedure. This can then be used to evaluate treatment efficacy.

Coding Instructions

- Record the date on which the surgery described by *Surgical Procedure of Primary Site* [1290] was performed at this or any facility.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date of Most Definitive Surgical Resection of the Primary Site* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of Most Definitive Surgical Resection of the Primary Site* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *RX Date Mst Defn Srg Flag* [3171] is used to explain why *Date of Most Definitive Surgical Resection of the Primary Site* is not a known date. See *RX Date Mst Defn Srg Flag* for an illustration of the relationships among these items.

Rx Date Mst Defn Srg Flag

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
3171	2	2132-2133	10-12, Blank	2010+	01/11

Description

This flag explains why there is no appropriate value in the corresponding date field, *Date of Most Definitive Surgical Resection of the Primary Site* [3170].

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

- Leave this item blank if *Date of Most Definitive Surgical Resection of the Primary Site* [3170] has a full or partial date recorded.
- Code 12 if the *Date of Most Definitive Surgical Resection of the Primary Site* cannot be determined, but the patient did receive first course surgery.
- Code 10 if it is unknown whether any surgery was performed.
- Code 11 if no surgical procedure was performed.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.
- Leave blank for cases diagnosed prior to January 1, 2003.

Code	Label
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any surgery performed).
11	No proper value is applicable in this context (for example, no surgery performed).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, surgery was performed but the date is unknown).
(blank)	A valid date value is provided in item *Date of Most Definitive Surgical Resection of the Primary Site* [3170]. Case was diagnosed prior to January 1, 2003.

Examples and descriptions left out on page 238.

Surgical Procedure of Primary Site

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1290	2	2225-2226	00, 10-80, 90, 98, 99	<1996, 2002+	06/05, 01/10, 01/12, 01/15

Description

Records the surgical procedure(s) performed to the primary site.

Rationale

This data item can be used to compare the efficacy of treatment options.

Coding Instructions

- Site-specific codes for this data item are found in Appendix B.
- If registry software allows only one procedure to be collected, document the most invasive surgical procedure for the primary site.
- If registry software allows multiple procedures to be recorded, this item refers to the most invasive surgical procedure of the primary site.
- For codes 00 through 79, the response positions are hierarchical. Last-listed responses take precedence over responses written above. Code 98 takes precedence over code 00. Use codes 80 and 90 only if more precise information about the surgery is not available.
- Excisional biopsies (those that remove the entire tumor and/or leave only microscopic margins) are to be coded in this item.
- If a needle biopsy precedes an excisional biopsy or more extensive surgery, and upon the excisional biopsy or more extensive surgery the surgical margins are clear (i.e., no tumor remains), DO NOT consider the needle biopsy to be an excisional biopsy. The needle biopsy should be recorded as such in the *Surgical Diagnostic and Staging Procedure* [1350] and the excisional biopsy or more extensive surgery in the *Surgical Procedure of the Primary Site* [1290].
- Surgery to remove regional tissue or organs is coded in this item only if the tissue/organs are removed in continuity with the primary site, except where noted in Appendix B.
- If a previous surgical procedure to remove a portion of the primary site is followed by surgery to remove the remainder of the primary site, then code the total or final results. Do not rely on registry software to perform this task for you.
- If the procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item *Palliative Care* [3270].
- There may be times when the first course of treatment information is incomplete. Therefore, it is important to continue follow-up efforts to be certain the complete treatment information is collected.

Code	Label	Definition
00	None	No surgical procedure of primary site. Diagnosed at autopsy.
10–19	Site-specific codes; tumor destruction	Tumor destruction, no pathologic specimen produced. Refer to Appendix B for the correct site-specific code for the procedure.
20–80	Site-specific codes; resection	Refer to Appendix B for the correct site-specific code for the procedure.

Code	Label	Definition
90	Surgery, NOS	A surgical procedure to the primary site was done, but no information on the type of surgical procedure is provided.
98	Site-specific codes; special	Special code. Refer to Appendix B for the correct site-specific code for the procedure.
99	Unknown	Patient record does not state whether a surgical procedure of the primary site was performed and no information is available. Death certificate only.

Surgical Procedure of Primary Site at this Facility

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
670	2	795-796	00, 10-80, 90, 98, 99	All Years	09/04, 01/10, 01/12, 01/15

Description

Records the surgical procedure(s) performed to the primary site at this facility.

Rationale

This data item can be used to compare the efficacy of treatment options.

Coding Instructions

- Site-specific codes for this data item are found in Appendix B.
- If registry software allows only one procedure to be collected, document the most invasive surgical procedure for the primary site.
- If registry software allows multiple procedures to be collected, this item refers to the most invasive surgical procedure for the primary site.
- For codes 00 through 79, the response positions are hierarchical. Last-listed responses take precedence over responses written above. Code 98 takes precedence over code 00. Use codes 80 and 90 only if more precise information about the surgery is not available.
- Excisional biopsies (those that remove the entire tumor and/or leave only microscopic margins) are to be coded in this item.
- If a needle biopsy precedes an excisional biopsy or more extensive surgery, and upon the excisional biopsy or more extensive surgery the surgical margins are clear (i.e., no tumor remains), DO NOT consider the needle biopsy to be an excisional biopsy. The needle biopsy should be recorded as such in the *Surgical Diagnostic and Staging Procedure* [1350] and the excisional biopsy or more extensive surgery in the *Surgical Procedure of the Primary Site* [1290].
- Surgery to remove regional tissue or organs is coded in this item only if the tissue/organs are removed in continuity with the primary site.
- If a previous surgical procedure to remove a portion of the primary site is followed by surgery to remove the remainder of the primary site, then code the total or final results. Do not rely on registry software to perform this task for you.
- If the procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item *Palliative Care at This Facility* [3280].

Code	Label	Definition
00	None	No surgical procedure of primary site. Diagnosed at autopsy.
10–19	Site-specific codes; tumor destruction	Tumor destruction, no pathologic specimen produced. Refer to Appendix B for the correct site-specific code for the procedure.
20–80	Site-specific codes; resection	Refer to Appendix B for the correct site-specific code for the procedure.
90	Surgery, NOS	A surgical procedure to primary site was done, but no information on the type of surgical procedure is provided.
98	Site-specific codes; special	Special code. Refer to Appendix B for the correct site-specific code for the procedure.

Code	Label	Definition
99	Unknown	Patient record does not state whether a surgical procedure of the primary site was performed and no information is available. Death certificate only.

Approach - Surgery of the Primary Site at this Facility (RxHospSurgApp 2010)

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
668	1	794-794	0-5, 9	2010+	05/10, 01/11, 01/13, 01/15

Description

This item is used to describe the surgical method used to approach the primary site for patients undergoing surgery of the primary site at this facility.

Rationale

This item is used to monitor patterns and trends in the adoption and utilization of minimally-invasive surgical techniques.

Coding Instructions

- This item may be left blank for cases diagnosed prior to 2010.
- If the patient has multiple surgeries of the primary site, this item describes the approach used for the most invasive, definitive surgery.
- For ablation procedures, assign code 3.
- Assign code 2 or 4 if the surgery began as robotic assisted or endoscopic and was converted to open.
- If both robotic and minimally invasive (for example, endoscopic or laparoscopic) surgery are used, code to robotic (codes 1 or 2).
- This item should not be confused with the obsolete item published in Registry Operations and Data Standards (ROADS), *Surgical Approach* [1310].

Code	Label
0	No surgical procedure of primary site at this facility; Diagnosed at autopsy
1	Robotic assisted
2	Robotic converted to open
3	Minimally invasive (such as endoscopic or laparoscopic)
4	Minimally invasive (endoscopic or laparoscopic) converted to open.
5	Open or approach unspecified
9	Unknown whether surgery was performed at this facility

Examples

Code	Reason
0	Patient received radiation at this facility after having surgery elsewhere
3	Endoscopic surgery was performed
3	Patient treated with RFA of kidney

5	The surgical report described conventional open surgery, but did not use the term “open”

Surgical Margins of the Primary Site

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1320	1	2232-2232	0-3, 7-9	All Years	08/02, 01/10, 02/10, 01/13

Description

Records the final status of the surgical margins after resection of the primary tumor.

Rationale

This data item serves as a quality measure for pathology reports and is used for staging, and may be a prognostic factor in recurrence.

Coding Instructions

- Record the margin status as it appears in the pathology report.
- Codes 0–3 are hierarchical; if two codes describe the margin status, use the numerically higher code.
- Code 7 if the pathology report indicates the margins could not be determined.
- If no surgery of the primary site was performed, code 8.
- Code 9 if the pathology report makes no mention of margins or no tissue was sent to pathology.
- For lymphomas (M-9590-9726, 9728-9732, 9734-9740, 9750-9762, 9811-9831, 9940, 9948 and 9971) with a lymph node primary site (C77.0–C77.9), code 9.
- For an unknown or ill-defined primary site (C76.0–C76.8, C80.9) or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4, or M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992), code 9.

Code	Label	Definition
0	No residual tumor	All margins are grossly and microscopically negative.
1	Residual tumor, NOS	Involvement is indicated, but not otherwise specified.
2	Microscopic residual tumor	Cannot be seen by the naked eye.
3	Macroscopic residual tumor	Gross tumor of the primary site which is visible to the naked eye.
7	Margins not evaluable	Cannot be assessed (indeterminate).
8	No primary site surgery	No surgical procedure of the primary site. Diagnosed at autopsy.
9	Unknown or not applicable	It is unknown whether a surgical procedure to the primary site was performed; death certificate-only; for lymphomas with a lymph node primary site; an unknown or ill-defined primary; or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease.

Example

Code	Reason
3	(C18-Colon) The pathology report from a colon resection describes the proximal margin as grossly involved with tumor (code 3) and the distal margin as microscopically involved (code 2). Code macroscopic involvement (code 3).

Scope of Regional Lymph Node Surgery

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1292	1	2227-2227	0-7, 9	All Years	01/04, 09/08, 02/10, 01/11, 01/12, 04/12, 01/13, 01/15

Description

Identifies the removal, biopsy, or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event.

Rationale

This data item can be used to compare and evaluate the extent of surgical treatment.

Coding Instructions

- The scope of regional lymph node surgery is collected for each surgical event even if surgery of the primary site was not performed.
- Record surgical procedures which aspirate, biopsy, or remove regional lymph nodes in an effort to diagnose or stage disease in this data item. Record the date of this surgical procedure in data item *Date of First Course of Treatment* [1270] and/or *Date of First Surgical Procedure* [1200] if applicable.
- Record the date of this procedure in *Date of Sentinel Lymph Node Biopsy* [832] and/or *Date Regional Lymph Node Dissection* [682], if applicable.
- Codes 0–7 are hierarchical. If only one procedure can be recorded, code the procedure that is numerically higher.
- If two or more surgical procedures of regional lymph nodes are performed, the codes entered in the registry for each subsequent procedure must include the cumulative effect of all preceding procedures. For example, a sentinel lymph node biopsy followed by a regional lymph node dissection at a later time is coded 7. Do not rely on registry software to determine the cumulative code.
- For intracranial and central nervous system primaries (C70.0–C70.9, C71.0–C71.9, C72.0–C72.9, C75.1–C75.3), code 9.
- For lymphomas (M-9590-9726, 9728-9732, 9734-9740, 9750-9762, 9811-9831, 9940, 9948 and 9971) with a lymph node primary site (C77.0–C77.9), code 9.
- For an unknown or ill-defined primary site (C76.0–C76.8, C80.9) or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4 or M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992), code 9.
- Do not code *distant* lymph nodes removed during surgery to the primary site for this data item. Distant nodes are coded in the data field *Surgical Procedure/Other Site* [1294].
- Refer to the current *AJCC Cancer Staging Manual* for site-specific identification of regional lymph nodes.
- If the procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item

Palliative Care [3270].

Note: One important use of registry data is the tracking of treatment patterns over time. In order to compare contemporary treatment with previously published treatment based on former codes, or to data unmodified from pre-1998 definitions, the ability to differentiate surgeries in which four or more regional lymph nodes are removed is desirable. However, it is *very important* to note that the distinction between codes 4 and 5 is made to permit comparison of current surgical procedures with procedures coded in the past when the removal of fewer than 4 lymph nodes was not reflected in surgery codes. *It is not intended to reflect clinical significance* when applied to a particular surgical procedure. It is important to *avoid inferring, by data presentation or other methods, that one category is preferable to another within the intent of these items*.

Codes and Labels

The following instructions should be applied to all surgically treated cases for all types of cancers. It is important to distinguish between sentinel lymph node biopsies (SLNBx) and more extensive dissection of regional lymph nodes.

Code	Label	General Instructions Applying to All Sites	Additional Notes Specific to Breast (C50.x)
		Use the operative report as the primary source document to determine whether the operative procedure was a sentinel lymph node biopsy (SLNBx), or a more extensive dissection of regional lymph nodes, or a combination of both SLNBx and regional lymph node dissection. The operative report will designate the surgeon's planned procedure as well as a description of the procedure that was actually performed. The pathology report may be used to complement the information appearing in the operative report, but the operative report takes precedence when attempting to distinguish between SLNBx and regional lymph node dissection or a combination of these two procedures. Do not use the number of lymph nodes removed and pathologically examined as the sole means of distinguishing between a SLNBx and a regional lymph node dissection.	Use the operative report as the primary source document to determine whether the operative procedure was a sentinel lymph node biopsy (SLNBx), an axillary lymph node dissection (ALND), or a combination of both SLNBx and ALND. The operative report will designate the surgeon's planned procedure as well as a description of the procedure that was actually performed. The pathology report may be used to complement the information appearing in the operative report, but the operative report takes precedence when attempting to distinguish between SLNBx and ALND, or a combination of these two procedures. Do not use the number of lymph nodes removed and pathologically examined as the sole means of distinguishing between a SLNBx and an ALND.
0	No regional lymph node surgery	No regional lymph node surgery.	

Code	Label	General Instructions Applying to All Sites	Additional Notes Specific to Breast (C50.x)
1	Biopsy or aspiration of regional lymph node(s)	Review the operative report to confirm whether an excisional biopsy or aspiration of regional lymph nodes was actually performed, and it did not include the use of dye or tracer for a SLNBx procedure (code 2). If additional procedures were performed on the lymph nodes, use the appropriate code 2-7.	Excisional biopsy or aspiration of regional lymph nodes for breast cancer is uncommon. Review the operative report of to confirm whether an excisional biopsy or aspiration of regional lymph nodes was actually performed; it is highly possible that the procedure is a SLNBx (code 2) instead. If additional procedures were performed on the lymph nodes, such as axillary lymph node dissection, use the appropriate code 2-7.
2	Sentinel Lymph Node Biopsy	• The operative report states that a SLNBx was performed. • Code 2 SLNBx when the operative report describes a procedure using injection of a dye, radio label, or combination to identify a lymph node (possibly more than one) for removal/examination. • When a SLNBx is performed, additional non-sentinel nodes can be taken during the same operative procedure. These additional non-sentinel nodes are palpably abnormal and selectively removed (or harvested) as part of the SLNBx procedure by the surgeon or may be discovered by the pathologist. Code this as a SLNBx (code 2). If review of the operative report confirms that a regional lymph node dissection followed the SLNBx, code these cases as 6.	• If a relatively large number of lymph nodes, more than 5, are pathologically examined, review the operative report to confirm the procedure was limited to a SLNBx and did not include an axillary lymph node dissection (ALND). • Infrequently, a SLNBx is attempted and the patient fails to map (i.e. no sentinel lymph nodes are identified by the dye and/or radio label injection) and no sentinel nodes are removed. Review the operative report to confirm that an axillary incision was made and a node exploration was conducted. Patients undergoing SLNBx who fail to map will often undergo ALND. Code these cases as 2 if no ALND was performed, or 6 when ALND was performed during the same operative event. Enter the appropriate number of nodes examined and positive in the data items Regional Lymph Nodes Examined [830] and Regional Lymph Nodes Positive [820].

Code	Label	General Instructions Applying to All Sites	Additional Notes Specific to Breast (C50.x)
Codes 3 -5 are used for regional lymph node dissection/removal; these do NOT include sentinel lymph node biopsy (SLNBx).			
3	Number of regional lymph nodes removed unknown or not stated; regional lymph nodes removed, NOS	The operative report states that a regional lymph node dissection was performed (a SLNBx was not done during this procedure or in a prior procedure). • Code 3 (Number of regional lymph nodes removed unknown, not stated; regional lymph nodes removed, NOS). Check the operative report to ensure this procedure is not a SLNBx only (code 2), or a SLNBx with a regional lymph node dissection (code 6 or 7). • Code 4 (1-3 regional lymph nodes removed) should be used infrequently. Review the operative report to ensure the procedure was not a SLNBx only. • Code 5 (4 or more regional lymph nodes removed). If a relatively small number of nodes was examined pathologically, review the operative report to confirm the procedure was not a SLNBx only (code 2). If a relatively large number of nodes was examined pathologically, review the operative report to confirm that there was not a SLNBx in addition to a more extensive regional lymph node dissection during the same, or separate, procedure (code 6 or 7). Infrequently, a SLNBx is attempted and the patient fails to map (i.e. no sentinel lymph nodes are identified by the dye and/or radio label injection). When mapping fails, surgeons usually perform a more extensive dissection of regional lymph nodes. Code these cases as 2 if no further dissection of regional lymph nodes was undertaken, or 6 when regional lymph nodes were dissected during the same operative event.	Generally, ALND removes at least 7-9 nodes. However, it is possible for these procedures to remove or harvest fewer nodes. Review the operative report to confirm that there was not a SLNBx in addition to a more extensive regional lymph node dissection during the same procedure (code 6 or 7).
4	1-3 regional lymph nodes removed		
5	4 or more regional lymph nodes removed		

Code	Label	General Instructions Applying to All Sites	Additional Notes Specific to Breast (C50.x)
6	Sentinel node biopsy and code 3, 4, or 5 at same time, or timing not stated	• SLNBx and regional lymph node dissection (code 3, 4, or 5) during the same surgical event, or timing not known. Generally, look for a report to the Operating Room (OR) by the pathologist on the SLNBx results prior to the regional node dissection. If the SLNBx shows positive nodes, then a dissection may be done. If the nodes are negative, it is rare that a node dissection is performed. • Generally, SLNBx followed by a regional lymph node completion will yield a relatively large number of nodes. However it is possible for these procedures to harvest only a few nodes. • If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only. • Infrequently, a SLNBx is attempted and the patient fails to map (i.e. no sentinel lymph nodes are identified by the dye and/or radio label injection.) When mapping fails, the surgeon usually performs a more extensive dissection of regional lymph nodes. Code these cases as 6.	• SLNBx and regional lymph node dissection (code 3, 4, or 5) during the same surgical event, or timing not known. Generally, look for a report to the Operating Room (OR) by the pathologist on the SLNBx results prior to the regional node dissection. If the SLNBx shows positive nodes, then a dissection may be done. If the nodes are negative, it is rare that a node dissection is performed. • Generally, SLNBx followed by ALND will yield a minimum of 7-9 nodes. However it is possible for these procedures to harvest fewer (or more) nodes. • If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx, or whether a SLNBx plus an ALND was performed.
7	Sentinel node biopsy and code 3, 4, or 5 at different times	• SLNBx and regional lymph node dissection (code 3, 4, or 5) in separate surgical events. • Generally, SLNBx followed by regional lymph node completion will yield a relatively large number of nodes. However, it is possible for these procedures to harvest only a few nodes. • If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only.	• Generally, SLNBx followed by ALND will yield a minimum of 7-9 nodes. However, it is possible for these procedures to harvest fewer (or more) nodes. • If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only, or whether a SLNBx plus an ALND was performed.

Code	Label	General Instructions Applying to All Sites	Additional Notes Specific to Breast (C50.x)
9	Unknown or not applicable	• The status of regional lymph node evaluation should be known for surgically-treated cases (i.e., cases coded 19-90 in the data item *Surgery of Primary Site* [1290]. Review surgically treated cases coded 9 in *Scope of Regional Lymph Node Surgery* to confirm the code.	

Examples

Code	Reason
0	No effort was made to locate sentinel lymph nodes, and no nodes were found in pathologic analysis.
2	(C50.1-Breast) There was an attempt at sentinel lymph node dissection, but no lymph nodes were found in the pathological specimen.
1	(C14.0-Pharynx) Aspiration of regional lymph node to confirm histology of widely metastatic disease.
2	(C44.5-Skin of Back) Patient has melanoma of the back. A sentinel lymph node dissection was done with the removal of one lymph node. This node was negative for disease.
3	(C61.9-Prostate) Bilateral pelvic lymph node dissection for prostate cancer.
6	(C50.3-Breast) Sentinel lymph node biopsy (SLNBx) of right axilla, followed by right axillary lymph node dissection (ALND) during the same surgical event.
7	(50.4-Breast) Sentinel lymph node biopsy (SLNBx) of left axilla, followed in a second procedure 5 days later by a left axillary lymph node dissection (ALND).
9	(C34.9-Lung) Patient was admitted for radiation therapy following surgery for lung cancer. There is no documentation on the extent of lymph node surgery in patient record.

Scope of Regional Lymph Node Surgery at this Facility

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
672	1	797-797	0-7, 9	All Years	01/04, 09/08, 02/10, 01/12

Description

Identifies the removal, biopsy, or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event at this facility.

Rationale

This item can be used to compare and evaluate the extent of surgical treatment.

Coding Instructions

- The scope of regional lymph node surgery is collected for each surgical event even if surgery of the primary site was not performed.
- If a surgical procedure which aspirates, biopsies, or removes regional lymph nodes to diagnose or stage this cancer, record the scope of regional lymph nodes surgery in this data item. Record the date of this surgical procedure in data item *Date of First Course of Treatment* [1270] and/or *Date of First Surgical Procedure* [1200] as appropriate.
- Record the date of this procedure in *Date of Sentinel Lymph Node Biopsy* [832] and/or *Date Regional Lymph Node Dissection* [682], if applicable.
- Codes 0–7 are hierarchical. If only one procedure can be recorded, code the procedure that is numerically higher.
- If two or more surgical procedures of regional lymph nodes are performed, the codes entered in the registry for each subsequent procedure must include the cumulative effect of all preceding procedures. For example, a sentinel lymph node biopsy followed by a regional lymph node dissection at a later time is coded 7. Do not rely on registry software to determine the cumulative code.
- For primaries of the meninges, brain, spinal cord, cranial nerves, and other parts of the central nervous system (C70.0–C70.9, C71.0–C71.9, C72.0–C72.9, C75.1–C75.3), code 9.
- For lymphomas (M-9590-9726, 9728-9732, 9734-9740, 9750-9762, 9811-9831, 9940, 9948 and 9971) with a lymph node primary site (C77.0–C77.9), code 9.
- For all unknown or ill-defined primary sites (C76.0–76.8, C80.9) or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4 or M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992), code 9.
- Do not code *distant* lymph nodes removed during surgery to the primary site for this data item. They are coded in the data field *Surgical Procedure/Other Site* [1294].
- Refer to the current *AJCC Cancer Staging Manual* for site-specific identification of regional lymph nodes.
- If the procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item *Palliative Care at This Facility* [3280].

Note: One important use of registry data is the tracking of treatment patterns over time. In order to compare contemporary treatment with previously published treatment based on former codes, or to data unmodified from pre-1998 definitions, the ability to differentiate surgeries in which four or more regional lymph nodes are removed is desirable. However, it is *very important* to note that the distinction between codes 4 and 5 is made to permit comparison of current surgical procedures with procedures coded in the past when the removal of fewer than 4 lymph nodes was not reflected in surgery codes. *It is not intended to reflect clinical significance* when applied to a particular surgical procedure. It is important to *avoid inferring, by data presentation or other methods, that one category is preferable to another within the intent of these items*.

Codes and Labels

The following instructions should be applied to all surgically treated cases for all types of cancers. It is important to distinguish between sentinel lymph node biopsies (SLNBx) and more extensive dissection of regional lymph nodes.

Code	Label	General Instructions Applying to All Sites	Additional Notes Specific to Breast (C50.x)
		Use the operative report as the primary source document to determine whether the operative procedure was a sentinel lymph node biopsy (SLNBx), or a more extensive dissection of regional lymph nodes, or a combination of both SLNBx and regional lymph node dissection. The operative report will designate the surgeon's planned procedure as well as a description of the procedure that was actually performed. The pathology report may be used to complement the information appearing in the operative report, but the operative report takes precedence when attempting to distinguish between SLNBx and regional lymph node dissection or a combination of these two procedures. Do not use the number of lymph nodes removed and pathologically examined as the sole means of distinguishing between a SLNBx and a regional lymph node dissection.	Use the operative report as the primary source document to determine whether the operative procedure was a sentinel lymph node biopsy (SLNBx), an axillary lymph node dissection (ALND), or a combination of both SLNBx and ALND. The operative report will designate the surgeon's planned procedure as well as a description of the procedure that was actually performed. The pathology report may be used to complement the information appearing in the operative report, but the operative report takes precedence when attempting to distinguish between SLNBx and ALND, or a combination of these two procedures. Do not use the number of lymph nodes removed and pathologically examined as the sole means of distinguishing between a SLNBx and an ALND.
0	No regional lymph node surgery	No regional lymph node surgery.	

Code	Label	General Instructions Applying to All Sites	Additional Notes Specific to Breast (C50.x)
1	Biopsy or aspiration of regional lymph node(s)	Review the operative report to confirm whether an excisional biopsy or aspiration of regional lymph nodes was actually performed, and it did not include the use of dye or tracer for a SLNBx procedure (code 2). If additional procedures were performed on the lymph nodes, use the appropriate code 2-7.	Excisional biopsy or aspiration of regional lymph nodes for breast cancer is uncommon. Review the operative report of to confirm whether an excisional biopsy or aspiration of regional lymph nodes was actually performed; it is highly possible that the procedure is a SLNBx (code 2) instead. If additional procedures were performed on the lymph nodes, such as axillary lymph node dissection, use the appropriate code 2-7.
2	Sentinel Lymph Node Biopsy	• The operative report states that a SLNBx was performed. • Code 2 SLNBx when the operative report describes a procedure using injection of a dye, radio label, or combination to identify a lymph node (possibly more than one) for removal/examination. • When a SLNBx is performed, additional non-sentinel nodes can be taken during the same operative procedure. These additional non-sentinel nodes are palpably abnormal and selectively removed (or harvested) as part of the SLNBx procedure by the surgeon or may be discovered by the pathologist. Code this as a SLNBx (code 2). If review of the operative report confirms that a regional lymph node dissection followed the SLNBx, code these cases as 6.	• If a relatively large number of lymph nodes, more than 5, are pathologically examined, review the operative report to confirm the procedure was limited to a SLNBx and did not include an axillary lymph node dissection (ALND). • Infrequently, a SLNBx is attempted and the patient fails to map (i.e. no sentinel lymph nodes are identified by the dye and/or radio label injection) and no sentinel nodes are removed. Review the operative report to confirm that an axillary incision was made and a node exploration was conducted. Patients undergoing SLNBx who fail to map will often undergo ALND. Code these cases as 2 if no ALND was performed, or 6 when ALND was performed during the same operative event. Enter the appropriate number of nodes examined and positive in the data items Regional Lymph Nodes Examined [830] and Regional Lymph Nodes Positive [820].

Code	Label	General Instructions Applying to All Sites	Additional Notes Specific to Breast (C50.x)
Codes 3 -5 are used for regional lymph node dissection/removal; these do NOT include sentinel lymph node biopsy (SLNBx).			
3	Number of regional lymph nodes removed unknown or not stated; regional lymph nodes removed, NOS	The operative report states that a regional lymph node dissection was performed (a SLNBx was not done during this procedure or in a prior procedure). • Code 3 (Number of regional lymph nodes removed unknown, not stated; regional lymph nodes removed, NOS). Check the operative report to ensure this procedure is not a SLNBx only (code 2), or a SLNBx with a regional lymph node dissection (code 6 or 7). • Code 4 (1-3 regional lymph nodes removed) should be used infrequently. Review the operative report to ensure the procedure was not a SLNBx only. • Code 5 (4 or more regional lymph nodes removed). If a relatively small number of nodes was examined pathologically, review the operative report to confirm the procedure was not a SLNBx only (code 2). If a relatively large number of nodes was examined pathologically, review the operative report to confirm that there was not a SLNBx in addition to a more extensive regional lymph node dissection during the same, or separate, procedure (code 6 or 7). Infrequently, a SLNBx is attempted and the patient fails to map (i.e. no sentinel lymph nodes are identified by the dye and/or radio label injection). When mapping fails, surgeons usually perform a more extensive dissection of regional lymph nodes. Code these cases as 2 if no further dissection of regional lymph nodes was undertaken, or 6 when regional lymph nodes were dissected during the same operative event.	Generally, ALND removes at least 7-9 nodes. However, it is possible for these procedures to remove or harvest fewer nodes. Review the operative report to confirm that there was not a SLNBx in addition to a more extensive regional lymph node dissection during the same procedure (code 6 or 7).
4	1-3 regional lymph nodes removed		
5	4 or more regional lymph nodes removed		

Code	Label	General Instructions Applying to All Sites	Additional Notes Specific to Breast (C50.x)
6	Sentinel node biopsy and code 3, 4, or 5 at same time, or timing not stated	• SLNBx and regional lymph node dissection (code 3, 4, or 5) during the same surgical event, or timing not known. Generally, look for a report to the Operating Room (OR) by the pathologist on the SLNBx results prior to the regional node dissection. If the SLNBx shows positive nodes, then a dissection may be done. If the nodes are negative, it is rare that a node dissection is performed. • Generally, SLNBx followed by a regional lymph node completion will yield a relatively large number of nodes. However it is possible for these procedures to harvest only a few nodes. • If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only. • Infrequently, a SLNBx is attempted and the patient fails to map (i.e. no sentinel lymph nodes are identified by the dye and/or radio label injection.) When mapping fails, the surgeon usually performs a more extensive dissection of regional lymph nodes. Code these cases as 6.	• SLNBx and regional lymph node dissection (code 3, 4, or 5) during the same surgical event, or timing not known. Generally, look for a report to the Operating Room (OR) by the pathologist on the SLNBx results prior to the regional node dissection. If the SLNBx shows positive nodes, then a dissection may be done. If the nodes are negative, it is rare that a node dissection is performed. • Generally, SLNBx followed by ALND will yield a minimum of 7-9 nodes. However it is possible for these procedures to harvest fewer (or more) nodes. • If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx, or whether a SLNBx plus an ALND was performed.
7	Sentinel node biopsy and code 3, 4, or 5 at different times	• SLNBx and regional lymph node dissection (code 3, 4, or 5) in separate surgical events. • Generally, SLNBx followed by regional lymph node completion will yield a relatively large number of nodes. However, it is possible for these procedures to harvest only a few nodes. • If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only.	• Generally, SLNBx followed by ALND will yield a minimum of 7-9 nodes. However, it is possible for these procedures to harvest fewer (or more) nodes. • If relatively few nodes are pathologically examined, review the operative report to confirm whether the procedure was limited to a SLNBx only, or whether a SLNBx plus an ALND was performed.

Code	Label	General Instructions Applying to All Sites	Additional Notes Specific to Breast (C50.x)
9	Unknown or not applicable	• The status of regional lymph node evaluation should be known for surgically-treated cases (i.e., cases coded 19-90 in the data item *Surgery of Primary Site* [1290]. Review surgically treated cases coded 9 in *Scope of Regional Lymph Node Surgery* to confirm the code.	

Surgical Procedure/Other Site

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1294	1	2228-2228	0-5, 9	All Years	01/04, 09/08, 01/10, 02/10, 01/12, 01/13

Description

Records the surgical removal of *distant lymph nodes* or other tissue(s) or organ(s) removed beyond the primary site.

Rationale

The removal of non-primary tissue documents the extent of surgical treatment and is useful in evaluating the extent of metastatic involvement.

Coding Instructions

- Assign the highest numbered code that describes the surgical resection of other tissue or organs beyond the primary site surgical code.
- If other tissue or organs are removed during primary site surgery that are not specifically defined by the site-specific *Surgical Procedure of the Primary Site* [1290 or 670] code, assign the highest numbered code that describes the surgical resection of other tissue or organs beyond the primary site surgical code. Assign the highest numbered code that describes the surgical resection of *distant lymph node(s).*
- Incidental removal of tissue or organs is not a "Surgical Procedure/Other Site."
- If multiple first course surgical procedures coded in this item are performed for a single primary, the code should represent the cumulative effect of those surgeries. Do not rely on registry software to perform this task for you.
- *Surgical Procedure/Other Site* is collected for each surgical event even if surgery of the primary site was not performed.
- Code 1 if any surgery is performed to treat tumors of unknown or ill-defined primary sites (C76.0–76.8, C80.9) or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4 or M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992).
- If the procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item *Palliative Care* [3270].

Code	Label	Definition
0	None	No surgical procedure of non-primary site was performed. Diagnosed at autopsy.
1	Non-primary surgical procedure performed	Non-primary surgical resection to other site(s), unknown if whether the site(s) is regional or distant.
2	Non-primary surgical procedure to other regional sites	Resection of regional site.

Code	Label	Definition
3	Non-primary surgical procedure to *distant lymph node(s)*	Resection of *distant lymph node(s)*.
4	Non-primary surgical procedure to distant site	Resection of distant site.
5	Combination of codes	Any combination of surgical procedures 2, 3, or 4.
9	Unknown	It is unknown whether any surgical procedure of a nonprimary site was performed. Death certificate only.

Examples

Code	Reason
0	(C18.1–Colon) The incidental removal of the appendix during a surgical procedure to remove a primary malignancy in the right colon.
1	Surgical removal of metastatic lesion from liver; unknown primary.
2	(C18.3–Colon) Surgical ablation of solitary liver metastasis, hepatic flexure primary.
4	(C34.9–Lung) Removal of solitary brain metastasis.
5	(C21.0–Anus) Excision of solitary liver metastasis and one large hilar lymph node.

Surgical Procedure/Other Site at this Facility

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
674	1	798-798	0-5, 9	All Years	01/04, 01/10, 02/10, 01/12

Description

Records the surgical removal of *distant lymph nodes* or other tissue(s)/organ(s) beyond the primary site at this facility.

Rationale

The removal of non-primary tissue documents the extent of surgical treatment and is useful in evaluating the extent of metastatic involvement.

Coding Instructions

- If other tissue or organs are removed during primary site surgery that are not specifically defined by the site-specific *Surgical Procedure of the Primary Site* [1290 or 670] code, assign the highest numbered code that describes the surgical resection of other tissue or organs beyond the primary site surgical code.
- Assign the highest numbered code that describes the surgical resection of other tissue or organs beyond the primary site surgical code.
- Assign the highest numbered code that describes the surgical resection of *distant lymph node(s).*
- Incidental removal of tissue or organs is not a "Surgical Procedure/Other Site."
- If multiple first course surgical procedures coded in this item are performed for a single primary, the code should represent the cumulative effect of those surgeries. Do not rely on registry software to perform this task for you.
- *Surgical Procedure/Other Site* is collected for each surgical event even if surgery of the primary site was not performed.
- Code 1 if any surgery is performed to treat tumors of unknown or ill-defined primary sites (C76.0–76.8, C80.9) or for hematopoietic, reticuloendothelial, immunoproliferative, or myeloproliferative disease (C42.0, C42.1, C42.3, C42.4 or M-9727, 9733, 9741-9742, 9764-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992).
- If the procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record this surgery in the item *Palliative Care at This Facility* [3280].

Code	Label	Definition
0	None	No non-primary surgical site resection was performed. Diagnosed at autopsy.
1	Non-primary surgical procedure performed	Non-primary surgical resection to other site(s), unknown if whether the site(s) is regional or distant.

Code	Label	Definition
2	Non-primary surgical procedure to other regional sites	Resection of regional site.
3	Non-primary surgical procedure to *distant lymph node(s)*	Resection of *distant lymph node(s)*.
4	Non-primary surgical procedure to distant site	Resection of distant site.
5	Combination of codes	Any combination of surgical procedures 2, 3, or 4.
9	Unknown	It is unknown whether any surgical procedure of a non-primary site was performed. Death certificate only.

Date of Surgical Discharge

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
3180	8	2134-2141	CCYYMMDD	2003+	01/10, 01/11

Description

Records the date the patient was discharged following primary site surgery. The date corresponds to the event recorded in *Surgical Procedure of Primary Site* [1290], and *Date of Most Definitive Surgical Resection* [3170].

Rationale

Length of stay is an important quality of care and financial measure among hospital administrations, those who fund public and private health care, and public health users. This date, in conjunction with the data item *Date of Most Definitive Surgical Resection* [3170], will allow for the calculation of a patient's length of hospitalization associated with primary site surgery.

Coding Instructions

- Record the date the patient was discharged from the hospital following the event recorded in *Surgical Procedure of Primary Site* [1290].
- If the patient died following the event recorded in *Surgical Procedure of Primary Site* [1290], but before being discharged from the treating facility, then the *Date of Surgical Discharge* is the same as the date recorded in the data item *Date of Last Contact or Death* [1750].
- If the patient received out-patient surgery, then the date of surgical discharge is the same as the date recorded in the data item *Date of Most Definitive Surgical Resection of the Primary Site* [3170].
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date of Surgical Discharge* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of Surgical Discharge* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *RX Date Surg Disch Flag* [3181] is used to explain why *Date of Surgical Discharge* is not a known date. See *RX Date Surg Disch Flag* for an illustration of the relationships among these items.

Rx Date Surg Disch Flag

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
3181	2	2142-2143	10-12, Blank	2010+	01/10

Description

This flag explains why there is no appropriate value in the corresponding date field, *Date of Surgical Discharge* [3180].

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

- Leave this item blank if *Date of Surgical Discharge* [3180] has a full or partial date recorded.
- Code 12 if the *Date of Surgical Discharge* cannot be determined, but the patient did receive first course surgery.
- Code 10 if it is unknown whether any surgery was performed.
- Code 11 if no surgical procedure was performed.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.
- Leave blank for cases diagnosed prior to January 1, 2003.

Code	Label
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any surgery was performed).
11	No proper value is applicable in this context (for example, no surgery performed).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, surgery was performed but the date is unknown).
(blank)	A valid date value is provided in item *Date of Surgical Discharge* [3180]. The case was diagnosed prior to January 1, 2003.

Readmission to the Same Hospital within 30 Days of Surgical Discharge

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
3190	1	2276-2276	0-3, 9	2003+	06/15, 01/10, 01/18

Description

Records a readmission to the same hospital, for the same illness, within 30 days of discharge following hospitalization for surgical resection of the primary site.

Rationale

This data item provides information related to the quality of care. A patient may have a readmission related to the primary diagnosis on discharge if the length of stay was too short, and then he/she needed to return due to problems or complications. A patient may also need to be readmitted if discharge planning and/or follow-up instructions were ineffective. It is important to distinguish a planned from an unplanned readmission, since a planned readmission is not an indicator of quality of care problems.

Coding Instructions

- Consult patient record or information from the billing department to determine if a readmission to the same hospital occurred within 30 days of the date recorded in the item *Date of Surgical Discharge* [3180].
- Only record a readmission related to the treatment of this cancer.
- Review the treatment plan to determine whether the readmission was planned.
- If there was an unplanned admission following surgical discharge, check for an ICD-9-CM "E" code and record it, space allowing, as an additional *Comorbidities and Complications* [3110, 3120, 3130, 3140, 3150, 3160, 3161, 3162, 3163, 3124] for cases diagnosed between 2003 and 2017. For cases diagnosed January 1, 2018 and later, check for an ICD-10-CM "Y" codes and record it, space allowing, as an additional *Secondary Diagnosis 1-10* [3780, 3782, 3784, 3786, 3788, 3790, 3792, 3794, 3796, 3798].
- There may be times when the first course of treatment information is incomplete. Therefore, it is important to continue follow-up efforts to be certain the complete treatment information is collected.

Code	Label
0	No surgical procedure of the primary site was performed, or the patient was not readmitted to the same hospital within 30 days of discharge.
1	A patient was surgically treated and was readmitted to the same hospital within 30 days of being discharged. This readmission was unplanned.
2	A patient was surgically treated and was then readmitted to the same hospital within 30 days of being discharged. This readmission was planned (chemotherapy port insertion, revision of colostomy, etc.)
3	A patient was surgically treated and, within 30 days of being discharged, the patient had both a planned and an unplanned readmission to the same hospital.
9	It is unknown whether surgery of the primary site was recommended or performed. It is unknown whether the patient was readmitted to the same hospital within 30 days of discharge. Death certificate only.

Examples

Code	Reason
0	A patient does not return to the hospital following a local excision for a Stage I breast cancer.
0	A patient was surgically treated and, upon discharge from acute hospital care, was admitted/transferred to an extended care ward of the hospital.
1	A patient is readmitted to the hospital three weeks (21 days) following a colon resection due to unexpected perirectal bleeding.
2	Following surgical resection the patient returns to the hospital for the insertion of a chemotherapy port.

Reason for No Surgery of Primary Site

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1340	1	2234-2234	0-2, 5-9	2002+	01/04, 01/13

Description

Records the reason that no surgery was performed on the primary site.

Rationale

This data item provides information related to the quality of care and describes why primary site surgery was not performed.

Coding Instructions

- If *Surgical Procedure of Primary Site* [1290] is coded 00, then record the reason based on documentation in the patient record.
- Code 1 if the treatment plan offered multiple alternative treatment options and the patient selected treatment that did not include surgery of the primary site, or if the option of "no treatment" was accepted by the patient.
- Code 1 if *Surgical Procedure of Primary Site* [1290] is coded 98.
- Code 7 if the patient refused recommended surgical treatment, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 8 if it is known that a physician recommended primary site surgery, but no further documentation is available yet to determine whether surgery was performed.
- Cases coded 8 should be followed and updated to a more definitive code as appropriate.
- Code 9 if the treatment plan offered multiple choices, but it is unknown which treatment, if any was provided.

Code	Label
0	Surgery of the primary site was performed.
1	Surgery of the primary site was not performed because it was not part of the planned first course treatment. Diagnosed at autopsy.
2	Surgery of the primary site was not recommended/performed because it was contraindicated due to patient risk factors (comorbid conditions, advanced age, progression of tumor prior to planned surgery etc.)
5	Surgery of the primary site was not performed because the patient died prior to planned or recommended surgery.
6	Surgery of the primary site was not performed; it was recommended by the patient's physician, but was not performed as part of the first course of therapy. No reason was noted in patient record.
7	Surgery of the primary site was not performed; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in patient record.
8	Surgery of the primary site was recommended, but it is unknown if it was performed. Further follow-up is recommended.
9	It is unknown whether surgery of the primary site was recommended or performed. Death certificate only.

Examples

Code	Reason
2	A patient with a primary tumor of the liver is not recommended for surgery due to advanced cirrhosis.
8	A patient is referred to another facility for recommended surgical resection of a gastric carcinoma, but further information from the facility to which the patient was referred is not available.

Radiation Data Items

Date Radiation Started

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1210	8	2144-2151	CCYYMMDD	All Years	06/05, 01/10, 01/11

Description

Records the date on which the first radiation therapy for this diagnosis began at any facility that is part of the first course of treatment.

Rationale

It is important to be able to sequence the use of multiple treatment modalities and to evaluate the time intervals between the treatments. For some diseases, the sequence of radiation and surgical therapy is important when determining the analytic utility of pathological stage information.

Coding Instructions

- Date radiation started will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the date radiation started may require assistance from the radiation oncologist for consistent coding.
- If radiation therapy is the first or only treatment administered to the patient, then the date radiation started should be the same as the date entered into the item *Date of First Course of Treatment* [1270].
- The date when treatment started will typically be found in the radiation oncologist's summary letter for the first course of treatment.
- There may be times when the first course of treatment information is incomplete. Therefore, it is important to continue follow-up efforts to be certain the complete treatment information is collected.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date Radiation Started* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date Radiation Started* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *RX Date–Radiation Flag* [1211] is used to explain why *Date Radiation Started* is not a known date. See *RX Date–Radiation Flag* for an illustration of the relationships among these items.

Examples

Code	Reason
20031215	A patient has external beam radiation on December 15, 2003.
20031012	A patient with a primary tumor of the brain undergoes stereotactic radiosurgery using a Gamma Knife on October 12, 2003.
20030602	A patient enters the facility for interstitial radiation boost for prostate cancer that is performed on August 6, 2003. Just prior to this, the patient had external beam therapy to

	the lower pelvis that was started on June 2, 2003 at another facility.

Rx Date–Radiation Flag

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1211	2	2152-2153	10-12, 15, Blank	2010+	01/10

Description

This flag explains why there is no appropriate value in the corresponding date field, *Date Radiation Started* [1210].

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

- Leave this item blank if *Date Radiation Started* [1210] has a full or partial date recorded.
- Code 12 if the *Date Radiation Started* cannot be determined, but the patient did receive first course radiation.
- Code 10 if it is unknown whether any radiation was given.
- Code 11 if no radiation is planned or given.
- Code 15 if radiation is planned but has not yet started and the start date is not yet available. Follow this patient for radiation treatment and update this item, *Date Radiation Started*, and all other radiation items.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Label
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any radiation was given).
11	No proper value is applicable in this context (for example, no radiation given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, radiation was given but the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (for example, radiation therapy is planned as part of the first course of therapy, but had not been started at the time of the most recent follow-up).
(blank)	A valid date value is provided in item *Date Radiation Started* [1210].

Location of Radiation Treatment

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1550	1	2263-2263	0-4, 8, 9	2003+	01/04, 01/12, 01/18

Description

Identifies the location of the facility where radiation therapy was administered during the first course of treatment.

Rationale

This data item provides information useful to understanding the referral patterns for radiation therapy services and for assessing the quality and outcome of radiation therapy by delivery site.

Coding Instructions

- Location of radiation treatment will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the location of radiation treatment may require assistance from the radiation oncologist for consistent coding.
- If the radiation treatment was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the radiation administered in the items *Palliative Care* [3270] and/or *Palliative Care at This Facility* [3280], as appropriate.
- In this context, "regional" is used to distinguish from "boost" or "cone down"; it does not refer to "regional" as used to identify stage or disease spread. In general, regional treatment will correspond to the phase in which the treatment fields had their largest dimension. In most, but not all, cases this will be phase I.
- For cases diagnosed January 1, 2018 and later, the first phase (regional treatment) may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase II, Phase III, etc. accordingly.
-

Code	Label	Definition
0	No radiation treatment	No radiation therapy was administered to the patient. Diagnosed at autopsy.
1	All radiation treatment at this facility	All radiation therapy was administered at the reporting facility.
2	Regional treatment at this facility, boost elsewhere	Regional treatment was administered at the reporting facility; a boost dose was administered elsewhere.
3	Boost radiation at this facility, regional elsewhere	Regional treatment was administered elsewhere; a boost dose was administered at the reporting facility.
4	All radiation treatment elsewhere	All radiation therapy was administered elsewhere.

Code	Label	Definition
8	Other	Radiation therapy was administered, but the pattern does not fit the above categories.
9	Unknown	Radiation therapy was administered, but the location of the treatment facility is unknown or not stated in patient record; or it is unknown whether radiation therapy was administered, or diagnosis was by Death certificate only.

Examples

Code	Reason
2	A patient received radiation therapy to the entire head and neck region at the reporting facility and is then referred to another facility for a high-dose-rate (HDR) intracavitary boost.
3	A patient was diagnosed with breast cancer at another facility and received surgery and regional radiation therapy at that facility before being referred to the reporting facility for boost dose therapy.
8	Regional treatment was initiated at another facility and midway through treatment the patient was transferred to the reporting facility to complete the treatment regime.
9	Patient is known to have received radiation therapy, but records do not define the facility or facility(s) where the treatment was administered.

Phase I Radiation Primary Treatment Volume

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1504	2	2281-2282	00-07, 09-14, 20-26, 29-32, 39-42, 50-68, 70-73, 80-86, 88, 90-99	All Years	01/18

Description

Identifies the primary treatment volume or primary anatomic target treated during the first phase of radiation therapy during the first course of treatment. This data item is required for CoC-accredited facilities as of 01/01/2018.

Rationale

Radiation treatment is commonly delivered in one or more phases. Typically, in each phase, the primary tumor or tumor bed is treated. This data item should be used to indicate the primary target volume, which might include the primary tumor or tumor bed. If the primary tumor was not targeted, record the other regional or distant site that was targeted. Draining lymph nodes may also be concurrently targeted during the first phase. These will be identified in a separate data item *Phase I Radiation to Draining Lymph Nodes* [1505].

This data item provides information describing the anatomical structure targeted by radiation therapy during the first phase of radiation treatment and can be used to determine whether the site of the primary disease was treated with radiation or if other regional or distant sites were targeted. This information is useful in evaluating the patterns of care within a facility and on a regional or national basis. The breakdown and reorganization of the sites will allow for concise reporting.

Coding Instructions

- Radiation treatment volume will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the exact treatment volume may require assistance from the radiation oncologist for consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase II, Phase III, etc. accordingly.
- If one or more discrete volumes are treated and one of those includes the primary site, record the treatment to the primary site in this data item.
- A new phase begins when there is a clinically meaningful change in target volume, treatment fraction size (i.e., dose given during a session), modality or treatment technique. Any one of these changes will generally mean that a new radiation plan will be generated in the treatment planning system, and it should be coded as a new phase of radiation therapy.
    - Note: "on-line adaptive therapy" refers to treatments where radiation treatment plans are adapted or updated while a patient is on the treatment table. When treatment plans are adapted, the shape of the target volume may change from day to day, but for registry purposes, the volume that is being targeted won't change. An adapted plan should not be coded as though a new phase of treatment has been initiated unless, as above, the radiation oncologist documents it as a new phase in the radiation treatment summary.
- Code 00 if the tumor was diagnosed at autopsy.
- Phase I of radiation treatment also commonly includes draining lymph node regions that are associated with the primary tumor or tumor bed. The draining lymph nodes are recorded in the

Phase I Radiation to Draining Lymph Nodes [1505]. Use codes 01 to 09 only when the lymph nodes are the primary target.

- Note: When the primary volume is lymph nodes, draining lymph nodes are not targeted. Record code 88 in the *Phase I Radiation to Draining Lymph Nodes* [1505].

- This data item, in conjunction with *Phase I Radiation to Draining Lymph Nodes* [1505], replaces the *Radiation Treatment Volume* [1540] and includes converted historical values. Conversion took place upon upgrade to NAACCR v18-compliant software; as of 2018 this data item is required for all cases regardless of diagnosis year.

Code	Label	Definition
00	No radiation treatment	Radiation therapy was not administered to the patient. Diagnosed at autopsy.
01	Neck lymph node regions	The primary treatment is directed at lymph node regions of the neck. Example situations include treatment of lymphoma or lymph node recurrence (in the absence of primary site failure) following definitive surgery of the primary tumor. If radiation to the neck lymph nodes includes the supraclavicular region use code 03.
02	Thoracic lymph node regions	Radiation therapy is directed to some combination of hilar, mediastinal, and supraclavicular lymph nodes without concurrent treatment of a visceral organ site. Example situations include mantle or mini-mantle for lymphomas, and treatment of lymphatic recurrence after complete surgical excision of a thoracic primary. Note that the supraclavicular region may be part of a head and neck lymph node region. Use code 03 for treatments directed at neck nodes and supraclavicular nodes with a head and neck primary. Use code 04 if supraclavicular lymph nodes are part of breast treatment.
03	Neck and thoracic lymph node regions	Treatment is directed to lymph nodes in the neck and thoracic region without concurrent treatment of a primary visceral tumor. This code might apply to some mantle or mini-mantle fields used in lymphoma treatments or some treatments for lymphatic recurrences following definitive treatment for tumors of the head and neck or thoracic regions.
04	Breast/ Chest wall lymph node regions	Radiation is directed primarily to some combination of axillary, supraclavicular, and/or internal mammary lymph node sites WITHOUT concurrent treatment of the breast or chest wall. If the breast AND lymph nodes are being treated, then code the Primary Treatment Volume to Breast (codes 40 or 41) and Breast/chest wall lymph nodes (code 04) in Radiation to Draining Lymph Nodes.
05	Abdominal lymph nodes	Treatment is directed to some combination of the lymph nodes of the abdomen, including retro-crural, peri-gastric, peri-hepatic, portocaval and para-aortic nodes. Possible situations might include seminoma, lymphoma or lymph node recurrence following surgical resection of the prostate, bladder or uterus.
06	Pelvic lymph nodes	Treatment is directed to some combination of the lymph nodes of the pelvis, including the common, internal and external iliac, obturator, inguinal and peri-rectal lymph nodes. This might be done for lymphoma or lymph node recurrence following definitive surgery for a pelvic organ.

Code	Label	Definition
07	Abdominal and pelvic lymph nodes	Treatment is directed to a combination of lymph nodes in both the abdomen and pelvis. This code includes extended fields ("hockey stick", "dog-leg", "inverted Y", etc.) utilized to treat seminomas and lymphomas or recurrence of a solid tumor.
09	Lymph node region, NOS	This category should be used to code treatments directed at lymph node regions that are not adequately described by codes 01-07.
10	Eye/orbit/optic nerve	Treatment is directed at all or a portion of the eye, orbit and/or optic nerve.
11	Pituitary	Treatment is directed at the pituitary gland.
12	Brain	Treatment is directed at all the brain and its meninges ("Whole brain").
13	Brain (Limited)	Treatment is directed at one or more sub-sites of the brain but not the whole brain. Chart may describe "SRS", "Stereotactic Radiosurgery", "Gamma Knife®".
14	Spinal cord	Treatment is directed at all or a portion of the spinal cord or its meninges.
20	Nasopharynx	Treatment is directed at all or a portion of the nasopharynx.
21	Oral Cavity	Treatment is directed at all or a portion of the oral cavity, including the lips, gingiva, alveolus, buccal mucosa, retromolar trigone, hard palate, floor of mouth and oral tongue.
22	Oropharynx	Treatment is directed at all or a portion of the oropharynx, including the soft palate, tonsils, base of tongue and pharyngeal wall.
23	Larynx (glottis) or hypopharynx	Treatment is directed at all or a portion of the larynx and/or hypopharynx.
24	Sinuses/Nasal tract	Treatment is directed at all or a portion of the sinuses and nasal tract, including the frontal, ethmoid, sphenoid and maxillary sinuses.
25	Parotid or other salivary glands	Treatment is directed at the parotid or other salivary glands, including the submandibular, sublingual and minor salivary glands.
26	Thyroid	Treatment is directed at all or a portion of the thyroid. Code this volume when the thyroid is treated with I-131 radioisotope.
29	Head and neck (NOS)	The treatment volume is directed at a primary tumor of the head and neck, but the primary sub-site is not a head and neck organ identified by codes 20-26 or it is an "unknown primary".
30	Lung or bronchus	Treatment is directed at all or a portion of the lung or bronchus.
31	Mesothelium	Treatment is directed to all or a portion of the mesothelium. This code should be used for mesothelioma primaries, even if a portion of the lung is included in the radiation field.
32	Thymus	Treatment is directed to all or a portion of the thymus.
39	Chest/lung (NOS)	The treatment is directed at a primary tumor of the chest, but the primary sub-site is unknown or not identified in codes 30-32. For example, this code should be used for sarcomas arising from the mediastinum.
40	Breast - whole	Treatment is directed at all the intact breast. Intact breast includes breast tissue that either was not surgically treated or received a lumpectomy or partial mastectomy.

Code	Label	Definition
41	Breast - partial	Treatment is directed at a portion of the intact breast but not the whole breast. The chart may have terms such as "Mammosite", "interstitial (seed) implant)", or "(accelerated) partial breast irradiation". Consider the possibility of partial breast irradiation when "IMRT" is documented in the record.
42	Chest wall	Treatment encompasses the chest wall (following mastectomy).
50	Esophagus	Treatment is directed at all or a portion of the esophagus. Include tumors of the gastro-esophageal junction.
51	Stomach	Treatment is directed at all or a portion of the stomach.
52	Small bowel	Treatment is directed at all or a portion of the small bowel.
53	Colon	Treatment is directed at all or a portion of the colon.
54	Rectum	Treatment is directed at all or a portion of the rectum.
55	Anus	Treatment is directed at all or a portion of the anus.
56	Liver	Treatment is directed at all or a portion of the liver.
57	Biliary tree or gallbladder	Treatment is directed at all or a portion of the biliary tree or gallbladder.
58	Pancreas or hepatopancreatic ampulla	Treatment is directed at all or a portion of the pancreas or the hepatopancreatic ampulla. Hepatopancreatic ampulla tumors are sometimes referred to as periampullary tumors.
59	Abdomen (NOS)	The treatment volume is directed at a primary tumor of the abdomen, but the primary sub-site is not an abdominal organ defined by codes 50-58 or it is considered to be an "unknown primary". For example, this code should be used for sarcomas arising from the abdominal retroperitoneum.
60	Bladder - whole	Treatment is directed at all the bladder.
61	Bladder - partial	Treatment is directed at a portion of the bladder but not the whole bladder.
62	Kidney	Treatment is directed at all or a portion of the kidney.
63	Ureter	Treatment is directed at all or a portion of the ureter.
64	Prostate - whole	Treatment is directed at all the prostate and/or seminal vesicles. Use this code even if seminal vesicles are not explicitly targeted.
65	Prostate - partial	Treatment is directed at a portion of the prostate but not the whole prostate.
66	Urethra	Treatment is directed at all or a portion of the urethra.
67	Penis	Treatment is directed at all or a portion of the penis. Treatments of urethral primaries should be coded as ‘urethra’ (code 66).
68	Testicle or scrotum	Treatment is directed at all or a portion of the testicle and/or scrotum.
70	Ovaries or fallopian tubes	Treatment is directed at all or a portion of the ovaries or fallopian tubes.
71	Uterus or Cervix	Treatment is directed at all or a portion of the uterus, endometrium or cervix.
72	Vagina	Treatment is directed at all or a portion of the vagina. Treatments of urethral primaries should be coded as ‘urethra’ (code 66).

Code	Label	Definition
73	Vulva	Treatment is directed at all or a portion of the vulva. Treatments of urethral primaries should be coded as 'urethra' (code 66).
80	Skull	Treatment is directed at all or a portion of the bones of the skull. Any brain irradiation is a secondary consequence.
81	Spine/vertebral bodies	Treatment is directed at all or a portion of the bones of the spine/vertebral bodies, including the sacrum. Spinal cord malignancies should be coded using 'spinal cord' (code 14).
82	Shoulder	Treatment is directed to all or a portion of the proximal humerus, scapula, clavicle, or other components of the shoulder complex.
83	Ribs	Treatment is directed at all or a portion of one or more ribs.
84	Hip	Treatment is directed at all or a portion of the proximal femur or acetabulum.
85	Pelvic bones	Treatment is directed at all or a portion of the bones of the pelvis other than the hip or sacrum.
86	Pelvis (NOS, non-visceral)	The treatment volume is directed at a primary tumor of the pelvis, but the primary sub-site is not a pelvic organ or is not known or indicated. For example, this code should be used for sarcomas arising from the pelvis.
88	Extremity bone, NOS	Treatment is directed at all or a portion of the bones of the arms or legs. This excludes the proximal femur (Hip, code 84). This excludes the proximal humerus (Shoulder, code 82).
90	Skin	Treatment is directed at all or a portion of the skin. The primary malignancy originates in the skin and the skin is the primary target. So-called skin metastases are usually subcutaneous and should be coded as a soft tissue site.
91	Soft tissue	This category should be used to code primary or metastatic soft tissue malignancies not fitting other categories.
92	Hemibody	A single treatment volume encompassing either all structures above the diaphragm, or all structures below the diaphragm. This is almost always administered for palliation of widespread bone metastasis in patients with prostate or breast cancer.
93	Whole body	Treatment is directed to the entire body included in a single treatment.
94	Mantle, mini-mantle (obsolete after 2017)	For conversion of historical data only
95	Lower extended field (obsolete after 2017)	For conversion of historical data only
96	Inverted Y (obsolete after 2017)	For conversion of historical data only
97	Invalid historical FORDS value	Conversion to new STORE data item could not take place due to an invalid FORDS Volume code
98	Other	Radiation therapy administered; treatment volume other than those previously categorized by codes 01-93.

Code	Label	Definition
99	Unknown	This category should be used to code treatments for which there is no information available about the treatment volume, or it is unknown if radiation treatment was administered.

Phase I Radiation to Draining Lymph Nodes

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1505	2	2283-2284	00-08, 88, 99	All Years	01/18

Description

Identifies the draining lymph nodes treated (if any) during the first phase of radiation therapy delivered to the patient during the first course of treatment. This data item is required for CoC-accredited facilities as of 01/01/2018.

Rationale

The first phase of radiation treatment commonly targets both the primary tumor (or tumor bed) and draining lymph nodes as a secondary site. This data item should be used to indicate the draining regional lymph nodes, if any, that were irradiated during the first phase of radiation to the primary site.

Coding Instructions

- Radiation treatment to draining lymph nodes will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the exact draining lymph nodes may require assistance from the radiation oncologist for consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase II, Phase III, etc. accordingly.
- Code 00 if the tumor was diagnosed at autopsy.
- Phase I of radiation treatment includes primary tumor or tumor bed in addition to the draining lymph node regions that are associated with the primary tumor or tumor bed. The primary tumor or tumor bed is recorded in the *Phase I Radiation Primary Treatment Volume* [1504].
    - Note: When the Primary Treatment Volume is lymph nodes, draining lymph nodes are not targeted. Record code 88 in this data item.
- This data item, in conjunction with *Phase I Radiation Primary Treatment Volume* [1504], replaces the *Radiation Treatment Volume* [1540] and includes converted historical values. Conversion took place upon upgrade to NAACCR v18-compliant software; as of 2018 this data item is required for all cases regardless of diagnosis year.

Code	Label
00	No radiation treatment to draining lymph nodes. Diagnosed at autopsy.
01	Neck lymph node regions
02	Thoracic lymph node regions
03	Neck and thoracic lymph node regions
04	Breast/Chest wall lymph node regions
05	Abdominal lymph nodes
06	Pelvic lymph nodes
07	Abdominal and pelvic lymph nodes
08	Lymph node region, NOS
88	Not applicable; Phase I Radiation Primary Treatment Volume is lymph nodes

Code	Label
99	Unknown if any radiation treatment to draining lymph nodes; Unknown if radiation treatment administered

Phase I Radiation Treatment Modality

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1506	2	2285-2286	00-16, 99	All Years	01/18

Description

Identifies the radiation modality administered during the first phase of radiation treatment delivered during the first course of treatment. This data item is required for CoC-accredited facilities as of 01/01/2018.

Rationale

Radiation modality reflects whether a treatment was external beam, brachytherapy, a radioisotope as well as their major subtypes, or a combination of modalities. This data item should be used to indicate the radiation modality administered during the first phase of radiation.

Historically, the previously-named *Regional Treatment Modality* [1570] utilized codes that were not mutually exclusive. Rather, it included codes describing a mix of modalities, treatment planning techniques, and delivery techniques that are commonly utilized by radiation oncologists. However, every phase of radiation treatment will include a specified modality, planning technique, and delivery technique. The goal of the 2018 implementation of separate phase-specific data items for the recording of radiation modality and external beam radiation treatment planning techniques is to clarify this information and implement mutually exclusive categories. A separate data item for delivery technique has not been implemented because this information is not consistently reported in end of treatment summaries.

Coding Instructions

- Radiation treatment modality will typically be found in the radiation oncologist's summary letter for the first course of treatment. Segregation of treatment components into Phases and determination of the respective treatment modality may require assistance from the radiation oncologist to ensure consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase II, Phase III, etc. accordingly.
- A new phase begins when there is a clinically meaningful change in target volume, treatment fraction size (I.e. dose given during a session), modality or treatment technique. Any one of these changes will mean that a new radiation plan will be generated in the treatment planning system, and it should be coded as a new phase of radiation therapy.
- For purposes of this data item, photons, x-rays and gamma-rays are equivalent.
- Use code 13 - Radioisotopes, NOS for radioembolization procedures, e.g. intravascular Yttrium-90.
- This data item intentionally does not include reference to various MV energies because this is not a clinically important aspect of technique. A change in MV energy (e.g., 6MV to 12MV) is not clinically relevant and does not represent a change in treatment technique. It is rare for change in MV energy to occur during any phase of radiation therapy.
- A new phase begins when there is a clinically meaningful change in target volume, treatment fraction size (i.e., dose given during a session), modality or treatment technique. Any one of these changes will generally mean that a new radiation plan will be generated in the treatment planning system and should be coded as a new phase of radiation therapy.
- If this data item is coded to any of the External beam codes (01-06), the planning technique must be recorded in the data item Phase I External Beam Radiation Planning Technique [1502].

- If this data item is coded to any of the Brachytherapy or Radioisotopes codes (07-16) the code of 88 must be recorded in the data item *Phase I External Beam Radiation Planning Technique* [1502].
    - Note: Do not confuse a radioiodine scan with treatment. Only treatment is recorded in this item.
- This data item, in conjunction with *Phase I Radiation External Beam Planning Technique* [1502], replaces the *Rad--Regional RX Modality* [1570] and includes converted historical values. Conversion took place upon upgrade to NAACCR v18-compliant software; as of 2018 this data item is required for all cases regardless of diagnosis year.

Code	Label
00	No radiation treatment
01	External beam, NOS
02	External beam, photons
03	External beam, protons
04	External beam, electrons
05	External beam, neutrons
06	External beam, carbon ions
07	Brachytherapy, NOS
08	Brachytherapy, intracavitary, LDR
09	Brachytherapy, intracavitary, HDR
10	Brachytherapy, Interstitial, LDR
11	Brachytherapy, Interstitial, HDR
12	Brachytherapy, electronic
13	Radioisotopes, NOS
14	Radioisotopes, Radium-223
15	Radioisotopes, Strontium-89
16	Radioisotopes, Strontium-90
99	Radiation treatment modality unknown; Unknown if radiation treatment administered

Phase I External Beam Radiation Planning Technique

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1502	2	2287-2288	00-10, 88, 98, 99	All Years	01/18

Description

Identifies the external beam radiation planning technique used to administer the first phase of radiation treatment during the first course of treatment. This data item is required for CoC-accredited facilities as of 01/01/2018.

Rationale

External beam radiation is the most commonly-used radiation modality in North America. In this data item we specified the planning technique for external beam treatment. Identifying the radiation technique is of interest for patterns of care and comparative effectiveness studies.

Historically, the previously-named *Regional Treatment Modality* [1570] utilized codes that were not mutually exclusive. Rather, it included codes describing a mix of modalities, treatment planning techniques, and delivery techniques that are commonly utilized by radiation oncologists. However, every phase of radiation treatment will include a specified modality, planning technique, and delivery technique. The goal of the 2018 implementation of separate phase-specific data items for the recording of *Phase I Radiation Treatment Modality* [1506] and *Phase I External Beam Radiation Planning Technique* [1502] is to clarify this information and implement mutually exclusive categories. Note that Planning Technique details are not being captured for non-External Beam modalities. A separate data item for delivery technique has not been implemented because this information is not consistently reported in end treatment summaries.

Coding Instructions

- Radiation external beam treatment planning technique will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the external beam planning technique may require assistance from the radiation oncologist to ensure consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase II, Phase III, etc. accordingly.
- A new phase begins when there is a clinically meaningful change in target volume, treatment fraction size (i.e., dose given during a session), modality or treatment technique. Any one of these changes will generally mean that a new radiation plan will be generated in the treatment planning system and should be coded as a new phase of radiation therapy.
    - Note: "on-line adaptive therapy" refers to treatments where radiation treatment plans are adapted or updated while a patient is on the treatment table. When treatment plans are adapted, the shape of the target volume may change from day to day but, for registry purposes, the volume that is being targeted won't change. An adapted plan should not be coded as though a new phase of treatment has been initiated unless, as above, the radiation oncologist documents it as a new phase in the radiation treatment summary. Two new technique codes have been added to capture when online adaptive therapy is occurring: CT guided and MR guided adaptive therapy.
- Code 00, no radiation treatment, when diagnosed at autopsy.
- Code 05 for Intensity Modulated Therapy (IMT) or Intensity Modulated Radiation Therapy (IMRT).
- Code 04 for Conformal or 3-D Conformal Therapy whenever either is explicitly mentioned.

- When code 98 is recorded, document the planning technique in the appropriate text data item.
- This data item, in conjunction with *Phase I Radiation Treatment Modality* [1506], replaces the *Rad--Regional RX Modality* [1570] and includes converted historical values. Conversion took place upon upgrade to NAACCR v18-compliant software; as of 2018 this data item is required for all cases regardless of diagnosis year.

Code	Label	Definition
00	No radiation treatment	Radiation therapy was not administered to the patient. Diagnosed at autopsy.
01	External beam, NOS	The treatment is known to be by external beam, but there is insufficient information to determine the specific planning technique.
02	Low energy x-ray/photon therapy	External beam therapy administered using equipment with a maximum energy of less than one (1) million volts (MV). Energies are typically expressed in units of kilovolts (kV). These types of treatments are sometimes referred to as electronic brachytherapy or orthovoltage or superficial therapy. Clinical notes may refer to the brand names of low energy x-ray delivery devices, e.g. Axxent®, INTRABEAM®, or Esteya®.
03	2-D therapy	An external beam planning technique using 2-D imaging, such as plain film x-rays or fluoroscopic images, to define the location and size of the treatment beams. Should be clearly described as 2-D therapy. This planning modality is typically used only for palliative treatments.
04	Conformal or 3-D conformal therapy	An external beam planning technique using multiple, fixed beams shaped to conform to a defined target volume. Should be clearly described as conformal or 3-D therapy in patient record.
05	Intensity modulated therapy	An external beam planning technique where the shape or energy of beams is optimized using software algorithms. Any external beam modality can be modulated but these generally refer to photon or proton beams. Intensity modulated therapy can be described as intensity modulated radiation therapy (IMRT), intensity modulated x-ray or proton therapy (IMXT/IMPT), volumetric arc therapy (VMAT) and other ways. If a treatment is described as IMRT with online re-optimization/re-planning, then it should be categorized as online re-optimization or re-planning.
06	Stereotactic radiotherapy or radiosurgery, NOS	Treatment planning using stereotactic radiotherapy/radiosurgery techniques, but the treatment is not described as Cyberknife® or Gamma Knife®. These approaches are sometimes described as SBRT (stereotactic body radiation), SABR (stereotactic ablative radiation), SRS (stereotactic radiosurgery), or SRT (stereotactic radiotherapy). If the treatment is described as robotic radiotherapy (e.g. Cyberknife®) or Gamma Knife®, use stereotactic radiotherapy subcodes below. If a treatment is described as stereotactic radiotherapy or radiosurgery with online re-optimization/re-planning, then it should be categorized as online re-optimization or re-planning.
07	Stereotactic radiotherapy or radiosurgery, robotic.	Treatment planning using stereotactic radiotherapy/radiosurgery techniques which is specifically described as robotic (e.g. Cyberknife®).

Code	Label	Definition
08	Stereotactic radiotherapy or radiosurgery, Gamma Knife®	Treatment planning using stereotactic radiotherapy/radiosurgery techniques which uses a Cobalt-60 gamma ray source and is specifically described as Gamma Knife®. This is most commonly used for treatments in the brain.
09	CT-guided online adaptive therapy	An external beam technique in which the treatment plan is adapted over the course of radiation to reflect changes in the patient's tumor or normal anatomy radiation using a CT scan obtained at the treatment machine (online). These approaches are sometimes described as CT-guided online re-optimization or online re-planning. If a treatment technique is described as both CT-guided online adaptive therapy as well as another external beam technique (IMRT, SBRT, etc.), then it should be categorized as CT-guided online adaptive therapy. If a treatment is described as "adaptive" but does not include the descriptor "online", this code should not be used.
10	MR-guided online adaptive therapy	An external beam technique in which the treatment plan is adapted over the course of radiation to reflect changes in the patient's tumor or normal anatomy radiation using an MRI scan obtained at the treatment machine (online). These approaches are sometimes described as MR-guided online re-optimization or online re-planning. If a treatment technique is described as both MR-guided online adaptive therapy as well as another external beam technique (IMRT, SBRT, etc.), then it should be categorized as MR-guided online adaptive therapy. If a treatment is described as "adaptive" but does not include the descriptor "online", this code should not be used.
88	Not Applicable	Treatment not by external beam.
98	Other, NOS	Other radiation, NOS; Radiation therapy administered, but the treatment modality is not specified or is unknown.
99	Unknown	It is unknown whether radiation therapy was administered.

Phase I Dose per Fraction

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1501	5	2289-2293	00000-99999	All Years	01/18

Description

Records the dose per fraction (treatment session) delivered to the patient in the first phase of radiation during the first course of treatment. The unit of measure is centi-Gray (cGy). This data item is required for CoC-accredited facilities as of 01/01/2018.

Rationale

Radiation therapy is delivered in one or more phases with identified dose per fraction. It is necessary to capture information describing the dose per fraction to evaluate patterns of radiation oncology care. Outcomes are strongly related to the dose delivered.

Coding Instructions

- The International Council for Radiation Protection (ICRP) recommends recording doses at the axis point where applicable (opposed fields, four field box, wedged pair, and so on). For maximum consistency in this data item, the ICRP recommendations should be followed whenever possible. Where there is no clear axis point, record the total dose as indicated in the summary chart.
- Radiation treatment Phase I dose will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the Phase I dose of radiation therapy may require assistance from the radiation oncologist for consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase II, Phase III, etc. accordingly.
- Record the actual dose delivered (NOT the initially prescribed dose) as documented in the treatment summary.
- For proton treatment, dosage may occasionally be specified as in cGe units (Cobalt Gray Equivalent) rather than cGy. 1 cGe = 100 cGy (for the Phase I Total Dose multiply cGe by 100).
- Note that dose is still occasionally specified in "rads". One rad is equivalent to one centi-Gray (cGy).
- There may be times when the first course of treatment information is incomplete. Therefore, it is important to continue follow-up efforts to be certain the complete treatment information is collected.
- Code 99998 when radioisotopes were administered to the patient (codes 13-16 for *Phase I Treatment Modality* [1506]).
- This data item replaces the *Rad--Regional Dose: cGy* [1510] and includes mapped historical values. 1-1 mapping took place upon upgrade to NAACCR v18-compliant software; as of 2018 this data item is required for all cases regardless of diagnosis year.

Code	Label
00000	No radiation treatment
00001-99997	Record the actual Phase I dose delivered in cGy
99998	Not applicable, radioisotopes administered to the patient
99999	Regional radiation therapy was administered but dose is unknown; Unknown whether

Code	Label
	radiation therapy was administered; Death Certificate only

Examples

Code	Reason
00200	A patient with Stage III prostate carcinoma received pelvic irradiation to 5,000 cGy over 25 fractions followed by a Phase II (boost) prostate irradiation to 7,000 cGy. Record the Phase I dose per fraction as 00200 (5000/25).
00150	A patient with a left supraclavicular metastasis from a gastric carcinoma received 6,000 cGy to the left supraclavicular region over 40 fractions. The dose is calculated at the prescribed depth of 3cm. A secondary calculation shows a Dmax dose of 6,450 cGy. Record the Phase I dose per fraction as 00150 (6000/40).
00220	A patient with a Stage II breast carcinoma is treated with the breast intact. Tangent fields are utilized to bring the dose of the breast to 5,500 cGy over 25 fractions. Phase II (boost) in the primary tumor bed delivered to a small volume in the breast. Record phase I dose per fraction as 00220 (5500/25).

Phase I Number of Fractions

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1503	3	2294-2296	000-999	All Years	01/18

Description

Records the total number of fractions (treatment sessions) delivered to the patient in the first phase of radiation during the first course of treatment. This data item is required for CoC-accredited facilities as of 01/01/2018.

Rationale

Radiation therapy is delivered in one or more phases with each phase spread out over a number of fractions (treatment sessions). It is necessary to capture information describing the number of fraction(s) to evaluate patterns of radiation oncology care.

Coding instructions

- The number of fractions or treatments will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the exact number of treatments or fractions delivered to the patient may require assistance from the radiation oncologist for consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase II, Phase III, etc. accordingly.
- Although a fraction or treatment session may include several treatment portals delivered within a relatively confined period of time-usually a few minutes-it is still considered one session.
- Count each separate administration of brachytherapy or implants as a single fraction or treatment.
- Record the actual number of fractions delivered (NOT initially prescribed), as documented in the treatment summary.
- Code 999 for Death Certificate Only (DCO) cases.
- There may be times when the first course of treatment information is incomplete. Therefore, it is important to continue follow-up efforts to be certain the complete treatment information is collected.
- This data item replaces the *Rad--No of Treatment Vol* [1520] and includes mapped values for historical cases. 1-1 mapping took place upon upgrade to NAACCR v18-compliant software; as of 2018 this data item is required for all cases regardless of diagnosis year.

Code	Label
000	No radiation treatment
001-998	Number of fractions administered to the patient during the first phase of radiation therapy
999	Phase I Radiation therapy was administered, but the number of fractions is unknown; It is unknown whether radiation therapy was administered

Examples

Code	Reason
025	A patient with breast carcinoma had treatment sessions in which treatment was delivered to the chest wall and encompassing the ipsilateral supraclavicular region for a total of three fraction portals. Twenty-five treatment sessions were given. Record 25 fractions as 025.
025	A patient with Stage IIIB bronchogenic carcinoma received 25 treatments to the left hilum and mediastinum, given in 25 daily fractions over five weeks.
050	A patient with advanced head and neck cancer was treated using "hyper-fractionation." Three fields were delivered in each session; two sessions were given each day, six hours apart, with each session delivering a total dose of 150 cGy. Treatment was given for a total of 25 days. Record 50 fractions as 050.
010	The patient was given Mammosite® brachytherapy, repeated in 10 separate sessions. Record 10 fractions as 010.
001	Prostate cancer patient treated with a single administration of seeds. Record 1 fraction as 001.

Phase I Total Dose

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1507	6	2297-2302	000000-999999	All Years	01/18

Description

Identifies the total radiation dose delivered to the patient in the first phase of radiation treatment during the first course of treatment. The unit of measure is centi-Gray (cGy). This data item is required for CoC-accredited facilities for cases diagnosed as of 01/01/2018.

Rationale

To evaluate the patterns of radiation care, it is necessary to capture information describing the prescribed dose of Phase I radiation to the patient during the first course of treatment. Outcomes are strongly related to the total dose delivered.

Coding instructions

- The International Council for Radiation Protection (ICRP) recommends recording doses at the axis point where applicable (opposed fields, four field box, wedged pair, and so on). For maximum consistency in this data item, the ICRP recommendations should be followed whenever possible. Where there is no clear axis point, record the total dose as indicated in the summary chart. Determining the exact dose may require assistance from the radiation oncologist for consistent coding.
- Phase I radiation treatment dose will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the Phase I dose of radiation therapy may require assistance from the radiation oncologist for consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase II, Phase III, etc. accordingly.
- Record the actual total dose delivered (NOT initially prescribed), as documented in the treatment summary. The value recorded for this data item should NOT be auto-calculated within the registry abstraction software.
- For proton treatment, dosage may occasionally be specified as in cGe units (Cobalt Gray Equivalent) rather than cGy. 1 cGe = 100 cGy (for the Phase I Total Dose, you would need to multiply cGe by 100).
- Note that dose is still occasionally specified in "rads". One rad is equivalent to one centi-Gray (cGy).
- Code 000000, radiation therapy not administered, when diagnosed at autopsy.
- Code 999998 when radioisotopes are administered to the patient (codes 13-16 recorded in the *Phase I Treatment Modality* [1506]).
- Code 999999 for Death Certificate Only (DCO) cases.
- There may be times when the first course of treatment information is incomplete. Therefore, it is important to continue follow-up efforts to be certain the complete treatment information is collected.
- This data item is an all new data item in 2018 includes mapped values for historical cases. Mapping took place upon upgrade to NAACCR v18-compliant software; as of 2018 this data item is required for all cases regardless of diagnosis year.

Code	Label
000000	No radiation treatment. Diagnosed at autopsy.
000001-999997	Record the actual total dose delivered in cGy
999998	Not applicable, radioisotopes administered to the patient
999999	Radiation therapy was administered, but the total dose is unknown; it is unknown whether radiation therapy was administered, or diagnosed by Death Certificate Only

Examples

Code	Reason
005000	A patient with Stage III prostate carcinoma received pelvic irradiation of 5,000 cGy during Phase I Radiation Treatment. Record the Phase I Total Dose of 5,000 cGy as 005000.
006000	A patient with a left supraclavicular metastasis from a gastric carcinoma received 6,000 cGy to the left supraclavicular region. Record the Phase I Total Dose of 6,000 cGy as 006000.
005500	A patient with a Stage II breast carcinoma is treated with the breast intact. Tangent fields are utilized to bring the dose of the breast to 5,500 cGy. The supraclavicular (draining) lymph nodes are treated 4,500 cGy, calculated to a depth of 3 cm, and Phase II radiation treatment in the primary tumor bed is delivered to a small volume in the breast. Record the Phase I Total Dose of 5,500cGy as 005500. Ignore the fact that a sub-region (supraclavicular nodes) received a lower dose than the breast in Phase I. Planned or otherwise, dose variations in the target volume may vary up to about 10%.

Phase II Radiation Primary Treatment Volume

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1514	2	2303-2304	00-07, 09-14, 20-26, 29-32, 39-42, 50-68, 70-73, 80-86, 88, 90-99, Blank	All Years	01/18

Description

Identifies the primary treatment volume or primary anatomic target treated during the second phase of radiation therapy during the first course of treatment. This data item is required for CoC-accredited facilities as of 01/01/2018.

Rationale

Radiation treatment is commonly delivered in one or more phases. Typically, in each phase, the primary tumor or tumor bed is treated. This data item should be used to indicate the primary target volume, which might include the primary tumor or tumor bed. If the primary tumor was not targeted, record the other regional or distant site that was targeted. Draining lymph nodes may also be targeted during the second phase. These will be identified in a separate data item *Phase II Radiation to Draining Lymph Nodes* [1515].

This data item provides information describing the anatomical structure targeted by radiation therapy during the second phase of radiation treatment and can be used to determine whether the site of the primary disease was treated with radiation or if other regional or distant sites were targeted. This information is useful in evaluating the patterns of care within a facility and on a regional or national basis. The breakdown and reorganization of the sites will allow for concise reporting.

Coding Instructions

- Radiation treatment volume will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the exact treatment volume may require assistance from the radiation oncologist for consistent coding.
- The first phase of radiation treatment may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded in this field with subsequent phases recorded as Phase II, Phase III, etc. accordingly.
- If one or more discrete volumes are treated and one of those includes the primary site, record the Phase II treatment to the primary site in this data item.
- A new phase begins when there is a clinically meaningful change in target volume, treatment fraction size (i.e., dose given during a session), modality or treatment technique. Any one of these changes will generally mean that a new radiation plan will be generated in the treatment planning system, and it should be coded as a new phase of radiation therapy.
    - Note: "on-line adaptive therapy" refers to treatments where radiation treatment plans are adapted or updated while a patient is on the treatment table. When treatment plans are adapted, the shape of the target volume may change from day to day, but for registry purposes, the volume that is being targeted won't change. An adapted plan should not be coded as though a new phase of treatment has been initiated unless, as above, the radiation oncologist documents it as a new phase in the radiation treatment summary.
- Code 00 if the tumor was diagnosed at autopsy.

- Phase II of radiation treatment also commonly includes draining lymph node regions that are associated with the primary tumor or tumor bed. The draining lymph nodes are recorded in the *Phase II Radiation to Draining Lymph Nodes* [1515].
- Note: When the primary volume is lymph nodes draining lymph nodes are not targeted. Record code 88 in the Phase *II Radiation to Draining Lymph Nodes* [1515].
- This data item may include converted historical values. It was converted *Radiation Treatment Volume* [1540] when *Rad--Boost RX Modality* [3200] was administered. Conversion took place upon upgrade to NAACCR v18-compliant software; as of 2018 this data item is required for all cases regardless of diagnosis year.
- Blanks allowed if no Phase II radiation treatment administered.

Code	Label	Definition
00	No radiation treatment	Phase II Radiation therapy was not administered to the patient. Diagnosed at autopsy.
01	Neck lymph node regions	The primary treatment is directed at lymph node regions of the neck. Example situations include treatment of lymphoma or lymph node recurrence (in the absence of primary site failure) following definitive surgery of the primary tumor. If radiation to the neck lymph nodes includes the supraclavicular region use code 03.
02	Thoracic lymph node regions	Radiation therapy is directed to some combination of hilar, mediastinal, and supraclavicular lymph nodes without concurrent treatment of a visceral organ site. Example situations include mantle or mini-mantle for lymphomas, and treatment of lymphatic recurrence after complete surgical excision of a thoracic primary. Note that the supraclavicular region may be part of a head and neck lymph node region. Use code 03 for treatments directed at neck nodes and supraclavicular nodes with a head and neck primary. Use code 04 if supraclavicular lymph nodes are part of breast treatment.
03	Neck and thoracic lymph node regions	Treatment is directed to lymph nodes in the neck and thoracic region without concurrent treatment of a primary visceral tumor. This code might apply to some mantle or mini-mantle fields used in lymphoma treatments or some treatments for lymphatic recurrences following definitive treatment for tumors of the head and neck or thoracic regions.
04	Breast/Chest wall lymph node regions	Radiation is directed primarily to some combination of axillary, supraclavicular, and/or internal mammary lymph node sites WITHOUT concurrent treatment of the breast or chest wall. If the breast AND lymph nodes are being treated then code the Primary Treatment Volume to Breast (codes 40 or 41) and Breast/chest wall lymph nodes (code 04) in Radiation to Draining Lymph Nodes.
05	Abdominal lymph nodes	Treatment is directed to some combination of the lymph nodes of the abdomen, including retro-crural, peri-gastric, peri-hepatic, portocaval and para-aortic nodes. Possible situations might include seminoma, lymphoma or lymph node recurrence following surgical resection of the prostate, bladder or uterus.

Code	Label	Definition
06	Pelvic lymph nodes	Treatment is directed to some combination of the lymph nodes of the pelvis, including the common, internal and external iliac, obturator, inguinal and peri-rectal lymph nodes. This might be done for lymphoma or lymph node recurrence following definitive surgery for a pelvic organ.
07	Abdominal and pelvic lymph nodes	Treatment is directed to a combination of lymph nodes in both the abdomen and pelvis. This code includes extended fields ("hockey stick", "dog-leg", "inverted Y", etc.) utilized to treat seminomas and lymphomas or recurrence of a solid tumor.
09	Lymph node region, NOS	This category should be used to code treatments directed at lymph node regions that are not adequately described by codes 01-07.
10	Eye/orbit/optic nerve	Treatment is directed at all or a portion of the eye, orbit and/or optic nerve.
11	Pituitary	Treatment is directed at the pituitary gland.
12	Brain	Treatment is directed at all the brain and its meninges ("Whole brain").
13	Brain (Limited)	Treatment is directed at one or more sub-sites of the brain but not the whole brain. Chart may describe "SRS", "Stereotactic Radiosurgery", "Gamma Knife®".
14	Spinal cord	Treatment is directed at all or a portion of the spinal cord or its meninges.
20	Nasopharynx	Treatment is directed at all or a portion of the nasopharynx.
21	Oral Cavity	Treatment is directed at all or a portion of the oral cavity, including the lips, gingiva, alveolus, buccal mucosa, retromolar trigone, hard palate, floor of mouth and oral tongue.
22	Oropharynx	Treatment is directed at all or a portion of the oropharynx, including the soft palate, tonsils, base of tongue and pharyngeal wall.
23	Larynx (glottis) or hypopharynx	Treatment is directed at all or a portion of the larynx and/or hypopharynx.
24	Sinuses/Nasal tract	Treatment is directed at all or a portion of the sinuses and nasal tract, including the frontal, ethmoid, sphenoid and maxillary sinuses.
25	Parotid or other salivary glands	Treatment is directed at the parotid or other salivary glands, including the submandibular, sublingual and minor salivary glands.
26	Thyroid	Treatment is directed at all or a portion of the thyroid. Code this volume when the thyroid is treated with I-131 radioisotope.
29	Head and neck (NOS)	The treatment volume is directed at a primary tumor of the head and neck, but the primary sub-site is not a head and neck organ identified by codes 20-26 or it is an "unknown primary".
30	Lung or bronchus	Treatment is directed at all or a portion of the lung or bronchus.
31	Mesothelium	Treatment is directed to all or a portion of the mesothelium. This code should be used for mesothelioma primaries, even if a portion of the lung is included in the radiation field.
32	Thymus	Treatment is directed to all or a portion of the thymus.
39	Chest/lung (NOS)	The treatment is directed at a primary tumor of the chest, but the primary sub-site is unknown or not identified in codes 30-32. For example, this code should be used for sarcomas arising from the mediastinum.

Code	Label	Definition
40	Breast - whole	Treatment is directed at all the intact breast. Intact breast includes breast tissue that either was not surgically treated or received a lumpectomy or partial mastectomy.
41	Breast - partial	Treatment is directed at a portion of the intact breast but not the whole breast. The chart may have terms such as "Mammosite", "interstitial (seed) implant)", or "(accelerated) partial breast irradiation". Consider the possibility of partial breast irradiation when "IMRT" is documented in the record.
42	Chest wall	Treatment encompasses the chest wall (following mastectomy).
50	Esophagus	Treatment is directed at all or a portion of the esophagus. Include tumors of the gastro-esophageal junction.
51	Stomach	Treatment is directed at all or a portion of the stomach.
52	Small bowel	Treatment is directed at all or a portion of the small bowel.
53	Colon	Treatment is directed at all or a portion of the colon.
54	Rectum	Treatment is directed at all or a portion of the rectum.
55	Anus	Treatment is directed at all or a portion of the anus.
56	Liver	Treatment is directed at all or a portion of the liver.
57	Biliary tree or gallbladder	Treatment is directed at all or a portion of the biliary tree or gallbladder.
58	Pancreas or hepatopancreatic ampulla	Treatment is directed at all or a portion of the pancreas or the hepatopancreatic ampulla. Hepatopancreatic ampulla tumors are sometimes referred to as periampullary tumors.
59	Abdomen (NOS)	The treatment volume is directed at a primary tumor of the abdomen, but the primary sub-site is not an abdominal organ defined by codes 50-58 or it is considered to be an "unknown primary". For example, this code should be used for sarcomas arising from the abdominal retroperitoneum.
60	Bladder - whole	Treatment is directed at all the bladder.
61	Bladder - partial	Treatment is directed at a portion of the bladder but not the whole bladder.
62	Kidney	Treatment is directed at all or a portion of the kidney.
63	Ureter	Treatment is directed at all or a portion of the ureter.
64	Prostate - whole	Treatment is directed at all the prostate and/or seminal vesicles. Use this code even if seminal vesicles are not explicitly targeted.
65	Prostate - partial	Treatment is directed at a portion of the prostate but not the whole prostate.
66	Urethra	Treatment is directed at all or a portion of the urethra.
67	Penis	Treatment is directed at all or a portion of the penis. Treatments of urethral primaries should be coded as ‘urethra’ (code 66).
68	Testicle or scrotum	Treatment is directed at all or a portion of the testicle and/or scrotum.
70	Ovaries or fallopian tubes	Treatment is directed at all or a portion of the ovaries or fallopian tubes.
71	Uterus or Cervix	Treatment is directed at all or a portion of the uterus, endometrium or cervix.

Code	Label	Definition
72	Vagina	Treatment is directed at all or a portion of the vagina. Treatments of urethral primaries should be coded as 'urethra' (code 66).
73	Vulva	Treatment is directed at all or a portion of the vulva. Treatments of urethral primaries should be coded as 'urethra' (code 66).
80	Skull	Treatment is directed at all or a portion of the bones of the skull. Any brain irradiation is a secondary consequence.
81	Spine/vertebral bodies	Treatment is directed at all or a portion of the bones of the spine/vertebral bodies, including the sacrum. Spinal cord malignancies should be coded using 'spinal cord' (code 14).
82	Shoulder	Treatment is directed to all or a portion of the proximal humerus, scapula, clavicle, or other components of the shoulder complex.
83	Ribs	Treatment is directed at all or a portion of one or more ribs.
84	Hip	Treatment is directed at all or a portion of the proximal femur or acetabulum.
85	Pelvic bones	Treatment is directed at all or a portion of the bones of the pelvis other than the hip or sacrum.
86	Pelvis (NOS, non-visceral)	The treatment volume is directed at a primary tumor of the pelvis, but the primary sub-site is not a pelvic organ or is not known or indicated. For example, this code should be used for sarcomas arising from the pelvis.
88	Extremity bone, NOS	Treatment is directed at all or a portion of the bones of the arms or legs. This excludes the proximal femur (Hip, code 84). This excludes the proximal humerus (Shoulder, code 82).
90	Skin	Treatment is directed at all or a portion of the skin. The primary malignancy originates in the skin and the skin is the primary target. So-called skin metastases are usually subcutaneous and should be coded as a soft tissue site.
91	Soft tissue	This category should be used to code primary or metastatic soft tissue malignancies not fitting other categories.
92	Hemibody	A single treatment volume encompassing either all structures above the diaphragm, or all structures below the diaphragm. This is almost always administered for palliation of widespread bone metastasis in patients with prostate or breast cancer.
93	Whole body	Treatment is directed to the entire body included in a single treatment.
94	Mantle, mini-mantle (obsolete after 2017)	For conversion of historical data only
95	Lower extended field (obsolete after 2017)	For conversion of historical data only
96	Inverted Y (obsolete after 2017)	For conversion of historical data only
97	Invalid historical FORDS value	Conversion to new STORE data item could not take place due to an invalid FORDS Volume code
98	Other	Radiation therapy administered; treatment volume other than those previously categorized by codes 01-93.

Code	Label	Definition
99	Unknown	This category should be used to code treatments for which there is no information available about the Phase II (Boost) treatment volume, or it is unknown if Phase II radiation treatment was administered.

Phase II Radiation to Draining Lymph Nodes

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1515	2	2305-2306	00-08, 88, 99, Blank	All Years	01/18

Description

Identifies the draining lymph nodes treated (if any) during the second phase of radiation therapy delivered to the patient during the first course of treatment. This data item is required for CoC-accredited facilities as of 01/01/2018.

Rationale

The second phase of radiation treatment commonly targets both the primary tumor (or tumor bed) and draining lymph nodes as a secondary site. This data item should be used to indicate the draining regional lymph nodes, if any, that were irradiated during the second phase of radiation to the primary site.

Coding Instructions

- Radiation treatment to draining lymph nodes will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the exact draining lymph nodes may require assistance from the radiation oncologist for consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase be referred to as a boost or cone down, and would be recorded as Phase II, Phase III, etc. accordingly.
- Code 00 if the tumor was diagnosed at autopsy.
- The second phase of radiation treatment includes primary tumor or tumor bed in addition to the draining lymph node regions that are associated with the primary tumor or tumor bed. The primary tumor or tumor bed is recorded in the *Phase II Radiation Primary Treatment Volume* [1514].
    - Note: When the Phase II Primary Treatment Volume is lymph nodes, draining lymph nodes are not targeted. Record code 88 in this data item.
- This data item may include converted historical values. For conversion of historical values, this data item includes a mapped value of 99 when *Rad--Boost RX Modality* [3200] was administered. Conversion took place upon upgrade to NAACCR v18-compliant software; as of 2018 this data item is required for all cases regardless of diagnosis year.
- Blanks allowed if no Phase II radiation treatment administered.

Code	Label
00	No radiation treatment to draining lymph nodes. Diagnosed at autopsy.
01	Neck lymph node regions
02	Thoracic lymph node regions
03	Neck and thoracic lymph node regions
04	Breast/chest wall lymph node regions
05	Abdominal lymph nodes
06	Pelvic lymph nodes
07	Abdominal and pelvic lymph nodes

Code	Label
08	Lymph node region, NOS
88	Not applicable; Phase II Radiation Primary Treatment Volume is lymph nodes
99	Unknown if any radiation treatment to draining lymph nodes; Unknown if radiation treatment administered

Phase II Radiation Treatment Modality

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1516	2	2307-2308	00-16, 99, Blank	All Years	01/18

Description

Identifies the radiation modality administered during the second phase of radiation treatment delivered during the first course of treatment. This data item is required for CoC-accredited facilities as of 01/01/2018.

Rationale

Radiation modality reflects whether a treatment was external beam, brachytherapy, a radioisotope as well as their major subtypes, or a combination of modalities. This data item should be used to indicate the radiation modality administered during the second phase of radiation.

Historically, the previously-named *Radiation Treatment Modality* [1570] utilized codes that were not mutually exclusive. Rather, it included codes describing a mix of modalities, treatment planning techniques, and delivery techniques that are commonly utilized by radiation oncologists. However, every phase of radiation treatment will include a specified modality, planning technique, and delivery technique. The goal of the 2018 implementation of separate phase-specific data items for the recording of radiation modality and external beam radiation treatment planning techniques is to clarify this information and implement mutually exclusive categories. A separate data item for delivery technique has not been implemented because this information is not consistently reported in end of treatment summaries.

Coding Instructions

- Radiation treatment modality will typically be found in the radiation oncologist's summary letter for the first course of treatment. Segregation of treatment components into Phases and determination of the respective treatment modality may require assistance from the radiation oncologist to ensure consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase II, Phase III, etc. accordingly.
- A new phase begins when there is a clinically meaningful change in target volume, treatment fraction size (I.e. dose given during a session), modality or treatment technique. Any one of these changes will mean that a new radiation plan will be generated in the treatment planning system, and it should be coded as a new phase of radiation therapy.
- For purposes of this data item, photons, x-rays and gamma-rays are equivalent.
- Use code 13 - Radioisotopes, NOS for radioembolization procedures, e.g. intravascular Yttrium-90.
- This data item intentionally does not include reference to various MV energies because this is not a clinically important aspect of technique. A change in MV energy (e.g., 6MV to 12MV) is not clinically relevant and does not represent a change in treatment technique. It is rare for change in MV energy to occur during any phase of radiation therapy.
- A new phase begins when there is a clinically meaningful change in target volume, treatment fraction size (i.e., dose given during a session), modality or treatment technique. Any one of these changes will generally mean that a new radiation plan will be generated in the treatment planning system and should be coded as a new phase of radiation therapy.
- If this data item is coded to any of the External beam codes (01-06), the planning technique must be recorded in the data item *Phase II External Beam Radiation Planning Technique* [1512].

- If this data item is coded to any of the Brachytherapy or Radioisotopes codes (07-16) the code of 88 must be recorded in the data item *Phase II External Beam Radiation Planning Technique* [1512].
    - Note: Do not confuse a radioiodine scan with treatment. Only treatment is recorded in this item.
- This data item, in conjunction with *Phase II Radiation External Beam Planning Technique* [1512], replaces the *Rad--Boost RX Modality* [3200] and may include converted historical values. Conversion took place upon upgrade to NAACCR v18-compliant software; as of 2018 this data item is required for all cases regardless of diagnosis year.
- Blanks allowed if no Phase II radiation treatment administered.

Code	Label
00	No radiation treatment
01	External beam, NOS
02	External beam, photons
03	External beam, protons
04	External beam, electrons
05	External beam, neutrons
06	External beam, carbon ions
07	Brachytherapy, NOS
08	Brachytherapy, intracavitary, LDR
09	Brachytherapy, intracavitary, HDR
10	Brachytherapy, Interstitial, LDR
11	Brachytherapy, Interstitial, HDR
12	Brachytherapy, electronic
13	Radioisotopes, NOS
14	Radioisotopes, Radium-223
15	Radioisotopes, Strontium-89
16	Radioisotopes, Strontium-90
99	Radiation treatment modality unknown; Unknown if radiation treatment administered

Phase II External Beam Radiation Planning Technique

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1512	2	2309-2310	00-10, 88, 98, 99, Blank	All Years	01/18

Description

Identifies the external beam radiation planning technique used to administer the second phase of radiation treatment during the first course of treatment. This data item is required for CoC-accredited facilities as of 01/01/2018.

Rationale

External beam radiation is the most commonly-used radiation modality in North America. In this data item we specified the planning technique for external beam treatment. Identifying the radiation technique is of interest for patterns of care and comparative effectiveness studies.

Historically, the previously-named *Regional Treatment Modality* [3200] utilized codes that were not mutually exclusive. Rather, it included codes describing a mix of modalities, treatment planning techniques, and delivery techniques that are commonly utilized by radiation oncologists. However, every phase of radiation treatment will include a specified modality, planning technique, and delivery technique. The goal of the 2018 implementation of separate phase-specific data items for the recording of *Phase II Radiation Treatment Modality* [1516] and *Phase II External Beam Radiation Planning Technique* [1512] is to clarify this information and implement mutually exclusive categories. Note that Planning Technique details are not being captured for non-External Beam modalities. A separate data item for delivery technique has not been implemented because this information is not consistently reported in end treatment summaries.

Coding Instructions

- Radiation external beam treatment planning technique will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the external beam planning technique may require assistance from the radiation oncologist to ensure consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase II, Phase III, etc. accordingly.
- A new phase begins when there is a clinically meaningful change in target volume, treatment fraction size (i.e., dose given during a session), modality or treatment technique. Any one of these changes will generally mean that a new radiation plan will be generated in the treatment planning system and should be coded as a new phase of radiation therapy.
    - Note: "on-line adaptive therapy" refers to treatments where radiation treatment plans are adapted or updated while a patient is on the treatment table. When treatment plans are adapted, the shape of the target volume may change from day to day but, for registry purposes, the volume that is being targeted won't change. An adapted plan should not be coded as though a new phase of treatment has been initiated unless, as above, the radiation oncologist documents it as a new phase in the radiation treatment summary. Two new technique codes have been added to capture when online adaptive therapy is occurring: CT guided and MR guided adaptive therapy.
- Code 00, no radiation treatment, when diagnosed at autopsy.
- Code 05 for Intensity Modulated Therapy (IMT) or Intensity Modulated Radiation Therapy (IMRT).
- Code 04 for Conformal or 3-D Conformal Therapy whenever either is explicitly mentioned.

- When code 98 is recorded, document the planning technique in the appropriate text data item.
- This data item, in conjunction with *Phase II Radiation Treatment Modality* [1516], replaces the *Rad--Boost RX Modality* [3200] and may include converted historical values. Conversion took place upon upgrade to NAACCR v18-compliant software; as of 2018 this data item is required for all cases regardless of diagnosis year.
- Blanks allowed if no Phase II radiation treatment administered.

Code	Label	Definition
00	No radiation treatment	Radiation therapy was not administered to the patient. Diagnosed at autopsy.
01	External beam, NOS	The treatment is known to be by external beam, but there is insufficient information to determine the specific planning technique.
02	Low energy x-ray/photon therapy	External beam therapy administered using equipment with a maximum energy of less than one (1) million volts (MV). Energies are typically expressed in units of kilovolts (kV). These types of treatments are sometimes referred to as electronic brachytherapy or orthovoltage or superficial therapy. Clinical notes may refer to the brand names of low energy x-ray delivery devices, e.g. Axxent®, INTRABEAM®, or Esteya®.
03	2-D therapy	An external beam planning technique using 2-D imaging, such as plain film x-rays or fluoroscopic images, to define the location and size of the treatment beams. Should be clearly described as 2-D therapy. This planning modality is typically used only for palliative treatments.
04	Conformal or 3-D conformal therapy	An external beam planning technique using multiple, fixed beams shaped to conform to a defined target volume. Should be clearly described as conformal or 3-D therapy in patient record.
05	Intensity modulated therapy	An external beam planning technique where the shape or energy of beams is optimized using software algorithms. Any external beam modality can be modulated but these generally refer to photon or proton beams. Intensity modulated therapy can be described as intensity modulated radiation therapy (IMRT), intensity modulated x-ray or proton therapy (IMXT/IMPT), volumetric arc therapy (VMAT) and other ways. If a treatment is described as IMRT with online re-optimization/re-planning, then it should be categorized as online re-optimization or re-planning.
06	Stereotactic radiotherapy or radiosurgery, NOS	Treatment planning using stereotactic radiotherapy/radiosurgery techniques, but the treatment is not described as Cyberknife® or Gamma Knife®. These approaches are sometimes described as SBRT (stereotactic body radiation), SABR (stereotactic ablative radiation), SRS (stereotactic radiosurgery), or SRT (stereotactic radiotherapy). If the treatment is described as robotic radiotherapy (e.g. Cyberknife®) or Gamma Knife®, use stereotactic radiotherapy subcodes below. If a treatment is described as stereotactic radiotherapy or radiosurgery with online re-optimization/re-planning, then it should be categorized as online re-optimization or re-planning.

Code	Label	Definition
07	Stereotactic radiotherapy or radiosurgery, robotic.	Treatment planning using stereotactic radiotherapy/radiosurgery techniques which is specifically described as robotic (e.g. Cyberknife®).
08	Stereotactic radiotherapy or radiosurgery, Gamma Knife®	Treatment planning using stereotactic radiotherapy/radiosurgery techniques which uses a Cobalt-60 gamma ray source and is specifically described as Gamma Knife®. This is most commonly used for treatments in the brain.
09	CT-guided online adaptive therapy	An external beam technique in which the treatment plan is adapted over the course of radiation to reflect changes in the patient's tumor or normal anatomy radiation using a CT scan obtained at the treatment machine (online). These approaches are sometimes described as CT-guided online re-optimization or online re-planning. If a treatment technique is described as both CT-guided online adaptive therapy as well as another external beam technique (IMRT, SBRT, etc.), then it should be categorized as CT-guided online adaptive therapy. If a treatment is described as "adaptive" but does not include the descriptor "online", this code should not be used.
10	MR-guided online adaptive therapy	An external beam technique in which the treatment plan is adapted over the course of radiation to reflect changes in the patient's tumor or normal anatomy radiation using an MRI scan obtained at the treatment machine (online). These approaches are sometimes described as MR-guided online re-optimization or online re-planning. If a treatment technique is described as both MR-guided online adaptive therapy as well as another external beam technique (IMRT, SBRT, etc.), then it should be categorized as MR-guided online adaptive therapy. If a treatment is described as "adaptive" but does not include the descriptor "online", this code should not be used.
88	Not Applicable	Treatment not by external beam
98	Other, NOS	Other radiation, NOS; Radiation therapy administered, but the treatment modality is not specified or is unknown.
99	Unknown	It is unknown whether radiation therapy was administered.

Phase II Dose per Fraction

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1511	5	2311-2315	00000-99999, Blank	All Years	01/18

Description

Records the dose per fraction (treatment session) delivered to the patient in the second phase of radiation during the first course of treatment. The unit of measure is centi-Gray (cGy). This data item is required for CoC-accredited facilities as of 01/01/2018.

Rationale

Radiation therapy is delivered in one or more phases with identified dose per fraction. It is necessary to capture information describing the dose per fraction to evaluate patterns of radiation oncology care. Outcomes are strongly related to the dose delivered.

Coding Instructions

- The International Council for Radiation Protection (ICRP) recommends recording doses at the axis point where applicable (opposed fields, four field box, wedged pair, and so on). For maximum consistency in this data item, the ICRP recommendations should be followed whenever possible. Where there is no clear axis point, record the total dose as indicated in the summary chart. Determining the exact dose may require assistance from the radiation oncologist for consistent coding.
- Radiation treatment Phase II dose will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the Phase II dose of radiation therapy may require assistance from the radiation oncologist for consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred as a boost or cone down, and would be recorded as Phase II, Phase III, etc. accordingly.
- Record the actual dose <u>delivered</u> (NOT the initially prescribed dose) as documented in the treatment summary.
- For proton treatment, dosage may occasionally be specified as in cGe units (Cobalt Gray Equivalent) rather than cGy. 1 cGe = 100 cGy (for the Phase I Total Dose, you would need to multiply cGe by 100).
    - Note that dose is still occasionally specified in "rads". One rad is equivalent to one centi-Gray (cGy).
- There may be times when the first course of treatment information is incomplete. Therefore, it is important to continue follow-up efforts to be certain the complete treatment information is collected.
- Code 99998 when radioisotopes were administered to the patient (codes 13-16 for *Phase II Radiation Treatment Modality* [1516]).
- This data item replaces the *Rad--Boost Dose cGy* [3210] and may include mapped values for historical cases. 1-1 mapping took place upon upgrade to NAACCR v18-compliant software; as of 2018 this data item is required for all cases regardless of diagnosis year.
- Blanks allowed if no Phase II radiation treatment administered.

Code	Label
00000	No radiation treatment
00001-99997	Record the actual Phase II dose delivered in cGy
99998	Not applicable, radioisotopes administered to the patient
99999	Phase II (Boost) radiation therapy was administered but dose is unknown; It is unknown whether Phase II radiation therapy was administered. Death Certificate only.

Examples

Code	Reason
00200	A patient with Stage III prostate carcinoma receives pelvic irradiation to 5,000 cGy in 25 fractions followed by a conformal prostate boost to 7,000 cGy in 10 additional fractions. Record the prescribed (and delivered) Phase II dose per fractions as 00200 (2000/10)
Blank	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 (dose at depth of maximum dose) of 6,450 cGy. Do not confuse D max doses with Phase II doses. In this case, there is no planned Phase II dose. Leave Phase II Dose per Fraction blank.
99999	A patient with a Stage II breast carcinoma is treated with the breast intact. Tangent fields are utilized to bring the central axis dose in the breast to 5,040 cGy encompassing the supraclavicular nodes, and an intracavitary boost in the primary tumor bed is delivered to a small volume in the breast in a single session. Record the Phase II dose per fraction as 99999. Dosage (brachytherapy) unknown.

Phase II Number of Fractions

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1513	3	2316-2318	000-999, Blank	All Years	01/18

Description

Records the total number of fractions (treatment sessions) administered to the patient in the second phase of radiation during the first course of treatment. This data item is required for CoC-accredited facilities as of 01/01/2018.

Rationale

Radiation therapy is delivered in one or more phases with each phase spread out over a number of fractions (treatment sessions). It is necessary to capture information describing the number of fraction(s) to evaluate patterns of radiation oncology care.

Coding Instructions

- The number of fractions or treatments will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the exact number of treatments or fractions delivered to the patient may require assistance from the radiation oncologist for consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase II, Phase III, etc. accordingly.
- Although a fraction or treatment session may include several treatment portals delivered within a relatively confined period of time-usually a few minutes-it is still considered one session.
- Count each separate administration of brachytherapy or implants as a single fraction or treatment.
- Record the actual number of fractions delivered (NOT initially prescribed), as documented in the treatment summary.
- Code 999 for Death Certificate Only (DCO) cases.
- There may be times when the first course of treatment information is incomplete. Therefore, it is important to continue follow-up efforts to be certain the complete treatment information is collected.
- This data item may include mapped values for historical cases. This data item includes a mapped value of 999 when *Rad--Boost RX Modality* [3200] was administered. Mapping took place upon upgrade to NAACCR v18-compliant software; as of 2018 this data item is required for all cases regardless of diagnosis year.
- Blanks allowed if no Phase II radiation treatment administered.

Code	Label
000	No radiation treatment
001-998	Number of fractions administered to the patient during the second phase of radiation therapy
999	Phase II Radiation therapy was administered, but the number of fractions is unknown; It is unknown whether radiation therapy was administered. Death Certificate only.

Examples

Code	Reason
005	A patient with breast carcinoma had treatment sessions in which treatment was delivered to the chest wall encompassing the ipsilateral supraclavicular region for a total of three fraction portals. Twenty-five treatment sessions were given. Additional 1000 cGy external beam boost to the tumor bed given in 5 fractions. Code 005 for 5 fractions for phase II.
Blank	A patient with Stage IIIB bronchogenic carcinoma received 25 treatments to the left hilum and mediastinum, given in 25 daily fractions over five weeks. No Phase II treatment, leave blank.
010	A patient with advanced head and neck cancer was treated with 6000 cGy in 25 fractions encompassing the primary site and draining nodes with a boost of 1200 cGy in 10 fractions to the tumor bed. Record 010 for 10 fractions for phase II.
005	The patient was given a course of external beam to the prostate followed by 5 HDR brachytherapy treatments. Record 005 for 5 fractions for phase II.
030	Prostate cancer patient treated with a single administration of seeds followed by 4500 cGy IMRT in 30 fractions. Code 030 for 30 fractions for phase II.

Phase II Total Dose

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1517	6	2319-2324	000000-999999, Blank	All Years	01/18

Description

Identifies the total radiation dose administered in the second phase of radiation treatment delivered to the patient during the first course of treatment. The unit of measure is centi-Gray (cGy). This data item is required for CoC-accredited facilities as of 01/01/2018.

Rationale

To evaluate the patterns of radiation care, it is necessary to capture information describing the prescribed dose of Phase II radiation to the patient during the first course of treatment. Outcomes are strongly related to the total dose delivered.

Coding Instructions

- The International Council for Radiation Protection (ICRP) recommends recording doses at the axis point where applicable (opposed fields, four field box, wedged pair, and so on). For maximum consistency in this data item, the ICRP recommendations should be followed whenever possible. Where there is no clear axis point, record the total dose as indicated in the summary chart. Determining the exact dose may be highly subjective and require assistance from the radiation oncologist for consistent coding.
- Phase II radiation treatment dose will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the Phase II dose of radiation therapy may require assistance from the radiation oncologist for consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase II, Phase III, etc. accordingly.
- Record the actual total dose delivered (NOT initially prescribed), as documented in the treatment summary. The value recorded for this data item should NOT be auto-calculated within the registry abstraction software.
- For proton treatment, dosage may occasionally be specified as in cGe units (Cobalt Gray Equivalent) rather than cGy. 1 cGe = 100 cGy (for the Phase II Total Dose, you would need to multiply cGe by 100).
- Note that dose is still occasionally specified in "rads". One rad is equivalent to one centi-Gray (cGy).
- Code 000000, radiation therapy not administered, when diagnosed at autopsy.
- Code 999998 when radioisotopes are administered to the patient (codes 13-16 recorded in the *Phase II Treatment Modality* [1516]).
- Code 999999 for Death Certificate Only (DCO) cases.
- There may be times when the first course of treatment information is incomplete. Therefore, it is important to continue follow-up efforts to be certain the complete treatment information is collected.
- This data item may include mapped values for historical cases. This data item includes a mapped value of 999999 when Rad--Boost RX Modality [3200] was administered. Mapping took place upon

upgrade to NAACCR v18-compliant software; as of 2018 this data item is required for all cases regardless of diagnosis year.

- Blanks allowed if no Phase II radiation treatment administered.

Code	Label
000000	No radiation treatment. Diagnosed at autopsy.
000001-999997	Record the actual total dose delivered in cGy
999998	Not applicable, radioisotopes administered to the patient
999999	Radiation therapy was administered, but the total dose is unknown; it is unknown whether radiation therapy was administered. Death Certificate only.

Examples

Code	Reason
005000	A patient with Stage III prostate carcinoma received pelvic irradiation of 5,000 cGy during Phase II Radiation Treatment. Record the Phase II Total Dose of 5,000 cGy as 005000.
006000	A patient with a left supraclavicular metastasis from a gastric carcinoma received 6,000 cGy to the left supraclavicular region during Phase II Radiation Treatment. Record the Phase II Total Dose of 6,000 cGy as 006000.
005500	A patient with a Stage II breast carcinoma is treated with the breast intact. During Phase II treatment tangent fields are utilized to bring the dose of the breast to 5,500 cGy. The supraclavicular (draining) lymph nodes are treated 4,500 cGy, calculated to a depth of 3 cm. Record the Phase II Total Dose of 5,500cGy as 005500.

Phase III Radiation Primary Treatment Volume

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1524	2	2325-2326	00-07, 09-14, 20-26, 29-32, 39-42, 50-68, 70-73, 80-86, 88, 90-96, 98-99, Blank	2018+	01/18

Description

Identifies the primary treatment volume or primary anatomic target treated during the third phase of radiation therapy during the first course of treatment. This data item is required for CoC-accredited facilities for cases diagnosed 01/01/2018 and later.

Rationale

Radiation treatment is commonly delivered in one or more phases. Typically, in each phase, the primary tumor or tumor bed is treated. This data item should be used to indicate the primary target volume, which might include the primary tumor or tumor bed. If the primary tumor was not targeted, record the other regional or distant site that was targeted. Draining lymph nodes may also be targeted during the first phase. These will be identified in a separate data item *Phase III Radiation to Draining Lymph Nodes* [1525].

This data item provides information describing the anatomical structure targeted by radiation therapy during the third phase of radiation treatment and can be used to determine whether the site of the primary disease was treated with radiation or if other regional or distant sites were targeted. This information is useful in evaluating the patterns of care within a facility and on a regional or national basis. The breakdown and reorganization of the sites will allow for concise reporting.

Coding Instructions

- Radiation treatment volume will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the exact treatment volume may require assistance from the radiation oncologist for consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase II, Phase III, etc. accordingly.
- If one or more discrete volumes are treated and one of those includes the primary site, record the treatment to the primary site in this data item.
- A new phase begins when there is a clinically meaningful change in target volume, treatment fraction size (i.e., dose given during a session), modality or treatment technique. Any one of these changes will generally mean that a new radiation plan will be generated in the treatment planning system, and it should be coded as a new phase of radiation therapy.
    - Note: "on-line adaptive therapy" refers to treatments where radiation treatment plans are adapted or updated while a patient is on the treatment table. When treatment plans are adapted, the shape of the target volume may change from day to day, but for registry purposes, the volume that is being targeted won't change. An adapted plan should not be coded as though a new phase of treatment has been initiated unless, as above, the radiation oncologist documents it as a new phase in the radiation treatment summary.
- Code 00 if the tumor was diagnosed at autopsy.

- Phase III of radiation treatment also commonly includes draining lymph node regions that are associated with the primary tumor or tumor bed. The draining lymph nodes are recorded in the *Phase III Radiation to Draining Lymph Nodes* [1525].
    - Note: When the Primary Treatment Volume is lymph nodes draining lymph nodes are not targeted. Record code 88 in the *Phase III Radiation to Draining Lymph Nodes* [1525].
- Blanks allowed if no Phase II radiation treatment administered

Code	Label	Definition
00	No radiation treatment	Radiation therapy was not administered to the patient. Diagnosed at autopsy.
01	Neck lymph node regions	The primary treatment is directed at lymph node regions of the neck. Example situations include treatment of lymphoma or lymph node recurrence (in the absence of primary site failure) following definitive surgery of the primary tumor. If radiation to the neck lymph nodes includes the supraclavicular region use code 03.
02	Thoracic lymph node regions	Radiation therapy is directed to some combination of hilar, mediastinal, and supraclavicular lymph nodes without concurrent treatment of a visceral organ site. Example situations include mantle or mini-mantle for lymphomas, and treatment of lymphatic recurrence after complete surgical excision of a thoracic primary. Note that the supraclavicular region may be part of a head and neck lymph node region. Use code 03 for treatments directed at neck nodes and supraclavicular nodes with a head and neck primary. Use code 04 if supraclavicular lymph nodes are part of breast treatment.
03	Neck and thoracic lymph node regions	Treatment is directed to lymph nodes in the neck and thoracic region without concurrent treatment of a primary visceral tumor. This code might apply to some mantle or mini-mantle fields used in lymphoma treatments or some treatments for lymphatic recurrences following definitive treatment for tumors of the head and neck or thoracic regions.
04	Breast/Chest wall lymph node regions	Radiation is directed primarily to some combination of axillary, supraclavicular, and/or internal mammary lymph node sites WITHOUT concurrent treatment of the breast or chest wall. If the breast AND lymph nodes are being treated then code the Primary Treatment Volume to Breast (codes 40 or 41) and Breast/chest wall lymph nodes (code 04) in Radiation to Draining Lymph Nodes.
05	Abdominal lymph nodes	Treatment is directed to some combination of the lymph nodes of the abdomen, including retro-crural, peri-gastric, peri-hepatic, portocaval and para-aortic nodes. Possible situations might include seminoma, lymphoma or lymph node recurrence following surgical resection of the prostate, bladder or uterus.
06	Pelvic lymph nodes	Treatment is directed to some combination of the lymph nodes of the pelvis, including the common, internal and external iliac, obturator, inguinal and peri-rectal lymph nodes. This might be done for lymphoma or lymph node recurrence following definitive surgery for a pelvic organ.

Code	Label	Definition
07	Abdominal and pelvic lymph nodes	Treatment is directed to a combination of lymph nodes in both the abdomen and pelvis. This code includes extended fields ("hockey stick", "dog-leg", "inverted Y", etc.) utilized to treat seminomas and lymphomas or recurrence of a solid tumor.
09	Lymph node region, NOS	This category should be used to code treatments directed at lymph node regions that are not adequately described by codes 01-07.
10	Eye/orbit/optic nerve	Treatment is directed at all or a portion of the eye, orbit and/or optic nerve.
11	Pituitary	Treatment is directed at the pituitary gland.
12	Brain	Treatment is directed at all the brain and its meninges ("Whole brain").
13	Brain (Limited)	Treatment is directed at one or more sub-sites of the brain but not the whole brain. Chart may describe "SRS", "Stereotactic Radiosurgery", "Gamma Knife®".
14	Spinal cord	Treatment is directed at all or a portion of the spinal cord or its meninges.
20	Nasopharynx	Treatment is directed at all or a portion of the nasopharynx.
21	Oral Cavity	Treatment is directed at all or a portion of the oral cavity, including the lips, gingiva, alveolus, buccal mucosa, retromolar trigone, hard palate, floor of mouth and oral tongue.
22	Oropharynx	Treatment is directed at all or a portion of the oropharynx, including the soft palate, tonsils, base of tongue and pharyngeal wall.
23	Larynx (glottis) or hypopharynx	Treatment is directed at all or a portion of the larynx and/or hypopharynx.
24	Sinuses/Nasal tract	Treatment is directed at all or a portion of the sinuses and nasal tract, including the frontal, ethmoid, sphenoid and maxillary sinuses.
25	Parotid or other salivary glands	Treatment is directed at the parotid or other salivary glands, including the submandibular, sublingual and minor salivary glands.
26	Thyroid	Treatment is directed at all or a portion of the thyroid. Code this volume when the thyroid is treated with I-131 radioisotope.
29	Head and neck (NOS)	The treatment volume is directed at a primary tumor of the head and neck, but the primary sub-site is not a head and neck organ identified by codes 20-26 or it is an "unknown primary".
30	Lung or bronchus	Treatment is directed at all or a portion of the lung or bronchus.
31	Mesothelium	Treatment is directed to all or a portion of the mesothelium. This code should be used for mesothelioma primaries, even if a portion of the lung is included in the radiation field.
32	Thymus	Treatment is directed to all or a portion of the thymus.
39	Chest/lung (NOS)	The treatment is directed at a primary tumor of the chest, but the primary sub-site is unknown or not identified in codes 30-32. For example, this code should be used for sarcomas arising from the mediastinum.
40	Breast - whole	Treatment is directed at all the intact breast. Intact breast includes breast tissue that either was not surgically treated or received a lumpectomy or partial mastectomy.

Code	Label	Definition
41	Breast - partial	Treatment is directed at a portion of the intact breast but not the whole breast. The chart may have terms such as "Mammosite", "interstitial (seed) implant)", or "(accelerated) partial breast irradiation". Consider the possibility of partial breast irradiation when "IMRT" is documented in the record.
42	Chest wall	Treatment encompasses the chest wall (following mastectomy).
50	Esophagus	Treatment is directed at all or a portion of the esophagus. Include tumors of the gastro-esophageal junction.
51	Stomach	Treatment is directed at all or a portion of the stomach.
52	Small bowel	Treatment is directed at all or a portion of the small bowel.
53	Colon	Treatment is directed at all or a portion of the colon.
54	Rectum	Treatment is directed at all or a portion of the rectum.
55	Anus	Treatment is directed at all or a portion of the anus.
56	Liver	Treatment is directed at all or a portion of the liver.
57	Biliary tree or gallbladder	Treatment is directed at all or a portion of the biliary tree or gallbladder.
58	Pancreas or hepatopancreatic ampulla	Treatment is directed at all or a portion of the pancreas or the hepatopancreatic ampulla. Hepatopancreatic ampulla tumors are sometimes referred to as periampullary tumors.
59	Abdomen (NOS)	The treatment volume is directed at a primary tumor of the abdomen, but the primary sub-site is not an abdominal organ defined by codes 50-58 or it is considered to be an "unknown primary". For example, this code should be used for sarcomas arising from the abdominal retroperitoneum.
60	Bladder - whole	Treatment is directed at all the bladder.
61	Bladder - partial	Treatment is directed at a portion of the bladder but not the whole bladder.
62	Kidney	Treatment is directed at all or a portion of the kidney.
63	Ureter	Treatment is directed at all or a portion of the ureter.
64	Prostate - whole	Treatment is directed at all the prostate and/or seminal vesicles. Use this code even if seminal vesicles are not explicitly targeted.
65	Prostate - partial	Treatment is directed at a portion of the prostate but not the whole prostate.
66	Urethra	Treatment is directed at all or a portion of the urethra.
67	Penis	Treatment is directed at all or a portion of the penis. Treatments of urethral primaries should be coded as ‘urethra’ (code 66).
68	Testicle or scrotum	Treatment is directed at all or a portion of the testicle and/or scrotum.
70	Ovaries or fallopian tubes	Treatment is directed at all or a portion of the ovaries or fallopian tubes.
71	Uterus or Cervix	Treatment is directed at all or a portion of the uterus, endometrium or cervix.
72	Vagina	Treatment is directed at all or a portion of the vagina. Treatments of urethral primaries should be coded as ‘urethra’ (code 66).

Code	Label	Definition
73	Vulva	Treatment is directed at all or a portion of the vulva. Treatments of urethral primaries should be coded as 'urethra'.
80	Skull	Treatment is directed at all or a portion of the bones of the skull. Any brain irradiation is a secondary consequence.
81	Spine/vertebral bodies	Treatment is directed at all or a portion of the bones of the spine/vertebral bodies, including the sacrum. Spinal cord malignancies should be coded using 'spinal cord' (code 14).
82	Shoulder	Treatment is directed to all or a portion of the proximal humerus, scapula, clavicle, or other components of the shoulder complex.
83	Ribs	Treatment is directed at all or a portion of one or more ribs.
84	Hip	Treatment is directed at all or a portion of the proximal femur or acetabulum.
85	Pelvic bones	Treatment is directed at all or a portion of the bones of the pelvis other than the hip or sacrum.
86	Pelvis (NOS, non-visceral)	The treatment volume is directed at a primary tumor of the pelvis, but the primary sub-site is not a pelvic organ or is not known or indicated. For example, this code should be used for sarcomas arising from the pelvis.
88	Extremity bone, NOS	Treatment is directed at all or a portion of the bones of the arms or legs. This excludes the proximal femur (Hip, code 84). This excludes the proximal humerus (Shoulder, code 82).
90	Skin	Treatment is directed at all or a portion of the skin. The primary malignancy originates in the skin and the skin is the primary target. So-called skin metastases are usually subcutaneous and should be coded as a soft tissue site.
91	Soft tissue	This category should be used to code primary or metastatic soft tissue malignancies not fitting other categories.
92	Hemibody	A single treatment volume encompassing either all structures above the diaphragm, or all structures below the diaphragm. This is almost always administered for palliation of widespread bone metastasis in patients with prostate or breast cancer.
93	Whole body	Treatment is directed to the entire body included in a single treatment.
94	Mantle, mini-mantle (obsolete after 2017)	For conversion of historical data only
95	Lower extended field (obsolete after 2017)	For conversion of historical data only
96	Inverted Y (obsolete after 2017)	For conversion of historical data only
98	Other	Radiation therapy administered; treatment volume other than those previously categorized by codes 01-93.
99	Unknown	This category should be used to code treatments for which there is no information available about the Phase III treatment volume, or it is unknown if Phase III radiation treatment was administered.

Phase III Radiation to Draining Lymph Nodes

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1525	2	2327-2328	00-08, 88, 99, Blank	2018+	01/18

Description

Identifies the draining lymph nodes treated (if any) during the third phase of radiation therapy delivered to the patient during the first course of treatment. This data item is required for CoC-accredited facilities for cases diagnosed 01/01/2018 and later.

Rationale

The third phase of radiation treatment commonly targets both the primary tumor (or tumor bed) and draining lymph nodes as a secondary site. This data item should be used to indicate the draining regional lymph nodes, if any, that were irradiated during the third phase of radiation to the primary site.

Coding Instructions:

- Radiation treatment to draining lymph nodes will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the exact draining lymph nodes may require assistance from the radiation oncologist for consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase II, Phase III, etc. accordingly.
- Code 00 if the tumor was diagnosed at autopsy.
- Phase III of radiation treatment includes primary tumor or tumor bed in addition to the draining lymph node regions that are associated with the primary tumor or tumor bed. The primary tumor or tumor bed is recorded in the *Phase III Radiation Primary Treatment Volume* [1524].
    - Note: When the Primary Treatment Volume is lymph nodes, draining lymph nodes are not targeted. Record code 88 in this data item.
- Blanks allowed if no Phase III radiation treatment administered.

Code	Label
00	No radiation treatment to draining lymph nodes. Diagnosed at autopsy.
01	Neck lymph node regions
02	Thoracic lymph node regions
03	Neck and thoracic lymph node regions
04	Breast/chest wall lymph node regions
05	Abdominal lymph nodes
06	Pelvic lymph nodes
07	Abdominal and pelvic lymph nodes
08	Lymph node region, NOS
88	Not applicable; Phase III Radiation Primary Treatment Volume is lymph nodes
99	Unknown if any radiation treatment to draining lymph nodes; Unknown if radiation treatment administered

Phase III Radiation Treatment Modality

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1526	2	2319-2324	00-16, 99, Blank	2018+	01/18

Description

Identifies the radiation modality administered during the third phase of radiation treatment delivered during the first course of treatment. This data item is required for CoC-accredited facilities for cases diagnosed 01/01/2018 and later.

Rationale

Radiation modality reflects whether a treatment was external beam, brachytherapy, a radioisotope as well as their major subtypes, or a combination of modalities. This data item should be used to indicate the radiation modality administered during the third phase of radiation.

Historically, the previously-named *Radiation Treatment Modality* [1570] utilized codes that were not mutually exclusive. Rather, it included codes describing a mix of modalities, treatment planning techniques, and delivery techniques that are commonly utilized by radiation oncologists. However, every phase of radiation treatment will include a specified modality, planning technique, and delivery technique. The goal of the 2018 implementation of separate phase-specific data items for the recording of radiation modality and external beam radiation treatment planning techniques is to clarify this information and implement mutually exclusive categories. A separate data item for delivery technique has not been implemented because this information is not consistently reported in end of treatment summaries.

Coding Instructions

- Radiation treatment modality will typically be found in the radiation oncologist's summary letter for the first course of treatment. Segregation of treatment components into Phases and determination of the respective treatment modality may require assistance from the radiation oncologist to ensure consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase II, Phase III, etc. accordingly.
- A new phase begins when there is a clinically meaningful change in target volume, treatment fraction size (I.e. dose given during a session), modality or treatment technique. Any one of these changes will mean that a new radiation plan will be generated in the treatment planning system, and it should be coded as a new phase of radiation therapy.
- For purposes of this data item, photons, x-rays and gamma-rays are equivalent.
- Use code 13 - Radioisotopes, NOS for radioembolization procedures, e.g. intravascular Yttrium-90.
- This data item intentionally does not include reference to various MV energies because this is not a clinically important aspect of technique. A change in MV energy (e.g., 6MV to 12MV) is not clinically relevant and does not represent a change in treatment technique. It is rare for change in MV energy to occur during any phase of radiation therapy.
- A new phase begins when there is a clinically meaningful change in target volume, treatment fraction size (i.e., dose given during a session), modality or treatment technique. Any one of these changes will generally mean that a new radiation plan will be generated in the treatment planning system and should be coded as a new phase of radiation therapy.

- If this data item is coded to any of the External beam codes (01-06), the planning technique must be recorded in the data item *Phase III External Beam Radiation Planning Technique* [1522].
- If this data item is coded to any of the radioisotopes codes (13-16) the code of 88 must be recorded in the data item *Phase III External Beam Radiation Planning Technique* [1522].
    - Note: Do not confuse a radioiodine scan with treatment. Only treatment is recorded in this item.
- Blanks allowed if no Phase III radiation treatment administered.

Code	Label
00	No radiation treatment
01	External beam, NOS
02	External beam, photons
03	External beam, protons
04	External beam, electrons
05	External beam, neutrons
06	External beam, carbon ions
07	Brachytherapy, NOS
08	Brachytherapy, intracavitary, LDR
09	Brachytherapy, intracavitary, HDR
10	Brachytherapy, Interstitial, LDR
11	Brachytherapy, Interstitial, HDR
12	Brachytherapy, electronic
13	Radioisotopes, NOS
14	Radioisotopes, Radium-223
15	Radioisotopes, Strontium-89
16	Radioisotopes, Strontium-90
99	Radiation treatment modality unknown; Unknown if radiation treatment administered

Phase III External Beam Radiation Planning Technique

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1522	2	2331-2332	00-10, 88, 98, 99, Blank	2018+	01/18

Description

Identifies the external beam radiation planning technique used to administer the third phase of radiation treatment during the first course of treatment. This data item is required for CoC-accredited facilities for cases diagnosed 01/01/2018 and later.

Rationale

External beam radiation is the most commonly-used radiation modality in North America. In this data item we specified the planning technique for external beam treatment. Identifying the radiation technique is of interest for patterns of care and comparative effectiveness studies.

Historically, the previously-named *Regional Treatment Modality* [1570] utilized codes that were not mutually exclusive. Rather, it included codes describing a mix of modalities, treatment planning techniques, and delivery techniques that are commonly utilized by radiation oncologists. However, every phase of radiation treatment will include a specified modality, planning technique, and delivery technique. The goal of the 2018 implementation of separate phase-specific data items for the recording of Phase III Radiation Treatment Modality [1526] and Phase III External Beam Radiation Planning Technique [1522] is to clarify this information and implement mutually exclusive categories. Note that Planning Technique details are not being captured for non-External Beam modalities. A separate data item for delivery technique has not been implemented because this information is not consistently reported in end treatment summaries.

Coding instructions

- Radiation external beam treatment planning technique will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the external beam planning technique may require assistance from the radiation oncologist to ensure consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase II, Phase III, etc. accordingly.
- A new phase begins when there is a clinically meaningful change in target volume, treatment fraction size (i.e., dose given during a session), modality or treatment technique. Any one of these changes will generally mean that a new radiation plan will be generated in the treatment planning system and should be coded as a new phase of radiation therapy.
    - Note: "on-line adaptive therapy" refers to treatments where radiation treatment plans are adapted or updated while a patient is on the treatment table. When treatment plans are adapted, the shape of the target volume may change from day to day but, for registry purposes, the volume that is being targeted won't change. An adapted plan should not be coded as though a new phase of treatment has been initiated unless, as above, the radiation oncologist documents it as a new phase in the radiation treatment summary. Two new technique codes have been added to capture when online adaptive therapy is occurring: CT guided and MR guided adaptive therapy.
- Code 00, no radiation treatment, when diagnosed at autopsy.
- Code 05 for Intensity Modulated Therapy (IMT) or Intensity Modulated Radiation Therapy (IMRT).
- Code 04 for Conformal or 3-D Conformal Therapy whenever either is explicitly mentioned.

- When code 98 is recorded, document the planning technique in the appropriate text data item.
- Blanks allowed if no Phase III radiation treatment administered.

Code	Label	Definition
00	No radiation treatment	Radiation therapy was not administered to the patient. Diagnosed at autopsy.
01	External beam, NOS	The treatment is known to be by external beam, but there is insufficient information to determine the specific planning technique.
02	Low energy x-ray/photon therapy	External beam therapy administered using equipment with a maximum energy of less than one (1) million volts (MV). Energies are typically expressed in units of kilovolts (kV). These types of treatments are sometimes referred to as electronic brachytherapy or orthovoltage or superficial therapy. Clinical notes may refer to the brand names of low energy x-ray delivery devices, e.g. Axxent®, INTRABEAM®, or Esteya®.
03	2-D therapy	An external beam planning technique using 2-D imaging, such as plain film x-rays or fluoroscopic images, to define the location and size of the treatment beams. Should be clearly described as 2-D therapy. This planning modality is typically used only for palliative treatments.
04	Conformal or 3-D conformal therapy	An external beam planning technique using multiple, fixed beams shaped to conform to a defined target volume. Should be clearly described as conformal or 3-D therapy in patient record.
05	Intensity modulated therapy	An external beam planning technique where the shape or energy of beams is optimized using software algorithms. Any external beam modality can be modulated but these generally refer to photon or proton beams. Intensity modulated therapy can be described as intensity modulated radiation therapy (IMRT), intensity modulated x-ray or proton therapy (IMXT/IMPT), volumetric arc therapy (VMAT) and other ways. If a treatment is described as IMRT with online re-optimization/re-planning, then it should be categorized as online re-optimization or re-planning.
06	Stereotactic radiotherapy or radiosurgery, NOS	Treatment planning using stereotactic radiotherapy/radiosurgery techniques, but the treatment is not described as Cyberknife® or Gamma Knife®. These approaches are sometimes described as SBRT (stereotactic body radiation), SABR (stereotactic ablative radiation), SRS (stereotactic radiosurgery), or SRT (stereotactic radiotherapy). If the treatment is described as robotic radiotherapy (e.g. Cyberknife®) or Gamma Knife®, use stereotactic radiotherapy subcodes below. If a treatment is described as stereotactic radiotherapy or radiosurgery with online re-optimization/re-planning, then it should be categorized as online re-optimization or re-planning.
07	Stereotactic radiotherapy or radiosurgery, robotic.	Treatment planning using stereotactic radiotherapy/radiosurgery techniques which is specifically described as robotic (e.g. Cyberknife®).

Code	Label	Definition
08	Stereotactic radiotherapy or radiosurgery, Gamma Knife®	Treatment planning using stereotactic radiotherapy/radiosurgery techniques which uses a Cobalt-60 gamma ray source and is specifically described as Gamma Knife®. This is most commonly used for treatments in the brain.
09	CT-guided online adaptive therapy	An external beam technique in which the treatment plan is adapted over the course of radiation to reflect changes in the patient's tumor or normal anatomy radiation using a CT scan obtained at the treatment machine (online). These approaches are sometimes described as CT-guided online re-optimization or online re-planning. If a treatment technique is described as both CT-guided online adaptive therapy as well as another external beam technique (IMRT, SBRT, etc.), then it should be categorized as CT-guided online adaptive therapy. If a treatment is described as "adaptive" but does not include the descriptor "online", this code should not be used.
10	MR-guided online adaptive therapy	An external beam technique in which the treatment plan is adapted over the course of radiation to reflect changes in the patient's tumor or normal anatomy radiation using an MRI scan obtained at the treatment machine (online). These approaches are sometimes described as MR-guided online re-optimization or online re-planning. If a treatment technique is described as both MR-guided online adaptive therapy as well as another external beam technique (IMRT, SBRT, etc.), then it should be categorized as MR-guided online adaptive therapy. If a treatment is described as "adaptive" but does not include the descriptor "online", this code should not be used.
88	Not Applicable	Treatment not by external beam
98	Other, NOS	Other radiation, NOS; Radiation therapy administered, but the treatment modality is not specified or is unknown.
99	Unknown	It is unknown whether radiation therapy was administered.

Phase III Dose per Fraction

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1521	5	2333-2337	00000-99999, Blank	2018+	01/18

Description

Records the dose per fraction (treatment session) delivered to the patient in the third phase of radiation during the first course of treatment. The unit of measure is centi-Gray (cGy). This data item is required for CoC-accredited facilities for cases diagnosed as of 01/01/2018 and later.

Rationale

Radiation therapy is delivered in one or more phases with identified dose per fraction. It is necessary to capture information describing the dose per fraction to evaluate patterns of radiation oncology care. Outcomes are strongly related to the dose delivered.

Coding Instructions

- The International Council for Radiation Protection (ICRP) recommends recording doses at the axis point where applicable (opposed fields, four field box, wedged pair, and so on). For maximum consistency in this data item, the ICRP recommendations should be followed whenever possible. Where there is no clear axis point, record the total dose as indicated in the summary chart. Determining the exact dose may require assistance from the radiation oncologist for consistent coding.
- Radiation treatment Phase III dose will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the Phase III dose of radiation therapy may require assistance from the radiation oncologist for consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase II, Phase III, etc. accordingly.
- Record the actual dose <u>delivered</u> (NOT the initially prescribed dose) as documented in the treatment summary.
- For proton treatment, dosage may occasionally be specified as in cGe units (Cobalt Gray Equivalent) rather than cGy. 1 cGe = 100 cGy (for the Phase I Total Dose, you would need to multiply cGe by 100).
    - Note that dose is still occasionally specified in "rads". One rad is equivalent to one centi-Gray (cGy).
- There may be times when the first course of treatment information is incomplete. Therefore, it is important to continue follow-up efforts to be certain the complete treatment information is collected.
- Code 99998 when radioisotopes were administered to the patient (codes 13-16 for Phase III Treatment Modality [1526]).
- Blanks allowed if no Phase III radiation treatment administered.

Code	Label
00000	No radiation treatment
00001-99997	Record the actual Phase III dose delivered in cGy

Code	Label
99998	Not applicable, radioisotopes administered to the patient
99999	Phase III radiation therapy was administered but dose is unknown; It is unknown whether Phase III radiation therapy was administered. Death Certificate only.

Examples

Code	Reason
00200	A patient with a metastatic left supraclavicular node and an isolated liver metastasis from a gastric carcinoma received 6,000 cGy to the stomach. 2000 cGy external beam administered to the supraclavicular node in 10 fractions followed by 2000 cGy administered to the liver metastasis in ten fractions. Record 00200 for phase III dose per fraction.
00200	A patient with a Stage II breast carcinoma is treated with the breast intact. Tangent fields are utilized to bring the dose of the breast to 5,500 cGy in 25 fractions. The axillary lymph nodes were then treated with an additional 1000 cGy in 10 fractions. Phase III in the primary tumor bed delivered to a small volume in the breast of 1000 cGy in 5 fractions. Record 00200 for phase III dose per fraction.

Phase III Number of Fractions

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1523	3	2338-2340	000-999, Blank	2018+	01/18

Description

Records the total number of fractions (treatment sessions) delivered to the patient in the third phase of radiation during the first course of treatment. This data item is required for CoC-accredited facilities for cases diagnosed as of 01/01/2018 and later.

Rationale

Radiation therapy is delivered in one or more phases with each phase spread out over a number of fractions (treatment sessions). It is necessary to capture information describing the number of fraction(s) to evaluate patterns of radiation oncology care.

Coding Instructions

- The number of fractions or treatments will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the exact number of treatments or fractions delivered to the patient may require assistance from the radiation oncologist for consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase II, Phase III, etc. accordingly.
- Although a fraction or treatment session may include several treatment portals delivered within a relatively confined period of time-usually a few minutes-it is still considered one session.
- Count each separate administration of brachytherapy or implants as a single fraction or treatment.
- Record the actual number of fractions delivered (NOT initially prescribed), as documented in the treatment summary.
- Code 999 for Death Certificate Only (DCO) cases.
- There may be times when the first course of treatment information is incomplete. Therefore, it is important to continue follow-up efforts to be certain the complete treatment information is collected.
- Blanks allowed if no Phase III radiation treatment administered.

Code	Label
000	No radiation treatment
001-998	Number of fractions administered to the patient during the second phase of radiation therapy
999	Phase III Radiation therapy was administered, but the number of fractions is unknown; It is unknown whether radiation therapy was administered. Death Certificate only.

Examples

Code	Reason
005	A patient with breast carcinoma had treatment sessions in which treatment was delivered to the chest wall and separately to the ipsilateral supraclavicular region for a total of three fraction portals. Phase III was an additional 1000 cGy to axillary nodes for 5 fractions. Record 005 for Phase III Number of Fractions.
Blank	A patient with Stage IIIB bronchogenic carcinoma received 25 treatments to the left hilum and mediastinum, given in 25 daily fractions over five weeks. Leave Phase III Number of Fractions blank. Only one phase of radiation therapy administered.
010	A patient with metastatic head and neck cancer was treated using "hyperfractionation." Three fields were delivered in each session; two sessions were given each day, six hours apart, with each session delivering a total dose of 150 cGy. Treatment was given for a total of 25 days. Additional 1000 cGy in 10 fractions given to thoracic spine followed by 1000 cGy in 10 fractions to liver. Record 010 for Phase III Number of Fractions.

Phase III Total Dose

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1527	6	2341-2346	000000-999999, Blank	2018+	01/18

Description

Identifies the total radiation dose administered during the third phase of radiation treatment delivered to the patient during the first course of treatment. The unit of measure is centi-Gray (cGy). This data item is required for CoC-accredited facilities for cases diagnosed as of 01/01/2018 and later.

Rationale

To evaluate the patterns of radiation care, it is necessary to capture information describing the prescribed dose of Phase III radiation to the patient during the first course of treatment. Outcomes are strongly related to the total dose delivered.

Coding Instructions

- The International Council for Radiation Protection (ICRP) recommends recording doses at the axis point where applicable (opposed fields, four field box, wedged pair, and so on). For maximum consistency in this data item, the ICRP recommendations should be followed whenever possible. Where there is no clear axis point, record the total dose as indicated in the summary chart. Determining the exact dose may be highly subjective and require assistance from the radiation oncologist for consistent coding.
- Phase III radiation treatment dose will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the Phase III dose of radiation therapy may require assistance from the radiation oncologist for consistent coding.
- The first phase may be commonly referred to as an initial plan and a subsequent phase may be referred to as a boost or cone down, and would be recorded as Phase II, Phase III, etc. accordingly.
- Record the actual total dose delivered (NOT initially prescribed), as documented in the treatment summary. The value recorded for this data item should NOT be auto-calculated within the registry abstraction software.
- For proton treatment, dosage may occasionally be specified as in cGe units (Cobalt Gray Equivalent) rather than cGy. 1 cGe = 100 cGy (for the Phase III Total Dose, you would need to multiply cGe by 100).
    - Note that dose is still occasionally specified in "rads". One rad is equivalent to one centi-Gray (cGy).
- Code 000000, radiation therapy not administered, when diagnosed at autopsy.
- Code 999998 when radioisotopes are administered to the patient (codes 13-16 recorded in the *Phase III Treatment Modality* [1526]).
- Code 999999 for Death Certificate Only (DCO) cases.
- There may be times when the first course of treatment information is incomplete. Therefore, it is important to continue follow-up efforts to be certain the complete treatment information is collected.
- Blanks allowed if no Phase III radiation treatment administered.

Code	Label
000000	No radiation treatment. Diagnosed at autopsy.
000001-999997	Record the actual total dose delivered in cGy
999998	Not applicable, radioisotopes administered to the patient
999999	Radiation therapy was administered, but the total dose is unknown; it is unknown whether radiation therapy was administered. Death Certificate only.

Examples

Code	Reason
005000	A patient with Stage III prostate carcinoma received pelvic irradiation of 5,000 cGy during Phase III Radiation Treatment. Record the Phase III Total Dose of 5,000 cGy as 005000.
006000	A patient with a left supraclavicular metastasis from a gastric carcinoma received 6,000 cGy to the left supraclavicular region during Phase III Radiation Treatment. Record the Phase III Total Dose of 6,000 cGy as 006000.
005500	A patient with a Stage II breast carcinoma is treated with the breast intact. During Phase III treatment tangent fields are utilized to bring the dose of the breast to 5,500 cGy. The supraclavicular (draining) lymph nodes are treated 4,500 cGy, calculated to a depth of 3 cm. Record the Phase III Total Dose of 5,500cGy as 005500.

Number of Phases of Radiation Treatment to this Volume

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1532	2	2347-2348	00-04, 99	2018+	01/18

Description

Identifies the total number of phases administered to the patient during the first course of treatment. A "phase" consists of one or more consecutive treatments delivered to the same anatomic volume with no clinically meaningful change in fraction size, modality or treatment technique. Although the majority of courses of radiation therapy are completed in one or two phases (historically, the "regional" and "boost" treatments) there are occasions in which three or more phases are used, most typically with head and neck malignancies. This data item is required for CoC-accredited facilities for cases diagnosed as of 01/01/2018 and later.

Rationale

The number of phases of radiation treatment is used to evaluate patterns of radiation therapy and the treatment schedule.

Coding Instructions

- The number of phases of radiation treatment will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the exact number of phases delivered to the patient may require assistance from the radiation oncologist for consistent coding.

Code	Label
00	No radiation treatment
01	1 phase
02	2 phases
03	3 phases
04	4 or more phases
99	Unknown number of phases; Unknown if radiation therapy administered.

Examples

Code	Reason
00	Radiation therapy was not administered.
02	Patient with breast carcinoma treated in two phases, the whole breast with opposed x-ray fields (Phase I) followed by an electron beam boost to the surgical bed (Phase II).

Radiation Treatment Discontinued Early

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1531	2	2349-2350	00-07, 99	2018+	01/18

Description

This field is used to identify patients/tumors whose radiation treatment course was discontinued earlier than initially planned. That is, the patients/tumors received fewer treatment fractions (sessions) than originally intended by the treating physician. This data item is required for CoC-accredited facilities for cases diagnosed 01/01/2018 and later.

Rationale

Currently, the total dose of radiation reflects what was actually delivered rather than what was intended. When a patient doesn't complete a radiation course as initially intended this is typically commented on within the radiation end of treatment summary. By flagging these patients within the cancer registry database, these patients can be excluded from analyses attempting to describe adherence to radiation treatment guidelines or patterns of care analyses.

Coding Instructions

- Radiation treatment recorded as discontinued early will typically be found in the radiation oncologist's summary letter for the first course of treatment.
- Use code 01 when there is no indication in the record that radiation therapy was discontinued or completed early.
- Use code 02-07 when there is an indication in the record that the radiation therapy discontinued or was completed early.
- Use code 99 when radiation therapy was administered, but it is not clear if the treatment course was discontinued early, or if it is unknown whether radiation therapy was administered, or it is a death certificate only case.

Code	Label
00	No radiation treatment
01	Radiation treatment completed as prescribed
02	Radiation treatment discontinued early - toxicity
03	Radiation treatment discontinued early - contraindicated due to other patient risk factors (comorbid conditions, advanced age, progression of tumor prior to planned radiation etc.)
04	Radiation treatment discontinued early - patient decision
05	Radiation discontinued early - family decision
06	Radiation discontinued early - patient expired
07	Radiation discontinued early - reason not documented
99	Unknown if radiation treatment discontinued; Unknown whether radiation therapy administered. Death Certificate only.

Total Dose

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1533	6	2351-2356	000000-999999	2018+	01/18

Description

Identifies the total cumulative radiation dose administered to the patient across all phases during the first course of treatment. The unit of measure is centi-Gray (cGy). This data item is required for CoC-accredited facilities for cases diagnosed 01/01/2018 and later.

Rationale

To evaluate the patterns of radiation care, it is necessary to capture information describing the prescribed total dose of radiation during the first course of treatment. Outcomes are strongly related to the dose delivered.

Coding Instructions

- The International Council for Radiation Protection (ICRP) recommends recording doses at the axis point where applicable (opposed fields, four field box, wedged pair, and so on). For maximum consistency in this data item, the ICRP recommendations should be followed whenever possible. Where there is no clear axis point, record the total dose as indicated in the summary chart. Determining the exact dose may require assistance from the radiation oncologist for consistent coding.
- Total radiation treatment dose will typically be found in the radiation oncologist's summary letter for the first course of treatment. If the total is not documented, then add the dose from each phase (I, II, III, or IV or more) and document the total cumulative dose. However, do not sum doses across phases if the phases use different treatment fraction sizes or modalities (i.e. external beam in Phase I and brachytherapy in Phase II). Determination of the total dose of radiation therapy may require assistance from the radiation oncologist for consistent coding.
- For proton treatment, dosage may occasionally be specified as in cGe units (Cobalt Gray Equivalent) rather than cGy. 1 cGe = 100 cGy (for the Phase I Total Dose, you would need to multiply cGe by 100).
    - Note that dose is still occasionally specified in "rads". One rad is equivalent to one centi-Gray (cGy).
- There may be times when the first course of treatment information is incomplete. Therefore, it is important to continue follow-up efforts to be certain the complete treatment information is collected.
- Code 999998 when radioisotopes are administered to the patient (codes 13-16 recorded in the Phase I, Phase II, or Phase III Treatment Modality [1506, 1516, 1526] data items).
- Doses should ONLY be summed across phases to create a Total Dose when all of the phases were delivered sequentially to the same body site using the same modality and dose-fractionation. If phases were delivered simultaneously (multiple body sites [volumes], e.g. simultaneous treatment to multiple metastatic sites, or dose-painting), with brachytherapy and any other different modality (e.g. external beam with a brachytherapy boost), or using different fractionation schemes, then code 999998, Not applicable.
- Code 000000, radiation therapy not administered, when diagnosed at autopsy.

Code	Label
000000	No radiation treatment. Diagnosed at autopsy.
000001-999997	Record the actual total dose delivered in cGy
999998	Not applicable, radioisotopes administered to the patient
999999	Radiation therapy was administered, but the total dose is unknown; it is unknown whether radiation therapy was administered

Radiation/Surgery Sequence

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1380	1	2240-2240	0, 2-7, 9	2003+	01/04, 01/10, 01/11, 01/12

Description

Records the sequencing of radiation and surgical procedures given as part of the first course of treatment.

Rationale

The sequence of radiation and surgical procedures given as part of the first course of treatment cannot always be determined using the date on which each modality was started or performed. This data item can be used to more precisely evaluate the timing of delivery of treatment to the patient.

Coding Instructions

- Surgical procedures include *Surgical Procedure of Primary Site* [1290]; *Scope of Regional Lymph Node Surgery* [1292]; *Surgical Procedure/Other Site* [1294]. If all these procedures are coded 0, or it is not known whether the patient received both surgery and radiation, then this item should be coded 0.
- If the patient received both radiation therapy and any one or a combination of the following surgical procedures: *Surgical Procedure of Primary Site, Regional Lymph Node Surgery,* or *Surgical Procedure/Other Site*, then code this item 2–9, as appropriate.
- If multiple first course treatment episodes were given such that both codes 4 and 7 seem to apply, use the code that defines the first sequence that applies.

Code	Label	Definition
0	No radiation therapy and/or surgical procedures	No radiation therapy given or unknown if radiation therapy given; and/or no surgery of the primary site; no scope of regional lymph node surgery; no surgery to other regional site(s), distant site(s), or distant lymph node(s) or it is unknown whether any surgery given.
2	Radiation therapy before surgery	Radiation therapy given before surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
3	Radiation therapy after surgery	Radiation therapy given after surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
4	Radiation therapy both before and after surgery	At least two courses of radiation therapy are given before and at least two more after surgery to the primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
5	Intraoperative radiation therapy	Intraoperative therapy given during surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).

Code	Label	Definition
6	Intraoperative radiation therapy with other therapy administered before or after surgery	Intraoperative radiation therapy given during surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s) with other radiation therapy administered before or after surgery to primary site; scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s).
7	Surgery both before and after radiation	Radiation was administered between two separate surgical procedures to the primary site; regional lymph nodes; surgery to other regional site(s), distant site(s), or distant lymph node(s).
9	Sequence unknown	Administration of radiation therapy and surgery to primary site, scope of regional lymph node surgery, surgery to other regional site(s), distant site(s), or distant lymph node(s) were performed and the sequence of the treatment is not stated in the patient record.

Examples

Code	Reason
0	Due to other medical conditions surgery was not performed. The patient received palliative radiation therapy to alleviate pain.
2	A large lung lesion received radiation therapy prior to resection.
3	A patient received a wedge resection of a right breast mass with axillary lymph node dissection followed by radiation to right breast.
4	Preoperative radiation therapy was given to a large, bulky vulvar lesion and was followed by a lymph node dissection. This was then followed by radiation therapy to treat positive lymph nodes.
5	A cone biopsy of the cervix was followed by intracavitary implant for IIIB cervical carcinoma.
6	Stage IV vaginal carcinoma was treated with 5,000 cGy to the pelvis followed by a lymph node dissection and 2,500 cGy of intracavitary brachytherapy.
9	An unknown primary of the head and neck was treated with surgery and radiation prior to admission, but the sequence is unknown. The patient enters for chemotherapy.

Date Radiation Ended

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
3220	8	2154-2161	CCYYMMDD	2003+	06/05, 01/10, 01/11, 01/12

Description

The date on which the patient completes or receives the last radiation treatment at any facility.

Rationale

The length of time over which radiation therapy is administered to a patient is a factor in tumor control and treatment morbidity. It is useful to evaluate the quality of care and the success of patient support programs designed to maintain continuity of treatment.

Coding Instructions

- Date radiation ended will typically be found in the radiation oncologist's summary letter for the first course of treatment. Determination of the date radiation ended may require assistance from the radiation oncologist for consistent coding.
- The date when treatment ended will typically be found in the radiation oncologist's summary letter for the first course of treatment.
- For brachytherapy if the treatment is applied only once, this date will be the same as *Date Radiation Started* [1210].
- There may be times when the first course of treatment information is incomplete. Therefore, it is important to continue follow-up efforts to be certain the complete treatment information is collected.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date Radiation Ended* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date Radiation Ended* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *RX Date–Radiation Flag* [1211] is used to explain why *Date Radiation Ended* is not a known date. See *RX Date–Rad Ended Flag* for an illustration of the relationships among these items.

Examples

Code	Reason
20050104	A patient starts IMRT radiation treatment on December 15, 2004 and treatment continues until January 4, 2005.
20091002	A patient receives one radiation treatment on October 2, 2009, then refuses further treatments.
20060404	A patient with a primary tumor of the brain undergoes stereotactic radiosurgery using a Gamma Knife on April 4, 2006.

Rx Date Rad Ended Flag

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
3221	2	2162-2163	10-12, 15, Blank	2010+	02/10, 03/10

Description

This flag explains why there is no appropriate value in the corresponding date field, *Date Radiation Ended* [3220].

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

- Leave this item blank if *Date Radiation Ended* [3220] has a full or partial date recorded.
- Code 12 if the *Date Radiation Ended* cannot be determined, but the patient did receive first course radiation.
- Code 10 if it is unknown whether any radiation was given.
- Code 11 if no radiation is planned or given.
- Code 15 if radiation is ongoing. Follow this patient for radiation treatment and update this item, *Date Radiation Ended*, and all other radiation items.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Label
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any radiation was given).
11	No proper value is applicable in this context (for example, no radiation was administered).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, radiation was given but the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (that is, radiation therapy had begun at the time of the most recent follow-up but was not yet completed).
(blank)	A valid date value is provided in item *Date Radiation Ended* [3220].

Reason for No Radiation

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1430	1	2250-2250	0-2, 5-9	2003+	09/04, 01/13

Description

Records the reason that no regional radiation therapy was administered to the patient.

Rationale

When evaluating the quality of care, it is useful to know the reason that various methods of therapy were not used, and whether the failure to provide a given type of therapy was due to the physician's failure to recommend that treatment, or due to the refusal of the patient, a family member, or the patient's guardian.

Coding Instructions

- If *Number of Phases of Radiation Treatment to this Volume* [1532] is coded 00, *Phase I Radiation Primary Treatment Volume* [1504] is coded 00, *Radiation Treatment Discontinued Early* [1531] is coded 00, and *Total Dose* [1533] is coded 000000, then record the reason based on documentation in patient record.
- Code 1 if the treatment plan offered multiple alternative treatment options and the patient selected treatment that did not include radiation therapy.
- Code 7 if the patient refused recommended radiation therapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 8 if it is known that a physician recommended radiation treatment, but no further documentation is available yet to confirm its administration.
- Code 8 to indicate referral to a radiation oncologist was made and the registry should follow to determine whether radiation was administered. If follow-up to the specialist or facility determines the patient was never there and no other documentation can be found, code 1.
- Cases coded 8 should be followed and updated to a more definitive code as appropriate.
- Code 9 if the treatment plan offered multiple alternative treatment options, but it is unknown which treatment, if any, was provided. Death Certificate only.

Code	Label
0	Radiation therapy was administered.
1	Radiation therapy was not administered because it was not part of the planned first course treatment. Diagnosed at autopsy.
2	Radiation therapy was not recommended/administered because it was contraindicated due to other patient risk factors (comorbid conditions, advanced age, progression of tumor prior to planned radiation etc.).
5	Radiation therapy was not administered because the patient died prior to planned or recommended therapy.
6	Radiation therapy was not administered; it was recommended by the patient's physician, but was not administered as part of first course treatment. No reason was noted in patient record.

Code	Label
7	Radiation therapy was not administered; it was recommended by the patient's physician, but this treatment was refused by the patient, the patient's family member, or the patient's guardian. The refusal was noted in patient record.
8	Radiation therapy was recommended, but it is unknown whether it was administered.
9	It is unknown if radiation therapy was recommended or administered. Death certificate cases only.

Examples

Code	Reason
1	A patient with Stage I prostate cancer is offered either surgery or brachytherapy to treat his disease. The patient elects to be surgically treated.

Systemic Therapy Data Items

Date Systemic Therapy Started

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
3230	8	2164-2171	CCYYMMDD	2003+	01/10, 01/11

Description

Records the date of initiation for systemic therapy that is part of the first course of treatment. Systemic therapy includes the administration of chemotherapy agents, hormonal agents, biological response modifiers, bone marrow transplants, stem cell harvests, and surgical and/or radiation endocrine therapy.

Rationale

Collecting dates for each treatment modality allows the sequencing of multiple treatments and aids in the evaluation of time intervals from diagnosis to treatment and from treatment to recurrence.

Coding Instructions

- Record the first or earliest date on which systemic therapy was administered. Systemic therapy includes *Chemotherapy* [1390], *Hormone Therapy* [1400], *Immunotherapy* [1410], and *Hematologic Transplant and Endocrine Procedures* [3250].
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date Systemic Therapy Started* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date Systemic Therapy Started* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *RX Date Systemic Flag* [3231] is used to explain why *Date Systemic Therapy Started* is not a known date. See *RX Date Systemic Flag* for an illustration of the relationships among these items.

Examples

Code	Reason
20031215	A patient with breast cancer begins her regimen of chemotherapy on December 15, 2003, and is subsequently given Tamoxifen on January 20, 2004.
20030602	A patient with Stage IV prostate cancer has an orchiectomy on June 2, 2003. He is then started on a regime of hormonal agents on June 9, 2003.

Rx Date Systemic Flag

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
3231	2	2172-2173	10-12, 15, Blank	2010+	01/12

Description

This flag explains why there is no appropriate value in the corresponding date field, *Date Systemic Therapy Started* [3230].

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

- Leave this item blank if *Date Systemic Therapy Started* [3230] has a full or partial date recorded.
- Code 12 if the *Date Systemic Therapy Started* cannot be determined, but the patient did receive first course systemic therapy.
- Code 10 if it is unknown whether any systemic therapy was given.
- Code 11 if no systemic therapy is planned or given.
- Code 15 if systemic therapy is planned, but not yet started. Follow this patient for systemic therapy and update this item, *Date Systemic Therapy Started*, and all relevant systemic therapy items.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Label
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any systemic therapy was given).
11	No proper value is applicable in this context (for example, no systemic therapy given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, systemic therapy was given but the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (that is, systemic therapy is planned as part of first course treatment, but had not yet started at the time of the last follow-up).
(blank)	A valid date value is provided in item *Date Systemic Therapy Started* [3230].

Chemotherapy

Date Chemotherapy Started

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1220	8	2174-2181	CCYYYMMDD	1996-2002, 2010+	01/11

Description

Records the date of initiation of chemotherapy that is part of the first course of treatment.

Rationale

Collecting dates for each treatment modality allows the sequencing of multiple treatments and aids in the evaluation of time intervals from diagnosis to treatment and from treatment to recurrence.

Coding Instructions

- Record the first or earliest date on which chemotherapy was administered by any facility. This date corresponds to administration of the agents coded in *Chemotherapy* [1390].
- This item was required in the past but discontinued in FORDS as a required item in 2003. If the date was not collected between 2003 and 2009, this field may be left blank. However, if it was collected for cases diagnosed in those years, it should be retained in this field.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date Chemotherapy Started* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date Chemotherapy Started* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *RX Date–Chemo Flag* [1221] is used to explain why *Date Chemotherapy Started* is not a known date. See *RX Date–Chemo Flag* for an illustration of the relationships among these items.

Rx Date–Chemo Flag

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1221	2	2182-2183	10-12, 15, Blank	2010+	01/10

Description

This flag explains why there is no appropriate value in the corresponding date field, *Date Chemotherapy Started* [1220].

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

- Leave this item blank if *Date Chemotherapy Started* [1220] has a full or partial date recorded.
- Code 12 if the *Date Chemotherapy Started* cannot be determined, but the patient did receive first course chemotherapy.
- Code 10 if it is unknown whether any chemotherapy was given.
- Code 11 if no chemotherapy is planned or given.
- Code 15 if chemotherapy is planned, but not yet started. Follow this patient for chemotherapy and update this item, *Date Chemotherapy Started*, and the relevant chemotherapy items.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.
- Leave this item blank for diagnoses between 2003 and 2009 (inclusive) if this facility did not collect *Date Chemotherapy Started* at that time.

Code	Label
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any chemotherapy was given).
11	No proper value is applicable in this context (for example, no chemotherapy given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, chemotherapy was given but the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (that is, chemotherapy is planned as part of first course treatment, but had not yet started at the time of the last follow-up).
(blank)	A valid date value is provided in item *Date Chemotherapy Started* [1220]. Case was diagnosed between 2003 and 2009 and the facility did not record *Date Chemotherapy Started* [1220] at that time.

Chemotherapy

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1390	2	2243-2244	00-03, 82, 85-88, 99	All Years	06/05, 09/08, 01/10, 01/15

Description

Records the type of chemotherapy administered as first course treatment at this and all other facilities. If chemotherapy was not administered, then this item records the reason it was not administered to the patient. Chemotherapy consists of a group of anticancer drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis.

Rationale

Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of the administration of chemotherapeutic agents as part of the first course of therapy. In addition, when evaluating the quality of care, it is useful to know the reason if chemotherapy was not administered.

Coding Instructions

- Code 00 if chemotherapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer. Diagnosed at autopsy.
- Code 00 if the treatment plan offered multiple alternative treatment options, and the patient selected treatment that did not include chemotherapy or if the option of “no treatment” was accepted by the patient.
- If it is known that chemotherapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
- Code 87 if the patient refused recommended chemotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 88 if it is known that a physician recommended the patient receive chemotherapy but no further documentation is available yet to confirm its administration
- Code 88 to indicate referral was made to a medical oncologist and the registry must follow to determine whether it was given. If follow-up with the specialist or facility indicates the patient was never there, code 00.
- Cases coded 88 must be followed to determine what kind of chemotherapy was administered or why it was not.
- Code 99 if it is not known whether chemotherapy is usually administered for this type and stage of cancer and there is no mention in the patient record whether it was recommended or administered. Death Certificate only.
- Code chemoembolization as 01, 02, or 03 depending on the number of chemotherapeutic agents involved.
- If the managing physician changes one of the agents in a combination regimen, and the replacement agent belongs to a different group (chemotherapeutic agents are grouped as alkylating agents, antimetabolites, natural products, or other miscellaneous) than the original agent, the new regimen represents the start of subsequent therapy, and *only the original agent or regimen is recorded as*

first course therapy.

- Refer to the *SEER*Rx Interactive Drug Database* (https://seer.cancer.gov/tools/seerrx/) for a list of chemotherapeutic agents.
- If chemotherapy was provided as a radiosensitizer or radioprotectant DO NOT code as chemotherapy treatment. When chemotherapy is given for radiosensitization or radioprotection it is given in low doses that do not affect the cancer.
- If chemotherapy was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the chemotherapy administered in the item Palliative Care [3270].

Important information affecting classification of some systemic therapies. The six drugs listed in the table below were previously classified as Chemotherapy and are now classified as BRM/Immunotherapy. **This change is effective for cases diagnosed January 1, 2013, and forward.** For cases diagnosed prior to January 1, 2013, registrars have been instructed to continue coding these drugs as Chemotherapy. Coding instructions related to this change have been added to the remarks field for the applicable drugs in *SEER*Rx Interactive Drug Database*.

Drug Name(s)	Category Prior to 2013	Category 2013 +
Alemtuzumab/Campath	Chemotherapy	BRM/Immunotherapy
Bevacizumab/Avastin	Chemotherapy	BRM/Immunotherapy
Rituximab	Chemotherapy	BRM/Immunotherapy
Trastuzumab/Herceptin	Chemotherapy	BRM/Immunotherapy
Pertuzumab/Perjeta	Chemotherapy	BRM/Immunotherapy
Cetuxumab/Erbitux	Chemotherapy	BRM/Immunotherapy

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Code	Label
00	None, chemotherapy was not part of the planned first course of therapy. Diagnosed at autopsy.
01	Chemotherapy administered as first course therapy, but the type and number of agents is not documented in patient record.
02	Single-agent chemotherapy administered as first course therapy.
03	Multiagent chemotherapy administered as first course therapy.
82	Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors (ie, comorbid conditions, advanced age progression of tumor prior to administration, etc.).
85	Chemotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Chemotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record.
87	Chemotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Chemotherapy was recommended, but it is unknown if it was administered.

Code	Label
99	It is unknown whether a chemotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Examples

Code	Reason
01	A patient with primary liver cancer is known to have received chemotherapy; however, the name(s) of agent(s) administered is not stated in patient record.
02	A patient with Stage III colon cancer is treated with a combination of fluorouracil and levamisole. Code the administration of fluorouracil as single agent chemotherapy, and levamisole as an immunotherapeutic agent.
02	A patient with non-Hodgkin's lymphoma is treated with fludarabine.
03	A patient with early stage breast cancer receives chemotherapy. The patient chart indicates that a regimen containing doxorubicin is to be administered.
86	After surgical resection of an ovarian mass the following physician recommends chemotherapy. The patient record states that chemotherapy was not subsequently administered to the patient, but the reason why chemotherapy was not administered is not given.

Chemotherapy at this Facility

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
700	2	802-803	00-03, 82, 85-88, 99	All Years	06/05, 09/08, 01/10, 01/12, 01/13, 01/15

Description

Records the type of chemotherapy administered as first course treatment at this facility. If chemotherapy was not administered, then this item records the reason it was not administered to the patient. Chemotherapy consists of a group of anticancer drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis.

Rationale

Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of the administration of chemotherapeutic agents as part of the first course of therapy. In addition, when evaluating the quality of care, it is useful to know the reason if chemotherapy was not administered.

Coding Instructions

- Record only chemotherapy received at this facility. Do not record agents administered at other facilities.
- Code 00 if chemotherapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer. Diagnosed at autopsy.
- Code 00 if the treatment plan offered multiple alternative treatment options, and the patient selected treatment that did not include chemotherapy or if the option of “no treatment” was accepted by the patient.
- If it is known that chemotherapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
- Code 87 if the patient refused recommended chemotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 88 if it is known that a physician recommended the patient receive chemotherapy but no further documentation is available yet to confirm its administration
- Cases coded 88 must be followed to determine what kind of chemotherapy was administered or why it was not.
- Code 99 if it is not known whether chemotherapy is usually administered for this type and stage of cancer and there is no mention in the patient record whether it was recommended or administered. Death Certificate only.
- Code chemoembolization as 01, 02, or 03 depending on the number of chemotherapeutic agents involved.
- If the managing physician changes one of the agents in a combination regimen, and the replacement agent belongs to a different group (chemotherapeutic agents are grouped as alkylating agents, antimetabolites, natural products, or other miscellaneous) than the original agent, the new regimen

represents the start of subsequent therapy, and *only the original agent or regimen is recorded as first course therapy*.

- Refer to the *SEER*Rx Interactive Drug Database (https://seer.cancer.gov/tools/seerrx/)* for a list of chemotherapeutic agents.
- If chemotherapy was provided as a radiosensitizer or radioprotectant DO NOT code as chemotherapy treatment. When chemotherapy is given for radiosensitization or radioprotection it is given in low doses that do not affect the cancer.
- If chemotherapy was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the chemotherapy administered in the item *Palliative Care at This Facility* [3280].

Important information affecting classification of some systemic therapies. The six drugs listed in the table below were previously classified as Chemotherapy and are now classified as BRM/Immunotherapy. **This change is effective for cases diagnosed January 1, 2013, and forward.** For cases diagnosed prior to January 1, 2013, registrars have been instructed to continue coding these drugs as Chemotherapy. Coding instructions related to this change have been added to the remarks field for the applicable drugs in *SEER*Rx Interactive Drug Database*.

Drug Name(s)	Category Prior to 2013	Category 2013 +
Alemtuzumab/Campath	Chemotherapy	BRM/Immunotherapy
Bevacizumab/Avastin	Chemotherapy	BRM/Immunotherapy
Rituximab	Chemotherapy	BRM/Immunotherapy
Trastuzumab/Herceptin	Chemotherapy	BRM/Immunotherapy
Pertuzumab/Perjeta	Chemotherapy	BRM/Immunotherapy
Cetuxumab/Erbitux	Chemotherapy	BRM/Immunotherapy

-

Code	Label
00	None, chemotherapy was not part of the planned first course of therapy. Diagnosed at autopsy.
01	Chemotherapy administered as first course therapy; but the type and number of agents is not documented in patient record.
02	Single-agent chemotherapy administered as first course therapy.
03	Multiagent chemotherapy administered as first course therapy
82	Chemotherapy was not recommended/administered because it was contraindicated due to patient risk factors (ie, comorbid conditions, advanced age, progression of tumor prior to planned administration).
85	Chemotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Chemotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record.
87	Chemotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.

Code	Label
88	Chemotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a chemotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Hormone Therapy

Date Hormone Therapy Started

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1230	8	2184-2191	CCYYMMDD	1996-2002, 2010+	01/11, 01/12

Description

Records the date of initiation of hormone therapy that is part of the first course of treatment.

Rationale

Collecting dates for each treatment modality allows the sequencing of multiple treatments and aids in the evaluation of time intervals from diagnosis to treatment and from treatment to recurrence.

Coding Instructions

- Record the first or earliest date on which hormone therapy was administered by any facility. This date corresponds to administration of the agents coded in *Hormone Therapy* [1400].
- This item was required in the past but discontinued in FORDS as a required item in 2003. If the date was not collected between 2003 and 2009, this field may be left blank. However, if it was collected for cases diagnosed in those years, it should be retained in this field.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date Hormone Therapy Started* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date Hormone Therapy Started* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *RX Date–Hormone Flag* [1231] is used to explain why *Date Hormone Therapy Started* is not a known date. See *RX Date–Hormone Flag* for an illustration of the relationships among these items.

Rx Date–Hormone Flag

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1231	2	2192-2193	10-12, 15, Blank	2010+	01/10

Description

This flag explains why there is no appropriate value in the corresponding date field, *Date Hormone Therapy Started* [1230].

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

- Leave this item blank if *Date Hormone Therapy Started* [1230] has a full or partial date recorded.
- Code 12 if the *Date Hormone Therapy Started* cannot be determined, but the patient did receive first course hormone therapy.
- Code 10 if it is unknown whether any hormone therapy was given.
- Code 11 if no hormone therapy is planned or given.
- Code 15 if hormone therapy is planned, but not yet started. Follow this patient for hormone therapy and update this item, *Date Hormone Therapy Started*, and the relevant hormone therapy items.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.
- Leave this item blank for diagnoses between 2003 and 2009 if this facility did not collect *Date Hormone Therapy Started* at that time.

Code	Label
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any hormone therapy was given).
11	No proper value is applicable in this context (for example, no hormone therapy given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, hormone therapy was given but the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (that is, hormone therapy is planned as part of first course treatment, but had not yet started at the time of the last follow-up).
(blank)	A valid date value is provided in item *Date Hormone Therapy Started* [1230]. Case was diagnosed between 2003 and 2009 and the facility did not record *Date Hormone Therapy Started* [1230] at that time.

Hormone Therapy (Hormone/Steroid Therapy)

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1400	2	2245-2246	00, 01, 82, 85-88, 99	All Years	06/05, 09/08, 01/10, 01/13

Description

Records the type of hormone therapy administered as first course treatment at this and all other facilities. If hormone therapy was not administered, then this item records the reason it was not administered to the patient. Hormone therapy consists of a group of drugs that may affect the long-term control of a cancer's growth. It is not usually used as a curative measure.

Rationale

Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of the administration of hormonal agents as part of the first course of therapy. In addition, when evaluating the quality of care, it is useful to know the reason if hormone therapy was not administered.

Coding Instructions

- Record prednisone as hormonal therapy when administered in combination with chemotherapy, such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone) or COPP (cyclophosphamide, vincristine, procarbazine, prednisone).
- Do not code prednisone as hormone therapy when it is administered for reasons other than chemotherapeutic treatment.
- Tumor involvement or 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 hormone replacement therapy as part of first course therapy.
- Code 00 if hormone therapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer. Diagnosed at autopsy.
- Code 00 if the treatment plan offered multiple alternative treatment options, and the patient selected treatment that did not include hormone therapy or if the option of "no treatment" was accepted by the patient.
- Code 01 for thyroid replacement therapy which inhibits TSH (thyroid-stimulating hormone). TSH is a product of the pituitary gland that can stimulate tumor growth.
- If it is known that hormone therapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
- Code 87 if the patient refused recommended hormone therapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 88 if it is known that a physician recommended hormone therapy, but no further documentation is available yet to confirm its administration.
- Code 88 to indicate the patient was referred to a medical oncologist and the registry should follow the case for hormone therapy. If follow-up with the specified specialist or facility indicates the patient was never there, code 00.
- Cases coded 88 should be followed to determine whether they received hormone therapy or why

not.

- Code 99 if it is not known whether hormone therapy is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered. Death certificate only.
- Refer to the *SEER*Rx Interactive Drug Database* (https://seer.cancer.gov/tools/seerrx/) for a list of hormonal agents.
- If hormone therapy was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the hormone therapy administered in the item *Palliative Care* [3270].

Code	Label
00	None, hormone therapy was not part of the planned first course of therapy. Diagnosed at autopsy.
01	Hormone therapy administered as first course therapy.
82	Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (ie, comorbid conditions, advanced age, progression of tumor prior to administration, etc.).
85	Hormone therapy was not administered because the patient died prior to planned or recommended therapy.
86	Hormone therapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record.
87	Hormone therapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Hormone therapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a hormonal agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Examples

Code	Reason
00	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 hormonal therapy.
00	A patient with breast cancer may be treated with aminoglutethimide (Cytadren, Elipten), which suppresses the production of glucocorticoids and mineralocorticoids. This patient must take glucocorticoid (hydrocortisone) and may also need a mineralocorticoid (Florinef) as a replacement therapy.
00	A patient with advanced disease is given prednisone to stimulate the appetite and improve nutritional status. Prednisone is not coded as hormone therapy.
01	A patient with metastatic prostate cancer is administered flutamide (an antiestrogen).
87	A patient with metastatic prostate cancer declines the administration of Megace (a progestational agent) and the refusal is noted in the patient record.

Hormone Therapy at this Facility (Hormone/Steroid Therapy)

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
710	2	804-805	00, 01, 82, 85-88, 99	All Years	06/05, 09/08, 01/10, 01/13

Description

Records the type of hormone therapy administered as first course treatment at this facility. If hormone therapy was not administered, then this item records the reason it was not administered to the patient. Hormone therapy consists of a group of drugs that may affect the long-term control of a cancer's growth. It is not usually used as a curative measure.

Rationale

Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of the administration of hormonal agents as part of the first course of therapy. In addition, when evaluating the quality of care, it is useful to know the reason if hormone therapy was not administered.

Coding Instructions

- Record only hormone therapy received at this facility. Do not record procedures done at other facilities.
- Record prednisone as hormonal therapy when administered in combination with chemotherapy, such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone) or COPP (cyclophosphamide, vincristine, procarbazine, prednisone).
- Do not code prednisone as hormone therapy when it is administered for reasons other than chemotherapeutic treatment.
- Tumor involvement or 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 hormone replacement therapy as part of first course therapy.
- Code 00 if hormone therapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer. Diagnosed at autopsy.
- Code 00 if the treatment plan offered multiple alternative treatment options, and the patient selected treatment that did not include hormone therapy or if the option of "no treatment" was accepted by the patient.
- Code 01 for thyroid replacement therapy which inhibits TSH (thyroid-stimulating hormone). TSH is a product of the pituitary gland that can stimulate tumor growth.
- If it is known that hormone therapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
- Code 87 if the patient refused recommended hormone therapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 88 if it is known that a physician recommended hormone therapy, but no further documentation is available yet to confirm its administration.

- Cases coded 88 should be followed to determine whether they received hormone therapy or why not.
- Code 99 if it is not known whether hormone therapy is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered. Death certificate only.
- Refer to the *SEER*Rx Interactive Drug Database (https://seer.cancer.gov/tools/seerrx/)* for a list of hormonal agents.
- If hormone therapy was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the hormone therapy administered in the item *Palliative Care* [3270].

Code	Label
00	None, hormone therapy was not part of the planned first course of therapy. Diagnosed at autopsy.
01	Hormone therapy administered as first course therapy.
82	Hormone therapy was not recommended/administered because it was contraindicated due to patient risk factors (ie, comorbid conditions, advanced age, progression of tumor prior to administration, etc.).
85	Hormone therapy was not administered because the patient died prior to planned or recommended therapy.
86	Hormone therapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record.
87	Hormone therapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Hormone therapy was recommended, but it is unknown if it was administered.
99	It is unknown whether a hormonal agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Immunotherapy

Date Immunotherapy Started

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1240	8	2194-2201	CCYYMMDD	1996-2002, 2010+	01/11

Description

Records the date of initiation of immunotherapy or a biologic response modifier (BRM) that is part of the first course of treatment.

Rationale

Collecting dates for each treatment modality allows the sequencing of multiple treatments and aids in the evaluation of time intervals from diagnosis to treatment and from treatment to recurrence.

Coding Instructions

- Record the first or earliest date on which immunotherapy or a biologic response modifier was administered by any facility. This date corresponds to administration of the agents coded in *Immunotherapy* [1410].
- This item was required in the past but discontinued in FORDS as a required item in 2003. If the date was not collected between 2003 and 2009, this field may be left blank. However, if it was collected for cases diagnosed in those years, it should be retained in this field.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date Immunotherapy Started* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date Immunotherapy Started* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *RX Date–BRM Flag* [1241] is used to explain why *Date Immunotherapy Started* is not a known date. See *RX Date–BRM Flag* for an illustration of the relationships among these items.

Rx Date–BRM Flag

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1241	2	2202-2203	10-12, 15, Blank	2010+	01/10

Description

This flag explains why there is no appropriate value in the corresponding date field, *Date Immunotherapy Started* [1240].

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

- Leave this item blank if *Date Immunotherapy Started* [1240] has a full or partial date recorded.
- Code 12 if the *Date Immunotherapy Started* cannot be determined, but the patient did receive first course immunotherapy or a biologic response modifier.
- Code 10 if it is unknown whether any immunotherapy or a biologic response modifier was given.
- Code 11 if no immunotherapy or biologic response modifier is planned or given.
- Code 15 if immunotherapy or a biologic response modifier is planned, but not yet started. Follow this patient for immunotherapy and update this item, *Date Immunotherapy Started*, and the relevant immunotherapy items.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.
- Leave this item blank for diagnoses between 2003 and 2009 if this facility did not collect *Date Immunotherapy Started* at that time.

Code	Label
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any immunotherapy was given).
11	No proper value is applicable in this context (for example, no immunotherapy given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, immunotherapy was given but the date is unknown).
15	Information is not available at this time, but it is expected that it will be available later (that is, immunotherapy is planned as part of first course treatment, but had not yet started at the time of the last follow-up).
(blank)	A valid date value is provided in item *Date Immunotherapy Started* [1240]. Case was diagnosed between 2003 and 2009 and the facility did not record *Date Immunotherapy Started* [1240] at that time.

Immunotherapy

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1410	2	2247-2248	00, 01, 82, 85-88, 99	All Years	06/05, 09/08, 01/10, 01/13, 01/15

Description

Records the type of immunotherapy administered as first course treatment at this and all other facilities. If immunotherapy was not administered, then this item records the reason it was not administered to the patient. Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to tumor cells.

Rationale

Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of the administration of immunotherapeutic agents as part of the first course of therapy. In addition, when evaluating the quality of care, it is useful to know the reason if immunotherapy was not administered.

Coding Instructions

- Code 00 if immunotherapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.
- Code 00 if the treatment plan offered multiple alternative treatment options, and the patient selected treatment that did not include immunotherapy or if the option of "no treatment" was accepted by the patient.
- If it is known that immunotherapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
- Code 87 if the patient refused recommended immunotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 88 if it is known that a physician recommended immunotherapy but no further documentation is available yet to confirm its administration.
- Code 88 to indicate a referral was made to a medical oncologist about immunotherapy and the registry should follow the case to determine whether it was given or why not. If follow-up to the specialist or facility determines the patient was never there, code 00.
- Cases coded 88 should be followed and the code updated as appropriate. Code 99 if it is not known whether immunotherapy is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered.
- Refer to the SEER*Rx Interactive Drug Database *(https://seer.cancer.gov/tools/seerrx/)* for immunotherapeutic agents.
- If immunotherapy was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the immunotherapy administered in the item Palliative Care [3270].

Important information affecting classification of some systemic therapies. The six drugs listed in the table below were previously classified as Chemotherapy and are now classified as BRM/Immunotherapy. **This change is effective for cases diagnosed January 1, 2013, and forward.** For cases diagnosed prior to January 1, 2013, registrars have been instructed to continue coding these drugs as Chemotherapy. Coding

instructions related to this change have been added to the remarks field for the applicable drugs in *SEER*Rx Interactive Drug Database*.

Drug Name(s)	Category Prior to 2013	Category 2013 +
Alemtuzumab/Campath	Chemotherapy	BRM/Immunotherapy
Bevacizumab/Avastin	Chemotherapy	BRM/Immunotherapy
Rituximab	Chemotherapy	BRM/Immunotherapy
Trastuzumab/Herceptin	Chemotherapy	BRM/Immunotherapy
Pertuzumab/Perjeta	Chemotherapy	BRM/Immunotherapy
Cetuxumab/Erbitux	Chemotherapy	BRM/Immunotherapy

Code	Label
00	None, immunotherapy was not part of the planned first course of therapy. Diagnosed at autopsy.
01	Immunotherapy administered as first course therapy.
82	Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (ie, comorbid conditions, advanced age, progression of tumor prior to administration, etc.).
85	Immunotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Immunotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record.
87	Immunotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Immunotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether an immunotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Examples

Code	Reason
01	A patient with malignant melanoma is treated with interferon.
85	Before recommended immunotherapy could be administered, the patient died from cancer.

Immunotherapy at this Facility

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
720	2	806-807	00, 01, 82, 85-88, 99	All Years	06/05, 09/08, 01/10, 01/13, 01/15

Description

Records the type of immunotherapy administered as first course treatment at this facility. If immunotherapy was not administered, then this item records the reason it was not administered to the patient. Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to tumor cells.

Rationale

Systemic therapy may involve the administration of one or a combination of agents. This data item allows for the evaluation of the administration of immunotherapeutic agents as part of the first course of therapy. In addition, when evaluating the quality of care, it is useful to know the reason immunotherapy was not administered.

Coding Instructions

- Record only immunotherapy received at this facility. Do not record agents administered at other facilities.
- Code 00 if immunotherapy was not administered to the patient, and it is known that it is not usually administered for this type and stage of cancer.
- Code 00 if the treatment plan offered multiple alternative treatment options, and the patient selected treatment that did not include immunotherapy or if the option of "no treatment" was accepted by the patient.
- If it is known that immunotherapy is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
- Code 87 if the patient refused recommended immunotherapy, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 88 if it is known that a physician recommended the patient receive immunotherapy but no further documentation is available yet to confirm its administration.
- Code 88 to indicate a referral was made to a medical oncologist about immunotherapy and the registry should follow the case to determine whether it was given or why not. If follow-up to the specialist or facility determines the patient was never there, code 00.
- Cases coded 88 should be followed to determine whether they received immunotherapy or why not.
- Code 99 if it is not known whether immunotherapy is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered.
- Refer to the *SEER*Rx Interactive Drug Database* (https://seer.cancer.gov/tools/seerrx/) for a list of immunotherapeutic agents.
- If immunotherapy was provided to prolong a patient's life by controlling symptoms, to alleviate

pain, or to make the patient more comfortable, then also record the immunotherapy administered in the item *Palliative Care at This Facility* [3280].

Important information affecting classification of some systemic therapies. The six drugs listed in the table below were previously classified as Chemotherapy and are now classified as BRM/Immunotherapy. **This change is effective for cases diagnosed January 1, 2013, and forward.** For cases diagnosed prior to January 1, 2013, registrars have been instructed to continue coding these drugs as Chemotherapy. Coding instructions related to this change have been added to the remarks field for the applicable drugs in *SEER*Rx Interactive Drug Database*.

Drug Name(s)	Category Prior to 2013	Category 2013 +
Alemtuzumab/Campath	Chemotherapy	BRM/Immunotherapy
Bevacizumab/Avastin	Chemotherapy	BRM/Immunotherapy
Rituximab	Chemotherapy	BRM/Immunotherapy
Trastuzumab/Herceptin	Chemotherapy	BRM/Immunotherapy
Pertuzumab/Perjeta	Chemotherapy	BRM/Immunotherapy
Cetuxumab/Erbitux	Chemotherapy	BRM/Immunotherapy

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Code	Label
00	None, immunotherapy was not part of the planned first course of therapy. Diagnosed at autopsy.
01	Immunotherapy administered as first course therapy.
82	Immunotherapy was not recommended/administered because it was contraindicated due to patient risk factors (ie, comorbid conditions, advanced age).
85	Immunotherapy was not administered because the patient died prior to planned or recommended therapy.
86	Immunotherapy was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record.
87	Immunotherapy was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Immunotherapy was recommended, but it is unknown if it was administered.
99	It is unknown whether an immunotherapeutic agent(s) was recommended or administered because it is not stated in patient record. Death certificate only.

Hematologic Transplant and Endocrine Procedures

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
3250	2	2241-2242	00, 10-12, 20, 30, 40, 82, 85-88, 99	All Years	06/05, 01/10, 01/12, 01/13

Description

Identifies systemic therapeutic *procedures* administered as part of the first course of treatment at this and all other facilities. If none of these *procedures* were administered, then this item records the reason they were not performed. These include bone marrow transplants, stem cell harvests, surgical and/or radiation endocrine therapy.

Rationale

This data item allows the evaluation of patterns of treatment which involve the alteration of the immune system or change the patient's response to tumor cells but does not involve the administration of antineoplastic agents. In addition, when evaluating the quality of care, it is useful to know the reason if these *procedures* were not performed.

Coding Instructions

- Bone marrow transplants should be coded as either autologous (bone marrow originally taken from the patient) or allogeneic (bone marrow donated by a person other than the patient). For cases in which the bone marrow transplant was syngeneic (transplanted marrow from an identical twin), the item is coded as allogeneic.
- Stem cell harvests involve the collection of immature blood cells from the patient and the reintroduction by transfusion of the harvested cells following chemotherapy or radiation therapy.
- Endocrine irradiation and/or endocrine surgery are procedures which suppress the naturally occurring hormonal activity of the patient and thus alter or affect the long-term control of the cancer's growth. These procedures must be bilateral to qualify as endocrine surgery or endocrine radiation. If only one gland is intact at the start of treatment, surgery and/or radiation to that remaining gland qualifies as endocrine surgery or endocrine radiation.
- Code 00 if a transplant or endocrine procedure was not administered to the patient, and it is known that these procedures are not usually administered for this type and stage of cancer. Diagnosed at autopsy.
- Code 00 if the treatment plan offered multiple alternative treatment options and the patient selected treatment that did not include a transplant or endocrine procedure or if the option of "no treatment" was accepted by the patient.
- If it is known that a transplant or endocrine procedure is usually administered for this type and stage of cancer, but was not administered to the patient, use code 82, 85, 86, or 87 to record the reason why it was not administered.
- Code 87 if the patient refused a recommended transplant or endocrine procedure, made a blanket refusal of all recommended treatment, or refused all treatment before any was recommended.
- Code 88 if it is known that a physician recommended a hematologic transplant or endocrine procedure, but no further documentation is available yet to confirm its administration.
- Code 88 to indicate referral to a specialist for hematologic transplant or endocrine procedures and the registry should follow the case. If follow-up to the specified specialist or facility determines the

patient was never there, code 00.

- Use code 88 if a bone marrow or stem cell harvest was undertaken, but was not followed by a rescue or re-infusion as part of first course treatment.
- Cases coded 88 should be followed to determine whether they were given a hematologic transplant or endocrine procedure or why not.
- Code 99 if it is not known whether a transplant or endocrine procedure is usually administered for this type and stage of cancer, and there is no mention in the patient record whether it was recommended or administered. Death certificate only.
- If the hematologic transplant or endocrine procedure coded in this item was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the hematologic transplant or endocrine procedure provided in the items *Palliative Care* [3270] and/or *Palliative Care at This Facility* [3280], as appropriate.

Code	Label
00	No transplant procedure or endocrine therapy was administered as part of first course therapy. Diagnosed at autopsy.
10	A bone marrow transplant procedure was administered, but the type was not specified.
11	Bone marrow transplant–autologous.
12	Bone marrow transplant–allogeneic.
20	Stem cell harvest and infusion. Umbilical cord stem cell transplant, with blood from one or multiple umbilical cords
30	Endocrine surgery and/or endocrine radiation therapy.
40	Combination of endocrine surgery and/or radiation with a transplant procedure. (Combination of codes 30 and 10, 11, 12, or 20.)
82	Hematologic transplant and/or endocrine surgery/radiation was not recommended/administered because it was contraindicated due to patient risk factors (ie, comorbid conditions, advanced age, progression of disease prior to administration, etc.).
85	Hematologic transplant and/or endocrine surgery/radiation was not administered because the patient died prior to planned or recommended therapy.
86	Hematologic transplant and/or endocrine surgery/radiation was not administered. It was recommended by the patient's physician, but was not administered as part of the first course of therapy. No reason was stated in patient record.
87	Hematologic transplant and/or endocrine surgery/radiation was not administered. It was recommended by the patient's physician, but this treatment was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in patient record.
88	Hematologic transplant and/or endocrine surgery/radiation was recommended, but it is unknown if it was administered.
99	It is unknown whether hematologic transplant and/or endocrine surgery/radiation was recommended or administered because it is not stated in patient record. Death certificate only.

Systemic/Surgery Sequence

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1639	1	2273-2273	0, 2-7, 9	2006+	01/10, 01/11, 01/12

Description

Records the sequencing of systemic therapy and surgical procedures given as part of the first course of treatment.

Rationale

The sequence of systemic therapy and surgical procedures given as part of the first course of treatment cannot always be determined using the date on which each modality was started or performed. This data item can be used to more precisely evaluate the timing of delivery of treatment to the patient.

Coding Instructions

- *Systemic/Surgery Sequence* is to be used for patients diagnosed on or after January 1, 2006.
- Code the administration of systemic therapy in sequence with the first surgery performed, described in the item *Date of First Surgical Procedure* [1200].
- If none of the following surgical procedures were performed: *Surgical Procedure of Primary Site* [1290], *Scope of Regional Lymph Node Surgery* [1292], *Surgical Procedure/Other Site* [1294], then this item should be coded 0.
- If the patient received both systemic therapy and any one or a combination of the following surgical procedures: *Surgical Procedure of the Primary Site* [1290], *Scope of Regional Lymph Node Surgery* [1292], or *Surgical Procedure/Other Site* [1294], then code this item 2-9, as appropriate.
- If multiple first course treatment episodes were given such that both codes 4 and 7 seem to apply, use the code that defines the first sequence that applies. For example: the sequence, chemo then surgery then hormone therapy then surgery is coded 4 for "chemo then surgery then hormone".

Code	Label	Definition
0	No systemic therapy and/or surgical procedures	No systemic therapy was given; and/or no surgical procedure of primary site; no scope of regional lymph node surgery; no surgery to other regional site(s), distant site(s), or distant lymph node(s); or no reconstructive surgery was performed. It is unknown whether both surgery and systemic treatment were provided.
2	Systemic therapy before surgery	Systemic therapy was given before surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
3	Systemic therapy after surgery	Systemic therapy was given after surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
4	Systemic therapy both before and after surgery	At least two courses of systemic therapy were given before and at least two more after a surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.

Code	Label	Definition
5	Intraoperative systemic therapy	Intraoperative systemic therapy was given during surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s).
6	Intraoperative systemic therapy with other systemic therapy administered before or after surgery	Intraoperative systemic therapy was given during surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) with other systemic therapy administered before or after surgical procedure of primary site; scope of regional lymph node surgery; surgery to other regional site(s), distant site(s), or distant lymph node(s) was performed.
7	Surgery both before and after systemic therapy	Systemic therapy was administered between two separate surgical procedures to the primary site; regional lymph nodes; surgery to other regional site(s), distant site(s), or distant lymph node(s).
9	Sequence unknown	Both surgery and systemic therapy were provided, but the sequence is unknown.

Examples

Code	Reason
0	Due to other medical conditions surgery was not performed. The patient received palliative radiation therapy to alleviate pain.
2	Patient with prostate cancer received hormone therapy prior to a radical prostatectomy.
3	Patient underwent a colon resection followed by a 5-FU based chemotherapy regimen.
4	Patient with breast cancer receives pre-operative chemotherapy followed by post-operative Tamoxifen.
5	Patient with an intracranial primary undergoes surgery at which time a glial wafer is implanted into the resected cavity.
6	Patient with metastatic colon cancer receives intraoperative chemotherapy to the liver.
9	An unknown primary of the head and neck was treated with surgery and chemotherapy prior to admission, but the sequence is unknown. The patient enters for radiation therapy.

Other Treatment

Date Other Treatment Started

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1250	8	2204-2211	CCYYMMDD	All Years	01/10, 01/11

Description

Records the date on which other treatment began at any facility.

Rationale

Collecting dates for each treatment modality allows for the sequencing of multiple treatments and aids in the evaluation of time intervals from diagnosis to treatment and from treatment to recurrence.

Coding Instructions

- Record the date on which the care coded as *Other Treatment* [1420] was initiated.
- If other treatment is the first or only treatment administered to the patient, then the date other treatment started should be the same as the *Date of First Course of Treatment* [1270].
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date Other Treatment Started* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date Other Treatment Started* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *RX Date–Other Flag* [1251] is used to explain why *Date Other Treatment Started* is not a known date. See *RX Date–Other Flag* for an illustration of the relationships among these items.

Examples

Code	Reason
20100316	A patient with metastatic disease was started on an experimental therapy on March 16, 2010.
20090801	Alcohol was used as an embolizing agent for a patient on August 1, 2009
20080917	A polycythemia vera patient was given several phlebotomies, the first being on September 17, 2008

Rx Date–Other Flag

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1251	2	2212-2213	10-12, Blank	2010+	01/15

Description

This flag explains why there is no appropriate value in the corresponding date field, *Date Other Treatment Started* [1250].

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

- Leave this item blank if *Date Other Treatment Started* [1250] has a full or partial date recorded.
- Code 12 if the *Date Other Treatment Started* cannot be determined, but the patient did receive first course other treatment.
- Code 10 if it is unknown whether any other treatment was given (*Other Treatment* [1420] is 9).
- Code 11 if no other treatment is planned or given (*Other Treatment* [1420] is 0, 7 or 8).
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Label
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if any Other Treatment was given).
11	No proper value is applicable in this context (for example, no Other Treatment given).
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, Other Treatment was given but the date is unknown).
15	Other therapy is planned as part of the first course of treatment, but had not been started at the time of the most recent follow-up.
(blank)	A valid date value is provided in item *Date Other Treatment Started* [1250].

Other Treatment

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1420	1	2249-2249	0-3, 6-9	All Years	06/05, 09/08, 01/10, 01/11, 01/12, 01/15

Description

Identifies other treatment that cannot be defined as surgery, radiation, or systemic therapy according to the defined data items in this manual.

Rationale

Information on other therapy is used to describe and evaluate the quality of care and treatment practices.

Coding Instructions

- The principal treatment for certain reportable hematopoietic diseases could be supportive care that does not meet the usual definition of treatment that "modifies, controls, removes, or destroys" proliferating cancer tissue.
- Supportive care may include phlebotomy, transfusion, or aspirin. In order to report the hematopoietic cases in which the patient received supportive care, SEER and the Commission on Cancer have agreed to record treatments such as phlebotomy, transfusion, or aspirin as "Other Treatment" (Code 1) for certain hematopoietic diseases ONLY. Consult the most recent version of the **Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual** for instructions for coding care of specific hematopoietic neoplasms in this item
- Code 1 for embolization using alcohol as an embolizing agent.
- Code 1 for embolization to a site other than the liver where the embolizing agent is unknown.
- Code 1 for PUVA (psoralen and long-wave ultraviolet radiation)
- Do not code presurgical embolization that given for a purpose to shrink the tumor.
- A complete description of the treatment plan should be recorded in the text field for "Other Treatment" on the abstract.
- If other treatment was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the other treatment administered in the item *Palliative Care* [3270].
- Code 8 if it is known that a physician recommended treatment coded as Other Treatment, and no further documentation is available yet to confirm its administration
- Code 8 to indicate referral to a specialist for Other Treatment and the registry should follow. If follow-up with the specialist or facility determines the patient was never there, code 0.
- Code 0 when diagnosed at autopsy.
- Code 9 for Death Certificate Only (DCO) cases.

Code	Label	Definition

Code	Label	Definition
0	None	All cancer treatment was coded in other treatment fields (surgery, radiation, systemic therapy). Patient received no cancer treatment. Diagnosed at autopsy.
1	Other	Cancer treatment that cannot be appropriately assigned to specified treatment data items (surgery, radiation, systemic therapy).
2	Other–Experimental	This code is not defined. It may be used to record participation in institution-based clinical trials.
3	Other–Double Blind	A patient is involved in a double-blind clinical trial. Code the treatment actually administered when the double-blind trial code is broken.
6	Other–Unproven	Cancer treatments administered by nonmedical personnel.
7	Refusal	Other treatment was not administered. It was recommended by the patient's physician, but this treatment (which would have been coded 1, 2, or 3) was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in the patient record.
8	Recommended; unknown if administered	Other treatment was recommended, but it is unknown whether it was administered.
9	Unknown	It is unknown whether other treatment was recommended or administered, and there is no information in the medical record to confirm the recommendation or administration of other treatment. Death certificate only.

Other Treatment at this Facility

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
730	1	808-808	0-3, 6-9	All Years	01/04, 09/08, 01/10, 01/12, 01/15

Description

Identifies other treatment given at this facility that cannot be defined as surgery, radiation, or systemic therapy according to the defined data items in this manual.

Rationale

Information on other therapy is used to describe and evaluate the quality of care and treatment practices.

Coding Instructions

- The principal treatment for certain reportable hematopoietic diseases could be supportive care that does not meet the usual definition of treatment that "modifies, controls, removes, or destroys' proliferating cancer tissue.
- Supportive care may include phlebotomy, transfusion, or aspirin. In order to report the hematopoietic cases in which the patient received supportive care, SEER and the Commission on Cancer have agreed to record treatments such as phlebotomy, transfusion, or aspirin as "Other Treatment" (Code 1) for certain hematopoietic diseases ONLY. Consult the most recent version of the **Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual** for instructions for coding care of specific hematopoietic neoplasms in this item
- Code 1 for embolization using alcohol as an embolizing agent.
- Code 1 for embolization to a site other than the liver where the embolizing agent is unknown.
- Code 1 for PUVA (psoralen and long-wave ultraviolet radiation)
- Do not code presurgical embolization that given for a purpose to shrink the tumor.
- A complete description of the treatment plan should be recorded in the text field for "Other Treatment" on the abstract.
- If other treatment was provided to prolong a patient's life by controlling symptoms, to alleviate pain, or to make the patient more comfortable, then also record the other treatment administered in the item *Palliative Care at This Facility* [3280].
- Code 8 if it is known that a physician recommended the patient receive treatment coded as Other Treatment, but no further documentation is available yet to confirm its administration.
- Code 0 when diagnosed at autopsy.
- Code 9 for Death Certificate Only (DCO) cases.

Code	Label	Definition
0	None	All cancer treatment was coded in other treatment fields (surgery, radiation, systemic therapy). Patient received no cancer treatment. Diagnosed at autopsy.

Code	Label	Definition
1	Other	Cancer treatment that cannot be appropriately assigned to specified treatment data items (surgery, radiation, systemic therapy). Use this code for treatment unique to hematopoietic diseases.
2	Other–Experimental	This code is not defined. It may be used to record participation in institution-based clinical trials.
3	Other–Double Blind	A patient is involved in a double-blind clinical trial. Code the treatment actually administered when the double-blind trial code is broken.
6	Other–Unproven	Cancer treatments administered by nonmedical personnel.
7	Refusal	Other treatment was not administered. It was recommended by the patient's physician, but this treatment (which would have been coded 1, 2, or 3) was refused by the patient, a patient's family member, or the patient's guardian. The refusal was noted in the patient record.
8	Recommended; unknown if administered	Other treatment was recommended, but it is unknown whether it was administered.
9	Unknown	It is unknown whether other treatment was recommended or administered, and there is no information in the medical record to confirm the recommendation or administration of other treatment. Death certificate only.

Palliative Care (Palliative Procedure)

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
3270	1	2237-2237	0-7, 9	All Years	01/04, 01/10

Description

Identifies any care provided in an effort to palliate or alleviate symptoms. Palliative care is performed to relieve symptoms and may include surgery, radiation therapy, systemic therapy (chemotherapy, hormone therapy, or other systemic drugs), and/or other pain management therapy.

Rationale

This data item allows reporting facilities to track care that is considered palliative rather than diagnostic or curative in intent.

Coding Instructions

- Record the type of palliative care provided.
- Surgical procedures, radiation therapy, or systemic therapy provided to prolong the patient's life by controlling symptoms, to alleviate pain, or to make the patient comfortable should be coded palliative care and as first course therapy if that procedure removes or modifies either primary or metastatic malignant tissue.
- Palliative care is not used to diagnose or stage the primary tumor.
- Do not code routine pain management following surgery or other treatment; do code first course pain management for persistent pain.

Code	Label
0	No palliative care provided. Diagnosed at autopsy.
1	Surgery (which may involve a bypass procedure) to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
2	Radiation therapy to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
3	Chemotherapy, hormone therapy, or other systemic drugs to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
4	Patient received or was referred for painmanagement therapy with no other palliative care.
5	Any combination of codes 1, 2, and/or 3 without code 4.
6	Any combination of codes 1, 2, and/or 3 with code 4.
7	Palliative care was performed or referred, but no information on the type of procedure is available in the patient record. Palliative care was provided that does not fit the descriptions for codes 1–6.
9	It is unknown if palliative care was performed or referred; not stated in patient record.

Examples

Code	Reason
0	No palliative care was given.
1	A patient undergoes palliative surgical removal of brain metastasis. [Surgery recorded in *Surgical Procedure/Other Site* [1294]
1	A patient with unresectable pancreatic carcinoma (no surgical procedure of the primary site is performed) receives bypass surgery to alleviate jaundice and pain.
2	A patient is diagnosed with Stage IV prostate cancer. His only symptoms are painful bony metastases in his right hip and lower spine. XRT is given to those areas. (Record all radiotherapy items also).
2	A patient with lung cancer with a primary tumor extending into the spine is treated with XRT to shrink tumor away from spine/nerves to provide pain relief. (Record all radiotherapy items also).
3	A patient is given palliative chemotherapy for Stage IIIB lung cancer. (Record all chemotherapy items also).
4	A 93-year old patient is diagnosed with multiple myeloma and enters a pain management clinic to treat symptoms. No other therapy is planned due to other medical problems.
5	A patient is diagnosed with widely disseminated small cell lung cancer. A palliative resection of a solitary brain metastasis is performed followed by XRT to the lower spine for painful bony metastasis. There is no known pain management. (Record all surgery and radiotherapy items also).
6	A patient diagnosed with colon cancer receives bypass surgery to alleviate symptoms and XRT to the liver for metastasis, and then enters a pain management clinic for treatment for unremitting abdominal pain. (Record all radiotherapy items also).
7	A patient enters the facility with a clinical diagnosis of unresectable carcinoma of the pancreas. A stent was inserted into the bile duct to relieve obstruction and improve the bile duct flow.

Palliative Care at this Facility (Palliative Procedure at this Facility)

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
3280	1	811-811	0-7, 9	All Years	01/04, 01/10

Description

Identifies care provided at this facility in an effort to palliate or alleviate symptoms. Palliative care is performed to relieve symptoms and may include surgery, radiation therapy, systemic therapy (chemotherapy, hormone therapy, or other systemic drugs), and/or other pain management therapy.

Rationale

This data item allows reporting facilities to track care that is considered palliative rather than diagnostic or curative in intent.

Coding Instructions

- Record only the type of palliative care at this facility.
- Surgical procedures, radiation therapy, or systemic therapy provided to prolong the patient's life by controlling symptoms, to alleviate pain, or to make the patient comfortable at this facility should be coded as palliative care and as first course therapy if that procedure removes or modifies either primary or secondary malignant tissue.
- Palliative care is not used to diagnose or stage the primary tumor.
- Do not code routine pain management following surgery or other treatment; do code first course pain management for persistent pain.

Code	Label
0	No palliative care provided. Diagnosed at autopsy.
1	Surgery (which may involve a bypass procedure) to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
2	Radiation therapy to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
3	Chemotherapy, hormone therapy, or other systemic drugs to alleviate symptoms, but no attempt to diagnose, stage, or treat the primary tumor is made.
4	Patient received or was referred for pain management therapy with no other palliative care.
5	Any combination of codes 1, 2, and/or 3 without code 4.
6	Any combination of codes 1, 2, and/or 3 with code 4.
7	Palliative care was performed or referred, but no information on the type of procedure is available in the patient record. Palliative care was provided that does not fit the descriptions for codes 1–6.
9	It is unknown if palliative care was performed or referred; not stated in patient record.

Outcomes

Date of First Recurrence

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1860	8	2867-2874	CCYYMMDD	All Years	06/05, 01/10, 01/11, 01/12

Description

Records the date of the first recurrence.

Rationale

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

Coding Instructions

- Record the date the physician diagnoses the first progression, metastasis, or recurrence of disease after a disease-free period.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date of First Recurrence* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of First Recurrence* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *Recurrence Date–1st Flag* [1861] is used to explain why *Date of First Recurrence* is not a known date. See *Recurrence Date–1st Flag* for an illustration of the relationships among these items.

Recurrence Date–1st Flag

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1861	2	2875-2876	10-12, Blank	2010	01/10

Description

This flag explains why there is no appropriate value in the corresponding date field, *Date of First Recurrence* [1860].

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

- Leave this item blank if *Date of First Recurrence* [1860] has a full or partial date recorded.
- Code 12 if the *Date of First Recurrence* cannot be determined, but the patient did have a recurrence following a disease-free period.
- Code 10 if it is unknown whether the patient had a recurrence.
- Code 11 if the patient was never disease free, became disease free but had no recurrence, or was initially diagnosed at autopsy.
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Label
10	No information whatsoever can be inferred from this exceptional value (that is, unknown if the patient was ever disease-free or had a first recurrence)
11	No proper value is applicable in this context (that is, patient became disease-free after treatment and never had a recurrence; or patient was never disease-free; autopsy only case)
12	A proper value is applicable but not known (that is, there was a recurrence, but the date is unknown
(blank)	A valid date value is provided in item *Date of First Recurrence* [1860].

Type of First Recurrence

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1880	2	2877-2878	00, 04, 06, 10, 13-17, 20-22, 25-27, 30, 36, 40, 46, 51-59, 60, 62, 70, 88, 99	All Years	06/05, 01/10, 01/11, 01/13, 01/15, 01/18

Description

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

Rationale

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

Coding Instructions

- Code the type of first recurrence. First recurrence may occur well after completion of the first course of treatment or after subsequent treatment.
- Check the SEER *Multiple Primary and Histology Coding Rules Manual* or the 2018 Solid Tumor Rules to determine which subsequent tumors should be coded as recurrences.
- If the patient has never been disease-free (code 70), continue to track for disease-free status which may occur after subsequent treatment has been completed.
- If the patient is disease-free (code 00), continue to track until a recurrence occurs. First recurrence may occur well after completion of the first course of treatment.
- Once a recurrence has been recorded (code 04-62 or 88), subsequent recurrences are NOT to be recorded.
- Codes 00 through 70 are hierarchical; record the highest-numbered applicable response, with the following limits. The first time a patient converts from disease status (70) to disease-free, change the code to 00. Then the first time a patient converts from 00 to a recurrence, then record the proper code for the recurrence. No further changes (other than corrections) should be made.
- If the tumor was originally diagnosed as in situ, code recurrence to 06, 16, 17, 26, 27, 36, or 46 only. Do not use those codes for any other tumors. Codes 00, 88, or 99 may apply to any tumor.
- Codes 51–59 (organ or organ system of distant recurrence) apply only if all first occurrences were in a single category. There may be multiple metastases (or “seeding”) within the distant location.
- Code lymphomas or leukemias that are in remission 00. If the patient relapses, then code recurrence as 59. If one of these is controlled by drugs (for example, Gleevec for CML), the patient is in remission.
- If there is more than one primary tumor and the physician is unable to decide which has recurred, code the recurrent disease for each tumor. If the recurrent primary is identified later, revise the codes appropriately.

Code	Label
00	Patient became disease-free after treatment and has not had a recurrence.
04	In situ recurrence of an invasive tumor.
06	In situ recurrence of an in situ tumor.

Code	Label
10	Local recurrence, and there is insufficient information available to code to 13–17. Local recurrence includes recurrence confined to the remnant of the organ of origin, to the organ of origin, to the anastomosis, or to scar tissue where the organ previously existed.
13	Local recurrence of an invasive tumor.
14	Trocar recurrence of an invasive tumor. Includes recurrence in the trocar path or entrance site following prior surgery.
15	Both local and trocar recurrence of an invasive tumor (both 13 and 14).
16	Local recurrence of an in situ tumor, NOS
17	Both local and trocar recurrence of an in situ tumor.
20	Regional recurrence, and there is insufficient information available to code to 21–27.
21	Recurrence of an invasive tumor in adjacent tissue or organ(s) only.
22	Recurrence of an invasive tumor in regional lymph nodes only.
25	Recurrence of an invasive tumor in adjacent tissue or organ(s) and in regional lymph nodes (both 21 and 22) at the same time.
26	Regional recurrence of an in situ tumor, NOS.
27	Recurrence of an in situ tumor in adjacent tissue or organ(s) and in regional lymph nodes at the same time.
30	Both regional recurrence of an invasive tumor in adjacent tissue or organs(s) and/or regional lymph nodes (20–25) and local and/or trocar recurrence (10, 13, 14, or 15).
36	Both regional recurrence of an in situ tumor in adjacent tissue or organ(s) and/or regional lymph nodes (26 or 27) and local and/or trocar recurrence (16 or 17).
40	Distant recurrence, to a site not listed in 46-62 or there is insufficient information available to code to 46–62.
46	Distant recurrence of an in situ tumor.
51	Distant recurrence of an invasive tumor in the peritoneum only. Peritoneum includes peritoneal surfaces of all structures within the abdominal cavity and/or positive ascitic fluid.
52	Distant recurrence of an invasive tumor in the lung only. Lung includes the visceral pleura.
53	Distant recurrence of an invasive tumor in the pleura only. Pleura includes the pleural surface of all structures within the thoracic cavity and/or positive pleural fluid.
54	Distant recurrence of an invasive tumor in the liver only.
55	Distant recurrence of an invasive tumor in bone only. This includes bones other than the primary site.
56	Distant recurrence of an invasive tumor in the CNS only. This includes the brain and spinal cord, but not the external eye.
57	Distant recurrence of an invasive tumor in the skin only. This includes skin other than the primary site.
58	Distant recurrence of an invasive tumor in lymph node only. Refer to the staging scheme for a description of lymph nodes that are distant for a particular site.
59	Distant systemic recurrence of an invasive tumor only. This includes lymphoma, leukemia, bone marrow metastasis, carcinomatosis, generalized disease.

Code	Label
60	Distant recurrence of an invasive tumor in a single distant site (51–58) and local, trocar and/or regional recurrence (10–15, 20–25, or 30).
62	Distant recurrence of an invasive tumor in multiple sites (recurrences that can be coded to more than one category 51–59).
70	Since diagnosis, patient has never been disease-free. This includes cases with distant metastasis at diagnosis, systemic disease, unknown primary, or minimal disease that is not treated.
88	Disease has recurred, but the type of recurrence is unknown.
99	It is unknown whether the disease has recurred or if the patient was ever disease-free.

Examples

Code	Reason
52	Distant recurrence in the lung.
62	Recurrence in liver, lung and bone

Date of Last Cancer (tumor) Status

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1772	8	2788-2795	CCYYMMDD, Blank	2018+	01/18

Description

This data item documents the date of last cancer (tumor status) of the patient's malignant or non-malignant tumor. Record in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. This data item is required for CoC-accredited facilities as of cases diagnosed 01/01/2018 and later.

Rationale

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

Coding Instructions

- Record the last date on which the patient's cancer status (*Cancer Status* [1770)] was known to be updated.
- *Cancer Status* is based on information from the patient's physician or other official source such as a death certificate.
- The patient's *Cancer Status* should be changed **only** if new information is received from the patient's physician or other official source. If information is obtained from the patient, a family member, or other non-physician, then *Cancer Status* is not updated.
- *Cancer Status* changes if the patient has a recurrence or relapse.
- This data item differs from the *Date of Last Contact or Death* [1750] as it is a tumor-level data item. If a patient has multiple primaries, each primary could have a different *Date of Last Cancer (tumor) Status* [1772].
- The *Date of Last Cancer (tumor) Status Flag* [1773] is used to explain why *Date of Last Cancer (tumor) Status* [1772] is not a known date. See *Date of Last Cancer (tumor) Status Flag* [1773] for an illustration of the relationships among these items.

Date of Last Cancer (tumor) Status Flag

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1773	2	2796-2797	12, Blank	2018+	01/18

Description

This flag explains why there is no appropriate value in the corresponding date field, *Date of Last Cancer (tumor) Status* [1772]. This data item is required for CoC-accredited facilities as of cases diagnosed 01/01/2018 and later.

Rationale

This information is used for patient follow-up and outcomes studies. As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

- Leave this item blank if *Date of Last Cancer (tumor) Status* [1772] has a full or partial date recorded.
- Code 12 if the *Date of Last Cancer (tumor) Status* [1772] cannot be determined
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Label
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, the Date of Last Cancer (tumor) Status is unknown)
(blank)	A valid date value is provided in item *Date of Last Cancer (tumor) Status* [1772]

Cancer Status

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1770	1	2787-2787	1, 2, 9	All Years	01/04, 01/18

Description

Records the presence or absence of clinical evidence of the patient's malignant or non-malignant tumor as of the *Date of Last Cancer (tumor) Status* [1772].

Rationale

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

Coding Instructions

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

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

Examples

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

Date of Last Contact or Death

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1750	8	2775-2782	CCYYMMDD	All Years	06/05, 01/10, 01/11, 01/15

Description

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

Rationale

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

Coding Instructions

- Record the last date on which the patient was known to be alive or the date of death.
- Note that failure to find a patient on a list of deceased individuals does not constitute evidence that the patient is alive. *Vital Status* is not changed, but neither is the *Date of Last Contact or Death* changed. Unless more information is located, follow up of this patient has failed.
- If a patient has multiple primaries, all records should have the same date of last contact.
- As of January 1, 2006, the CoC does not require *Class of Case* 00 cases to be followed.
- Beginning in 2010, the way dates are transmitted has changed. In order that registry data can be interoperable with other data sources, dates are transmitted in a format widely accepted outside of the registry setting. However, this does not necessarily mean that the way dates are entered in any particular registry software product has changed. Software providers can provide the best information about data entry in their own systems. The traditional format for *Date of Last Contact or Death* is MMDDCCYY, with 99 identifying unknown month or day, and 99999999 representing an entirely unknown date. The interoperable form of *Date of Last Contact or Death* transmits in CCYYMMDD form, where blank spaces are used for unknown trailing portions of the date or where a date is not applicable. The *Date of Last Contact Flag* [1751] is used to explain why *Date of Last Contact or Death* is not a known date. See *Date of Last Contact Flag* for an illustration of the relationships among these items.

Date of Last Contact Flag

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1751	2	2783-2784	12, Blank	2010	01/10

Description

This flag explains why there is no appropriate value in the corresponding date field, *Date of Last Contact or Death* [1750].

Rationale

As part of an initiative to standardize date fields, date flag fields were introduced to accommodate non-date information that had previously been transmitted in date fields.

Coding Instructions

- Leave this item blank if *Date of Last Contact or Death* [1750] has a full or partial date recorded.
- Code 12 if the *Date of Last Contact or Death* cannot be determined
- Registrars should enter this data item directly (when appropriate) even if the traditional form of date entry is used in the software.

Code	Label
12	A proper value is applicable but not known. This event occurred, but the date is unknown (that is, the date of last contact is unknown).
(blank)	A valid date value is provided in item *Date of Last Contact or Death* [1750].

Vital Status

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1760	1	2785-2785	0, 1	All Years	01/15

Description

Records the vital status of the patient as of the date entered in *Date of Last Contact or Death* [1750].

Rationale

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

Coding Instructions

- This item is collected during the follow-up process with *Date of Last Contact or Death* [1750].
- Note that failure to find a patient on a list of deceased individuals does not constitute evidence that the patient is alive. *Vital Status* is not changed, but neither is the *Date of Last Contact or Death* changed. Unless more information is located, follow up of this patient has failed.
- If a patient has multiple primaries, all records should have the same vital status.

Code	Label
0	Dead
1	Alive

Examples

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

NPI–Following Registry

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
2445	10	4905-4914	10 digits, Blank	2008+	04/07, 09/08, 01/11

Description

Records the registry responsible for following the patient.

Rationale

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

Coding Instructions

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

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

Follow-Up Source

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1790	1	2801-2801	0-5, 7-9	All Years	

Description

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

Rationale

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

Coding Instructions

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

Next Follow-Up Source (Next Follow-Up Method)

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1800	1	2802-2802	0-5, 8, 9	All Years	01/10

Description

Identifies the method planned for the next follow-up.

Rationale

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

Coding Instructions

- Registries in CoC-accredited cancer programs are not required to follow foreign residents.
- As of January 1, 2006, the CoC does not require Class of Case 00 cases to be followed.

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

Case Administration

Abstracted By

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
570	3	756-758	Alphanumeric	1996+	

Description

Records the initials or assigned code of the individual abstracting the case.

Rationale

This item can be used for quality control and management in multistaffed registries.

Coding Instructions

- Code the initials of the abstractor.

Code	Label
(fill spaces)	Initials or code of abstractor.

Facility Identification Number (FIN)

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
540	10	715-724	10 digits	All Years	09/08, 01/12

Description

Identifies the facility reporting the case.

Rationale

Each facility's identification number (FIN) is unique. The number is essential to the National Cancer Database (NCDB) for monitoring data submissions, ensuring the accuracy of data, and for identifying areas for special studies.

Coding Instructions

- *Facility Identification Number* is automatically coded by the software provider.
- For facilities with seven-digit FINs in the range of 6020009–6953290 that were assigned by the CoC before January 1, 2001, the coded FIN will consist of three leading zeros followed by the full seven-digit number.
- For facilities with eight-digit FINs greater than or equal to 10000000 that were assigned by the CoC after January 1, 2001, the coded FIN will consist of two leading zeros followed by the full eight-digit number.
- Facilities that are part of an Integrated Network Cancer Program (INCP) *must* use the hospital-specific FIN in their data for submission to the National Cancer Database.
- Facilities that merge are legally a single hospital. Consult NCDB for instructions for recording the FIN for newly-merged programs.

Examples

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

Note: A complete list of FINs is available on the American College of Surgeons Web site at https://www.facs.org/quality-programs/cancer/accredited/info/fin.

NPI–Reporting Facility

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
545	10	704-714	10 digits, Blank	2008+	04/07, 09/08, 01/10, 01/12

Description

Identifies the facility whose data are in the record.

Rationale

Each facility's NPI is unique. The number is essential to the National Cancer Database (NCDB) for monitoring data submissions, ensuring the accuracy of data, and for identifying areas for special studies.

NPI–Reporting Facility is the NPI equivalent of *Facility Identification Number* [540]. Both are required during a period of transition.

Coding Instructions

- *NPI–Reporting Facility* is automatically coded by the software provider.
- NPI should be recorded as available for cases diagnosed during 2007, and is required to be recorded for all cases diagnosed January 1, 2008, and later.
- The facility's NPI can be obtained from the billing or accounting department, or searched at https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.
- If the facility has more than one NPI number assigned, use the "umbrella" number that applies to the entire facility.
- Facilities that are part of an Integrated Network Cancer Program (INCP) must use the hospital-specific NPI number in their data for submission to the National Cancer Database.
- Facilities that merge are legally a single hospital. Use the NPI number for the merged hospital.
- NPI may be blank for cases diagnosed on or before December 31, 2007.

Examples

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

Archive FIN

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
3100	10	735-744	10 digits	2003+	01/10, 01/12

Description

Identifies the facility that originally abstracted the case.

Rationale

It is essential for hospital registries to have the ability to distinguish cases originally accessioned by each registry of the merged unit. This enables the CoC to manage the receipt of historical data and to appropriately attribute these data.

Coding Instructions

- *Archive FIN* is automatically coded by the software provider.
- This data item never changes and must be included as part of the patient record when data are submitted to the NCDB.
- For facilities that have not merged, the *Archive FIN* and *FIN* [540] will be the same.
- If facilities merged after January 1, 2003, a new FIN was assigned to represent the merged facility. This new FIN was assigned to all cases in the *merged* registry, but the *Archive* FIN for cases from each registry prior to the merger does not change.
- If a merged program continues to operate multiple campuses, the Archive FIN is the historic FIN for the respective facilities that are now separate campuses of the same hospital.
- Facilities that are part of an Integrated Network Cancer Program (INCP) *must* use the hospital-specific FIN for the Archive FIN in their data for submission to the National Cancer Database.
- Programs that are not part of a merged facility or an INCP will use their hospital's FIN as the Archive FIN.
- For facilities with seven-digit FINs in the range of 6020009–6953290 that were assigned by the CoC before January 1, 2001, the coded FIN will consist of three leading zeros followed by the full seven-digit number. The Archive FIN must be recorded similarly.
- For facilities with eight-digit FINs greater than or equal to 10000000 that were assigned by the CoC after January 1, 2001, the coded FIN will consist of two leading zeros followed by the full eight-digit number. The Archive FIN must be recorded similarly.

Examples

Code	Reason
0006439999	General Hospital, Anytown, Illinois (FIN: 6439999). Original diagnosis was made at this facility; both the FIN and the Archive FIN are the same.
0006439999 or 0006430000	General Hospital (FIN: 6439999) and Anytown Medical Center (FIN: 6430000) in Anytown IL merged; the two cancer registries were combined and now report as Anytown Medical Center. The new FIN for this reporting facility is 10000099. All cases from the merged General Hospital and Anytown Medical Center registry have the new FIN (0010000099) assigned to them. In addition, either the General Hospital Archive FIN (0006439999) or the Anytown Medical Center Archive FIN (0006430000) is retained in each record depending on which registry originally accessioned the case.

NPI–Archive FIN

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
3105	10	725-734	10 digits, Blank	2008+	01/10, 01/12

Description

Identifies the facility that originally abstracted the case.

Rationale

It is essential for hospital registries to have the ability to distinguish cases originally accessioned by each registry of the merged unit. This enables the CoC to manage the receipt of historical data and to appropriately attribute these data.

NPI–Archive FIN is the NPI equivalent of *Archive FIN* [3100]. Both are required during a period of transition.

Coding Instructions

- *NPI–Archive FIN* is automatically coded by the software provider.
- This data item never changes and must be included as part of the patient record when data are submitted to the NCDB.
- The facility's NPI can be obtained from the billing or accounting department, or searched at https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.
- For facilities that have not merged, the *NPI–Archive FIN* and the *NPI–Reporting Facility* [545] will be the same. Facilities that are part of an Integrated Network Cancer Program (INCP) must use the hospital-specific NPI number for the NPI-Archive FIN in their data for submission to the National Cancer Database.
- If the facility has more than one NPI number assigned, use the "umbrella" number that applies to the entire facility.
- NPI should be recorded as available for cases diagnosed during 2007, and is required to be recorded for all cases diagnosed January 1, 2008, and later.
- NPI may be blank for cases diagnosed on or before December 31, 2007.

Examples

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

Date Case Completed – CoC

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
2092	8	2656-2663	CCYYMMDD	2010+	01/12, 01/18

Description

This data item identifies the date that specified items are completed, based on the *Class of Case*, and those items pass the relevant edits. Follow-up information, including delayed treatment received elsewhere, may be coded after the *Date Case Completed–CoC*. This item should be autocoded by the registry software. The CoC specifications will not necessarily be the same as those used for *Date Case Completed* [NAACCR Item #2090], which CoC does not require.

Rationale

This item was created to measure abstracting timeliness of information that should be available when the facility's main involvement in the patient's first course care is completed, based on *Class of Case*. It is assumed that for all except some unusual cases, all required items, not just those used to determine *Date Case Completed – CoC*, will have been completed for all analytic cases by the time the NCDB annual Call for Data begins.

Coding Instructions

- This item may be left blank for cases diagnosed prior to 2010.
- Follow-up information, information about delayed treatment received elsewhere, and information about multiple tumors diagnosed later may be coded after the *Date Case Completed – CoC*.
- Corrections and updates may be made after the *Date Case Completed – CoC*.
- Appendix C provides a list of items in each broad completion category below.
- After all required items identified below for the patient's *Class of Case* have been abstracted, the registrar should run the standard NAACCR edit set "Hosp: vs 18 CoC Required - All" using the registry software. The registry software will record the *Date Case Completed – CoC* when those items are abstracted and the case passes all edits in that set.

Class of Case	Description	Items that Must Be Completed by Date Case Completed - CoC
00-22	All analytic cases	Identification, demographic, diagnostic
10-22	Patient received part or all first course treatment from facility	Staging, hospital-specific treatment
10, 12, 14, 20, 22	Patient received all first course treatment from facility, or unspecified whether all or part	Summary treatment (treatment at any facility)
00	Patient diagnosed at facility, received all treatment elsewhere	NPI number for the facility the patient was referred to or a treating physician
20-22	Patient diagnosed elsewhere, received part or all of treatment from facility	NPI number for the facility the patient was referred to or from OR the physician who diagnosed or treated the patient

RQRS NCDB Submission Flag

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
2155	1	2623-2623	1, 2	2018+	01/18

Description

This flag identifies the type of data submission from reporting facilities to the CoC National Cancer Database (NCDB). This data item is required for CoC-accredited facilities with submission starting 01/01/2018.

Rationale

CoC-accredited hospitals make multiple data submissions for various reasons:

- Rapid Quality Reporting System (current, generally incomplete cases)
- NCDB Call for Data (older, complete cases)

The NCDB is moving to submission of data via a single data portal rather than the current separate data portals for RQRS and NCDB. This data item will facilitate identification of the purpose of the data submission at the receiving end.

Coding Instructions

- This data item will be automatically set upon file extraction by the hospital registry software. It is not to be manually abstracted by the registrar.

Code	Label
1	Data Submission for RQRS
2	Data Submission for NCDB Annual Call for Data

Override Acsn/Class/Seq

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1985	1	2574-2574	1, Blank	All Years	09/06, 09/08, 01/10

Description

Used with the EDITS software to override the edit *Accession Number, Class of Case, Seq Number (CoC).*

Rationale

Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

EDITS Use

The edit, *Accession Number, Class of Case, Seq Number (CoC)*, checks the following:

- If the case is the only case or the first of multiple cases diagnosed at the facility (*Sequence Number–Hospital* = 00, 01, 60 or 61, and *Class of Case* = 00, 10, 12, 13, or14), then the first 4 characters of the *Accession Number* [550] must equal the year of the *Date of First Contact* [580].
- If the case is first diagnosed at autopsy (*Class of Case* = 38), and the case is the only case or the first of multiple cases for a patient (*Sequence Number–Hospital* = 00, 01, 60, or 61), then the first 4 characters of the *Accession Number* must equal the year of the *Date of Last Contact or Death* [1750] AND must equal the year of the *Date of First Contact*.
- If the case is first diagnosed at autopsy (Class of Case = 38), and the case is the second or more case for a patient (*Sequence Number–Hospital* greater than 01 or greater than 61), then the year of the *Date of First Contact* must equal the year of *Date of Last Contact or Death*.

There are some exceptions to the above rules. *Override Acsn/Class/Seq* may be used to override the edit when the circumstances fit the following situation or one similar to it:

- The case may be the only or the first of multiple malignant cases for a patient (*Sequence Number–Hospital* = 00 or 01), but there is an earlier benign case (with an earlier year of the *Date of First Contact*) for which the *Accession Number* applies.

Coding Instructions

- Leave blank if the EDITS program does not generate an error message for the edit *Accession Number, Class of Case, Sequence Number (CoC).*
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if a review of all items in the error or warning message confirms that all are correct.

Code	Label
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed and confirmed as reported.

Override HospSeq/DxConf

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1986	1	2575-2575	1, Blank	All Years	09/06, 09/08

Description

Used with the EDITS software to override the edit *Diagnostic Confirm, Seq Num–Hosp (CoC)*.

Rationale

Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

EDITS Use

The edit, *Diagnostic Confirm, Seq Num–Hosp (CoC)*, does the following:

- If any case is one of multiple primaries and is not microscopically confirmed or positive lab test/marker study, i.e., *Diagnostic Confirmation* > 5 and *Sequence Number–Hospital* > 00 (more than one primary), review is required.
- If *Primary Site* [400] specifies an ill-defined or unknown primary (C76.0–C76.8, C80.9), no further checking is done. If *Sequence Number–Hospital* is in the range of 60-88, this edit is skipped.

It is important to verify that the non-microscopically-confirmed case is indeed a separate primary from any others that may have been reported. This edit forces review of multiple primary cancers when one of the primaries is coded to a site other than ill-defined or unknown and is not microscopically confirmed or confirmed by a positive lab test/marker study.

- If this edit is failed and the suspect case is confirmed accurate as coded, and the number of primaries is correct, set the *Override HospSeq/DxConf* to 1. Do not set the override flag on the patient's other primary cancers.
- However, if it turns out that the non-microscopically-confirmed cancer is considered a manifestation of one of the patient's other cancers, delete the non-microscopically-confirmed case. Check the sequence numbers of remaining cases, correcting them if necessary. Also check for other data items on the remaining cases that may need to be changed as a result of the corrections, such as stage and treatment.

Coding Instructions

- Leave blank if the EDITS program does not generate an error message for the edit *Diagnostic Confirm, Seq Num–Hosp (CoC)*.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if a review of all items in the error or warning message confirms that all are correct.

Code	Label
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed and confirmed as reported.

Override CoC–Site/Type

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1987	1	2576-2576	1, Blank	All Years	09/06, 09/08

Description

Used with the EDITS software to override the edits *Primary Site, Morphology-Type ICDO2 (CoC), Primary Site, Morphology-Type ICDO3 (CoC)*, and/or *Primary Site, Morphology-Type, Behavior ICDO3 (CoC)*.

Rationale

Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

EDITS Use

There are multiple versions of edits of the type, *Primary Site, Morphology-Type*, which check for "usual" combinations of site and ICD-O-2 or ICD-O-3 histology. The SEER version of the edit is more restrictive than the CoC edit, and thus uses a different override flag. The CoC version of the edit will accept Override CoC-Site/Type or Override Site/Type as equivalent.

- The Site/Histology Validation List (available on the SEER Web site) contains those histologies commonly found in the specified primary site. Histologies that occur only rarely or never are not be included. These edits require review of all combinations *not* listed.
- Since basal and squamous cell carcinomas of non-genital skin sites are not reportable to SEER, these site/histology combinations do not appear on the SEER validation list. For the CoC version of the edit, if *Primary Site* [400] is in the range C44.0-C44.9 (skin), and the ICD-O-3 histology is in the range 8000-8005 (neoplasms, malignant, NOS), 8010-8046 (epithelial carcinomas), 8050-8084 (papillary and squamous cell carcinomas), or 8090-8110 (basal cell carcinomas), no further editing is done. No override is necessary for these cases in the CoC version of the edit.

Review of these cases requires investigating whether the combination is biologically implausible or there are cancer registry coding conventions that would dictate different codes for the diagnosis (See *Cancer Identification* in Section I). Review of these rare combinations often results in changes to the primary site and/or morphology, rather than a decision that the combination is correct.

Coding Instructions

- Leave blank if the EDITS program does not generate an error message for the edit *Accession Number*, *Class of Case*, *Sequence Number (CoC).*
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if a review of all items in the error or warning message confirms that all are correct.

Code	Label
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed and confirmed as reported.

Override HospSeq/Site

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1988	1	2577-2577	1, Blank	All Years	09/06 09/08, 02/10

Description

Used with the EDITS software to override the edit *Seq Num–Hosp, Primary Site, Morph ICDO2 (CoC)* and/or the edit *Seq Num–Hosp, Primary Site, Morph ICDO3 (CoC)*.

Rationale

Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

EDITS Use

Edits of the type, *Seq Num–Hosp, Primary Site, Morph*, differ in use of ICD-O-2 or ICD-O-3 morphology. They force review of multiple primary cancers when one of the primaries is coded to a site-morphology combination that could indicate a metastatic site rather than a primary site. If *Sequence Number–Hospital* indicates the person has had more than one primary, then any case with one of the following site-histology combinations requires review:

- C76.0–C76.8 (Ill-defined sites) or C80.9 (unknown primary) and ICD-O-2 or ICD-O-3 histology < 9590. (Look for evidence that the unknown or ill-defined primary is a secondary site from one of the patient's other cancers. For example, a clinical discharge diagnosis of “abdominal carcinomatosis” may be attributable to the patient's primary ovarian cystadenocarcinoma already in the registry, and should not be entered as a second primary.)
- Lymph node primary sites (C77.0-C77.9) for histologies other than lymphomas, or hematopoietic primary sites for histologies not in range for hematopoietic diseases. (That combination is most likely a metastatic lesion. Check whether the lesion could be a manifestation of one of the patient's other cancers.)
- Any site and ICD-O-2 histology in the range 9720-9723, 9740-9741 or ICD-O-3 histology in the range 9740-9758. (Verify that these diagnoses are coded correctly and are indeed separate primaries from the others.)

If it turns out that the suspect tumor is a manifestation of one of the patient's other cancers, delete the metastatic or secondary case, re-sequence remaining cases, and correct the coding on the original case as necessary.

Coding Instructions

- Leave blank if the EDITS program does not generate an error message for an edit of the type *Seq Num–Hosp, Primary Site, Morph*
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if review of all items in the error or warning message confirms that all are correct.

Code	Label
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed and confirmed as reported.

Override Site/TNM-Stage Group

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1989	1	2578-2578	1, Blank	All Years	09/04, 09/08, 01/10, 01/12

Description

Used with the EDITS software to override the edits of the type *Primary Site, AJCC Stage Group*, for AJCC staging editions 6 and later.

Rationale

This override flag allows identification of pediatric cancers that were staged according to a system other than the **AJCC** staging manual (which is predominantly directed toward adult staging) if they are not also **AJCC**-staged. In that situation an otherwise-stageable case may be coded 88 (not applicable) for all **AJCC** items.

EDITS Use

Edits of the type, *Primary Site, AJCC Stage Group*, check that the pathological and clinical AJCC stage group codes are valid for the site and histology group according to the applicable *AJCC Cancer Staging Manual*, using the codes described for the items *Clinical Stage Group* [970] and *Pathological Stage Group* [910]. Combinations of site and histology not represented in any AJCC schema must be coded 88. Unknown codes must be coded 99. Blanks are not permitted.

Since pediatric cancers whose sites and histologies have an AJCC scheme may be coded according to a pediatric scheme instead, use *Override Site/TNM-Stage Group* to indicate the case was coded according to a pediatric staging system if it was not also coded according to the AJCC manual. Pediatric stage groups should *not* be recorded in the *Clinical Stage Group* or *Pathological Stage Group* items. When neither clinical nor pathological AJCC staging is used for pediatric cases, code all AJCC items 88. When any AJCC component is used to stage a pediatric case, follow the instructions for coding AJCC items and leave *Override Site/TNM-Stage Group* blank.

Coding Instructions

- Leave blank if the EDITS program does not generate an error message for the edits of the type, *Primary Site, AJCC Stage Group*.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if the case is confirmed to be a pediatric case that was coded using a pediatric coding system.

Code	Label
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed and confirmed as reported.

Override Age/Site/Morph

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1990	1	2579-2579	1-3, Blank	All Years	04/07, 09/08, 01/10

Description

Used with the EDITS software to override edits of the type *Age, Primary Site, Morphology; Age, Primary Site, Morph ICDO3–Adult*, and *Age, Primary Site, Morph ICDO3–Pediatric*.

Rationale

Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

EDITS Use

Edits of the type *Age, Primary Site, Morphology; Age, Primary Site, Morph ICDO3–Adult*; and *Age, Primary Site, Morph ICDO3–Pediatric* require review if a site-morphology combination occurs in an age group for which it is extremely rare or if the cancer was diagnosed in utero.

If the edit generates an error or warning message, check that the primary site and histologic type are coded correctly and that the age, date of birth, and date of diagnosis are correct.

Coding Instructions

- Leave blank if the EDITS program does not generate an error message for the Age, Primary Site, Morphology; Age, Primary Site, Morph ICDO3–Adult, and Age, Primary Site, Morph ICDO3–Pediatric edits.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 for an unusual occurrence of a particular age/site/histology combination for a given age has been confirmed by review to be correct.
- Code 2 if the case was diagnosed in utero.
- Code 3 if both conditions apply.

Code	Label
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed; age, site, and morphology combination confirmed as reported.
2	Reviewed; diagnosis in utero.
3	Reviewed; both conditions apply.

Override Surg/DxConf

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
2020	1	2585-2585	1, Blank	All Years	09/06, 09/08

Description

Used with the EDITS software to override the edits *RX Summ–Surg Prim Site, Diag Conf (SEER IF76); RX Summ–Surgery Type, Diag Conf (SEER IF46)*; and/or the edit *RX Summ–Surg Site 98-02, Diag Conf (SEER 106)*.

Rationale

Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

EDITS Use

Edits of the type, *RX Summ–Surg Prim Site, Diag Conf*, check that cases with a primary site surgical procedure coded 20-90 are histologically confirmed.

If the patient had a surgical procedure, most likely there was a microscopic examination of the cancer.

- Verify the surgery and diagnostic confirmation codes, and correct any errors.
- Sometimes there are valid reasons why no microscopic confirmation is achieved with the surgery, for example, the tissue removed may be inadequate for evaluation.

Coding Instructions

- Leave blank if the EDITS program does not generate an error message for edits of the type, *RX Summ–Surg Prim Site, Diag Conf*.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if review of all items in the error or warning message confirms that all are correct.

Code	Label
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed, confirmed as reported.

Override Site/Type

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
2030	1	2586-2586	1, Blank	All Years	09/06, 09/08, 01/10

Description

Used with the EDITS software to override edits of the type *Primary Site, Morphology-Type and Primary Site, Morphology-Type, Behavior ICDO3*.

Rationale

Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

EDITS Use

There are multiple versions of edits of the type, *Primary Site, Morphology-Type*, which check for "usual" combinations of site and ICD-O-2 or ICD-O-3 histology. The SEER version of the edit is more restrictive than the CoC edit, and thus uses a different override flag. The CoC version of the edit will accept *Override CoC-Site/Type* or *Override Site/Type* as equivalent.

- The Site/Histology Validation List (available on the SEER website) contains those histologies commonly found in the specified primary site. Histologies that occur only rarely or never are not be included. These edits require review of all combinations *not* listed.
- Since basal and squamous cell carcinomas of non-genital skin sites are not reportable to SEER, these site/histology combinations do not appear on the SEER validation list. For the CoC version of the edit, if *Primary Site* [400] is in the range C440-C449 (skin), and the ICD-O-3 histology is in the range 8000-8005 (neoplasms, malignant, NOS), 8010-8046 (epithelial carcinomas), 8050-8084 (papillary and squamous cell carcinomas), or 8090-8110 (basal cell carcinomas), no further editing is done. No override is necessary for these cases in the CoC version of the edit.

Review of these cases requires investigating whether the combination is biologically implausible or there are cancer registry coding conventions that would dictate different codes for the diagnosis (See *Cancer Identification* in Section I). Review of these rare combinations often results in changes to the primary site and/or morphology, rather than a decision that the combination is correct.

Coding Instructions

- Leave blank if the EDITS program does not generate an error message for edits of the type *Primary Site, Morphology-Type*.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if review of all items in the error or warning message confirms that all are correct.

Code	Label
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed, confirmed as reported.

Override Histology

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
2040	1	2587-2587	1-3, Blank	All Years	04/07, 09/08

Description

Used with the EDITS software to override any of five edits: *Diagnostic Confirmation, Behavior ICDO2 (SEER IF31); Diagnostic Confirmation, Behavior ICDO3 (SEER IF31); Morphology–Type/Behavior ICDO2 (SEER MORPH); Morphology–Type/Behavior ICDO3 (SEER MORPH)*; and/or the edit *Morph (1973-91) ICD-O-1 (SEER MORPH)*.

Rationale

Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

EDITS Use

- Edits of the type, *Diagnostic Confirmation, Behavior Code*, differ in the use of ICD-O-2 or ICD-O-3 and check that, for in situ cases (Behavior = 2), *Diagnostic Confirmation* specifies microscopic confirmation (1, 2 or 4). The distinction between in situ and invasive is very important to a registry, since prognosis is so different. Since the determination that a neoplasm has not invaded surrounding tissue, i.e. is in situ, is made microscopically, cases coded in situ in behavior should have a microscopic confirmation code. Very rarely, a physician will designate a case noninvasive or in situ without microscopic evidence.

If an edit of the type, *Diagnostic Confirmation, Behavior Code*, gives an error message or warning, check that *Behavior Code* [523] and *Diagnostic Confirmation* [490] have been coded correctly. Check carefully for any cytologic or histologic evidence that may have been missed in coding.

- Edits of the type, *Morphology–Type/Behavior*, perform the following overrideable check:

Codes listed in ICD-O-2 or ICD-O-3 with behavior codes of only 0 or 1 are considered valid, since use of the behavior matrix of ICD-O-2 and ICD-O-3 allows for the elevation of the behavior of such histologies when the tumor is in situ or malignant. This edit forces review of these rare cases to verify that they are indeed in situ or malignant.

If a *Morphology-Type/Behavior* edit produces an error or warning message and the case is one in which the 4-digit morphology code is one that appears in ICD-O-2 or ICD-O-3 only with behavior codes of 0 or 1, verify the coding of morphology and that the behavior should be coded malignant or in situ. The registrar may need to consult a pathologist or medical advisor in problem cases.

Exceptions to the above: If year of *Date of Diagnosis* > 2000, then a behavior code of 1 is valid for the following ICD-O-2 histologies and no override flag is needed: 8931, 9393, 9538, 9950, 9960-9962, 9980-9984, 9989. Similarly, the following ICD-O-3 histologies are valid with a behavior code of 1: 8442, 8451, 8462, 8472, and 8473.

Note: The *Morphology-Type/Behavior* edits are complex and perform several additional types of checks. No other aspects of their checks are subject to override.

Coding Instructions

- Leave blank if the EDITS program does not generate an error message for the edits of the types *Diagnostic Confirmation or Morph or Morphology–Type/Behavior*.

- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1, 2 or 3 as indicated if review of all items in the error or warning message confirms that all are correct.

Code	**Label**
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed, confirmed as reported for edits of the type *Morphology–Type/Behavior*.
2	Reviewed, confirmed as reported for edits of the type *Diagnostic Confirmation, Behavior Code*.
3	Reviewed: conditions 1 and 2 above both apply.

Override Leuk, Lymphoma

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
2070	1	2590-2590	1, Blank	All Years	09/06, 09/08, 01/10

Description

Used with the EDITS software to override edits of the type *Diagnostic Confirmation, Histology*.

Rationale

Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

EDITS Use

Edits of the type *Diagnostic Confirmation, Histology* differ in use of ICD-O-2 [420] or ICD-O-3 [522] and check the following:

- Since lymphoma and leukemia are almost exclusively microscopic diagnoses, this edit forces review of any cases of lymphoma that have diagnostic confirmation of direct visualization or clinical, and any leukemia with a diagnostic confirmation of direct visualization.
- For lymphomas, *Diagnostic Confirmation* [490] cannot be 6 (direct visualization) or 8 (clinical).
- For leukemia and other hematopoietic neoplasms, *Diagnostic Confirmation* cannot be 6 (direct visualization)

If an edit of the type, *Diagnostic Confirmation*, Histology, produces an error or warning message, check that the *Histology and Diagnostic Confirmation* items are correctly coded. Remember that positive hematologic findings and bone marrow specimens are included as histologic confirmation (code 1 in *Diagnostic Confirmation*) for leukemia.

Coding Instructions

- Leave blank if the EDITS program does not generate an error message for the edits of the type *Diagnostic Confirmation, Histology*.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if review of all items in the error or warning message confirms that all are correct.

Code	Label
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed, confirmed as reported.

Override Site/Behavior

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
2071	1	2591-2591	1, Blank	All Years	09/06, 09/08

Description

Used with the EDITS software to override the edits of the type *Primary Site, Behavior Code*.

Rationale

Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

EDITS Use

Edits of the type, *Primary Site, Behavior*, require review of the following primary sites with a behavior of in situ (ICD-O-2 or ICD-O-3 behavior = 2):

Code	Label
C26.9	Gastrointestinal tract, NOS
C39.9	Ill-defined sites within respiratory system
C55.9	Uterus, NOS
C57.9	Female genital tract, NOS
C63.9	Male genital organs, NOS
C68.9	Urinary system, NOS
C72.9	Nervous system, NOS
C75.9	Endocrine gland, NOS
C76.0-C76.8	Ill-defined sites
C80.9	Unknown primary site

Since the designation of in situ is very specific and almost always requires microscopic confirmation, ordinarily specific information should also be available regarding the primary site. Conversely, if inadequate information is available to determine a specific primary site, it is unlikely that information about a cancer being in situ is reliable.

- If a specific in situ diagnosis is provided, try to obtain a more specific primary site. A primary site within an organ system can sometimes be identified based on the diagnostic procedure or treatment given or on the histologic type. If a more specific site cannot be determined, it is usually preferable to code a behavior code of 3. In the exceedingly rare situation in which it is certain that the behavior is in situ and no more specific-site code is applicable, set *Override Site/Behavior* to 1.

Coding Instructions

- Leave blank if the EDITS program does not generate an error message for *Primary Site, Behavior* edits.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.

- Code 1 if review of all items in the error or warning message confirms that all are correct.

Code	Label
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed, confirmed as reported.

Override Site/Lat/Morph

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
2074	1	2594-2594-2591	1, Blank	All Years	09/06, 09/08

Description

Used with the EDITS software to override edits of the type *Laterality, Primary Site, Morph*.

Rationale

Some edits in the EDITS software package check for code combinations that are possible, but quite rare. If the code combination generates an error message and review of the case indicates that the codes are correct for the case, then the override flag is used to skip the edit on future runs of the EDITS package.

EDITS Use

Edits of the type *Laterality, Primary Site, Morph* differ in whether they produce a warning or an error message and in use of ICD-O-2 or ICD-O-3 morphology and do the following:

- If the *Primary Site* [400] is a paired organ and *Behavior Code* [523] is in situ (2), then *Laterality* [410] must be 1, 2, 3 or 5.
- If diagnosis year is less than 1988 and *Histology* [522] is greater than or equal to 9590, then no further editing is performed. If diagnosis year is greater than 1987 and *Histology* equals 9140, 9700, 9701, 9590-9980, then no further editing is performed.

The intent of this edit is to force a review of in situ cases for which *Laterality* is coded 4 (bilateral) or 9 (unknown laterality) as to origin.

- In rare instances when the tumor is truly midline and the case was diagnosed prior to 2010 (when midline was coded 9), either change the *Laterality* code to 5 and leave the override blank, or enter code 1 for *Override Site/Lat/Morph*. For cases diagnosed in 2010 or later, *Laterality* must be coded 5 for midline tumors.
- If the rare combination is otherwise confirmed correct, enter code 1 for *Override Site/Lat/Morph*.

Coding Instructions

- Leave blank if the EDITS program does not generate an error message for the *Laterality, Primary Site, Morphology* edits.
- Leave blank and correct any errors for the case if an item is discovered to be incorrect.
- Code 1 if a review of all items in the error or warning message confirms that all are correct.

Code	Label
(leave blank)	Not reviewed; or reviewed and corrected.
1	Reviewed, confirmed as reported.

CoC Coding System–Current

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
2140	2	2619-2620	00–09, 99	2003+	01/10, 01/18

Description

Indicates the Commission on Cancer coding system currently used in the record.

Rationale

Knowledge of the coding system that describes the meaning of the codes currently stored for each case is necessary for interpretation of the coded data. It is also necessary for correct conversion of the record to a different coding system or to a different registry software system. This item differs from *CoC Coding System–Original* [2150] if the record has been converted to a more recent coding system.

Coding Instructions

- All fields in a case record should be coded according to the same Commission on Cancer coding system following record conversion.
- This code does not apply to patient race, primary site, histology, TNM stage and its components, Collaborative Stage, comorbidities and complications, or cause of death. The original coding systems for these items are recorded in other fields.
- This item should be updated every time the record is converted to another coding system.

Code	Label	Definition
00	None	No CoC coding system used.
01	Pre-1988	Pre-1988 version (Cancer Program Manual Supplement)
02	1988	1988 *Data Acquisition Manual*
03	1989	1989 *Data Acquisition Manual*
04	1990	1990 *Data Acquisition Manual*
05	1994	1994 *Data Acquisition Manual*
06	1996	*Standards of the Commission on Cancer Volume II: Registry Operations and Data Standards (ROADS)*
07	1998	*Standards of the Commission on Cancer, Volume II: Registry Operations and Data Standards (ROADS)* 1998 Revisions
08	2003	*Facility Oncology Registry Data Standards (FORDS)*
09	2018	*STORE (effective with cases diagnosed 2018 and forward)*
99	Unknown	Unknown coding system.

Examples

Code	Reason
00	A case accessioned in 1980 was coded according to codes developed locally by the hospital before it became involved in the Commission on Cancer Approvals Program and no conversion of the record has occurred since its accession into the registry.

Code	Reason
08	A case accessioned in 1980 was coded according to codes developed locally by the hospital before it became involved in the Commission on Cancer Approvals Program. In 1989, the registry records were converted to conform to the codes defined in the 1989 *Data Acquisition Manual*. The registry data were subsequently converted in 1996, 1998, and 2003 with the publication of each manual.
08	A case accessioned in 1997 was coded according to 1996 *Standards of the Commission on Cancer, Volume II: Registry Operations and Data Standards (ROADS)*, and subsequently converted to correspond to the coding system expressed in *Facility Oncology Registry Data Standards (FORDS).*
09	A new case diagnosed in 2018 was abstracted using *STandards for Oncology Registry Entry (STORE).*
99	A case was accessioned in 1989, but it is unknown whether the 1988 or 1989 version of the *Data Acquisition Manual* was used to code the case. The conversion of this record to a more recent coding system is not possible due the uncertainty of its original coding system.

CoC Coding System–Original

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
2150	2	2621-2622	00–09, 99	2003+	01/10, 01/18

Description

Indicates the Commission on Cancer coding system used to originally code the items.

Rationale

The coding system used when a case is originally coded limits the possible categories that could have been applied to code the case. Because code categories may change over time as new coding systems are developed, this item is used to assist interpretation when cases that may have been coded originally according to multiple coding systems are analyzed.

Coding Instructions

- All fields in a case record should be coded according to the same Commission on Cancer coding system.
- This code does not apply to patient race, primary site, histology, TNM stage and its components, Collaborative Stage, comorbidities or complications, or cause of death. The original coding systems for these items are recorded in other fields.
- This item must not be changed when the record is converted to another coding system. That information is reflected in the data item *CoC Coding System–Current* [2140].
- Code 99 for cases coded prior to 2003 if the correct CoC coding system is not known, or if multiple coding systems were used to code a single case. Ordinarily, it will not be necessary to use code 99 for cases accessioned in 2003 or later.

Code	Label	Definition
00	None	No CoC coding system used.
01	Pre-1988	Pre-1988 version (Cancer Program Manual Supplement)
02	1988	1988 *Data Acquisition Manual*
03	1989	1989 *Data Acquisition Manual*
04	1990	1990 *Data Acquisition Manual*
05	1994	1994 *Data Acquisition Manual*
06	1996	*Standards of the Commission on Cancer, Volume II: Registry Operations and Data Standards (ROADS)*
07	1998	*Standards of the Commission on Cancer Volume II: Registry Operations and Data Standards (ROADS)* 1998 Revisions
08	2003	*Facility Oncology Registry Data Standards (FORDS)*
09	2018	*STORE (effective with cases diagnosed 2018 and forward)*
99	Unknown	Original CoC coding system used is not known.

Examples

Code	Reason
00	A case accessioned in 1980 was coded according to codes developed locally by the hospital before it became involved in the Commission on Cancer Approvals Program.
00	A case accessioned in 1980 was coded according to codes developed locally by the hospital before it became involved in the Commission on Cancer Approvals Program. In 1989, the registry records were converted to conform to the codes defined in the 1989 *Data Acquisition Manual*. The registry data were subsequently converted in 1996, 1998, and 2003 with the publication of each manual.
06	A case accessioned in 1997 was coded according to *1996 Standards of the Commission on Cancer, Volume II: Registry Operations and Data Standards* (ROADS), and subsequently converted to correspond to the coding rules expressed in *Facility Oncology Registry Data Standards (FORDS)*.
99	A case was accessioned in 1989, but it is unknown whether the 1988 or 1989 version of the *Data Acquisition Manual* was used to code the case.

Race Coding System–Current

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
170	1	217-217	1–7, 9	All Years	01/04, 01/10

Description

Describes how race is currently coded. If converted, this field shows the system to which it was converted.

Rationale

Race codes (NAACCR Items #160–164) have changed over time. To accurately group and analyze data, it is necessary to record the system used to record the race codes.

Coding Instructions

- This item is autocoded by the software provider.

Code	Label
1	4-value coding: 1 = White, 2 = Black, 3 = Other, 9 = Unknown
2	<1988 (1-digit)
3	1988 + (2-digit)
4	1991 + (added codes 20–97)
5	1994 + (added code 14)
6	2000 + (no new codes added, new items *Race #2–Race #5* added)
7	2010 + (added codes 15, 16, and 17; removed 09)
9	Other

Race Coding System–Original

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
180	1	218-218	1–7, 9	2003+	01/04, 01/10

Description

Describes how race was originally coded.

Rationale

Race #1–#5 codes (NAACCR Items #160–164) have changed over time. Identifying both the original and current coding systems used to code race promotes accurate data grouping and analysis.

Coding Instructions

- This item is autocoded by the software provider.
- For cases diagnosed on or after January 1, 2010, this data item must be coded 7.

Code	Label
1	4-value coding: 1 = White, 2 = Black, 3 = Other, 9 = Unknown
2	<1988 (1-digit)
3	1988 + (2-digit)
4	1991 + (added codes 20–97)
5	1994 + (added code 14)
6	2000 + (no new codes added, new items *Race #2–Race #5* added)
7	2010 + (added codes 15, 16, and 17; removed 09)
9	Other

Site Coding System–Current

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
450	1	572-572	1–6, 9	All Years	

Description

Describes how the primary site is currently coded. If converted, this field shows the system to which it was converted.

Rationale

This information is used for some data analysis and for further item conversions.

Coding Instructions

- This item is autocoded by the software provider.

Code	Label
1	ICD-8 and Manual of Tumor Nomenclature and Coding (MOTNAC)
2	ICD-9
3	ICD-O, First Edition
4	ICD-O, Second Edition
5	ICD-O, Third Edition
6	ICD-10
9	Other

Site Coding System–Original

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
460	1	573-573	1–6, 9	2003+	01/03

Description

Describes how the primary site was originally coded.

Rationale

This information is used for some data analysis. Converted codes have a slightly different distribution and meaning than codes entered directly. Cancer registries record case histories over many years, so not all cases will originally be assigned according to the same code version.

Coding Instructions

- This item is autocoded by the software provider.

Code	Label
1	ICD-8 and Manual of Tumor Nomenclature and Coding (MOTNAC)
2	ICD-9
3	ICD-O, First Edition
4	ICD-O, Second Edition
5	ICD-O, Third Edition
6	ICD-10
9	Other

Morphology Coding System–Current

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
470	1	574-574	A, 1–9	All Years	01/10, 01/18

Description

Describes how morphology is currently coded. If converted, this field shows the system to which it was converted.

Rationale

This information is used for some data analysis and for further item conversions. New versions of the codes used for recording histology and behavior reflect advances in medical and pathologic knowledge, and converted codes have a slightly different distribution and meaning than codes entered directly. Cancer registries record case histories over many years, so not all cases will originally be assigned according to the same code version.

Coding Instructions

- This item is autocoded by the software provider.

Code	Label
1	ICD-O, First Edition
2	ICD-O, 1986 Field Trial
3	ICD-O, 1988 Field Trial
4	ICD-O, Second Edition
5	ICD-O, Second Edition, plus REAL lymphoma codes effective 1/1/95
6	ICD-O, Second Edition, plus FAB codes effective 1/1/98
7	ICD-O, Third Edition
8	ICD-O, Third Edition, plus 2008 WHO hematopoietic/lymphoid new terms effective 1/1/2010
A	ICD-O, Third Edition, plus WHO new terms used for conditions, effective 1/1/2018
9	Other

Morphology Coding System–Original

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
480	1	575-575	A, 1–9	All Years	01/04, 01/10, 01/11, 01/18

Description

Describes how morphology was originally coded. If later converted, this field shows the original codes used.

Rationale

This information is used for some data analysis and for further item conversions. New versions of the codes used for recording histology and behavior reflect advances in medical and pathologic knowledge, and converted codes have a slightly different distribution and meaning than codes entered directly. Cancer registries record case histories over many years, so not all cases will originally be assigned according to the same code version.

Coding Instructions

- This item is autocoded by the software provider.
- For cases diagnosed on or after January 1, 2010, this data item must be coded 8.

Code	Label
1	ICD-O, First Edition
2	ICD-O, 1986 Field Trial
3	ICD-O, 1988 Field Trial
4	ICD-O, Second Edition
5	ICD-O, Second Edition, plus REAL lymphoma codes effective 1/1/95
6	ICD-O, Second Edition, plus FAB codes effective 1/1/98
7	ICD-O, Third Edition
8	ICD-O, Third Edition, plus 2008 WHO hematopoietic/lymphoid new terms effective 1/1/2010
A	ICD-O, Third Edition, plus WHO new terms used for conditions, effective 1/1/2018
9	Other

ICD-O-2 Conversion Flag

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1980	1	2606-2606	0-6, Blank	All Years	01/04

Description

Specifies whether or how site and morphology codes were converted to ICD-O-2.

Rationale

This information is used for some data analysis and for further item conversions.

Coding Instructions

- Codes 0, 1, and 2 are autocoded by the software provider.
- Codes 3 and 4 are manually entered following a review of the automated morphology conversion from ICD-O-1 or ICD-O-3 to ICD-O-2.

Code	Label
(leave blank)	Not converted
0	Primary site and morphology originally coded in ICD-O-2
1	Primary site and morphology converted without review
2	Primary site and morphology converted with review; morphology machine-converted without review
3	Primary site machine-converted without review; morphology converted with review
4	Primary site and morphology converted with review
5	Morphology converted from ICD-O-3 without review
6	Morphology converted from ICD-O-3 with review

ICD-O-3 Conversion Flag

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
2116	1	2704-2704	0, 1, 3, Blank	All Years	01/04

Description

Identifies how the conversion of morphology codes from ICD-O-2 to ICD-O-3 was accomplished.

Rationale

This information is used for some data analysis and for further item conversions. New versions of the codes used for recording histology and behavior reflect advances in medical and pathologic knowledge, and converted codes have a slightly different distribution and meaning than codes entered directly. Cancer registries record case histories over many years, so not all cases will originally be assigned according to the same code version.

Coding Instructions

- Codes 0 and 1 are autocoded by the software provider.
- Code 3 is manually entered following review of the automated morphology conversion from ICD-O-2 to ICD-O-3.

Code	Label
(leave blank)	Not converted.
0	Morphology (Morph–Type&Behav ICD-O-3, NAACCR Item #521) originally coded in ICD-O-3.
1	Morphology (Morph–Type&Behav ICD-O-3, NAACCR Item #521) converted from (Morph–Type&Behav ICD-O-2, NAACCR Item #419) without review.
3	Morphology (Morph–Type&Behav ICD-O-3, NAACCR Item #521) converted from (Morph–Type&Behav ICD-O-2, NAACCR Item #419) with review.

TNM Edition Number

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1060	1	1046-1047	00–08, 88, 99	1996+	01/04, 01/10, 01/18

Description

Identifies the edition of the *AJCC Cancer Staging Manual* used to stage the case.

Rationale

AJCC stage and component T, N, and M codes and rules have changed over time. This item enables the analysis of cases grouped by edition number.

Coding Instructions

- This item is autocoded by the software provider.

Code	Label
00	Not staged (cases that have an AJCC staging scheme and staging was not done).
01	First Edition
02	Second Edition
03	Third Edition
04	Fourth Edition
05	Fifth Edition
06	Sixth Edition
07	Seventh Edition
08	Eighth Edition
88	Not applicable (cases that do not have an AJCC staging scheme)
99	Staged, but the edition is unknown

Rx Coding System–Current

Item #	Length	Column #	Allowable Values	Required Status	Date Revised
1460	2	2251-2252	00–07, 09, 99	All Years	01/18

Description

Describes how treatment for this case is now coded.

Rationale

This information is used for some data analysis and for further item conversions.

Coding Instructions

- This item is autocoded by the software provider.
- The STORE manual **must** be used to record treatment for all cases diagnosed January 1, 2018, or later, and this item **must** be coded 08.

Code	Label
00	Treatment data not coded/transmitted, i.e., all treatment fields blank
01	Treatment data coded using 1-digit surgery codes
02	Treatment data coded according to 1983–1992 SEER manuals and CoC manuals 1983–1995
03	Treatment data coded according to 1996 ROADS manual
04	Treatment data coded according to 1998 ROADS supplement
05	Treatment data coded according to 1998 SEER manual
06	Treatment data coded according to FORDS
07	Treatment data coded according to 2010 SEER manual
08	Treatment data coded according to STORE Manual
99	Other coding, including partial or nonstandard coding

APPENDIX A: STORE UPDATES for 2018

Updates since FORDS: Revised for 2016

1. Added AJCC 8th Edition Staging System items and Summary Stage 2018 [764].
2. Added 2018 grade data items.
3. Added SSDI data items.
4. Added new SNL and Regional Lymph Node data items.
5. Added new phase-specific and summary radiation data items.
6. Added new follow-up data items.
7. Updated coding system data items.
8. The allowable values listed in the header for Sex [220] were corrected to 1-6, 9 to reflect the addition of codes 5 and 6 in 2015.
9. For Mets at DX—Other [1117] the following code has been added:

   2 Generalized metastases such as carcinomatosis.
10. Minor coding clarifications were made to Tumor Size Summary [#756].
11. Codes and coding instructions for LVI [1182] were updated.
12. The coding clarification in APPENDIX B: Site-Specific Surgery Codes for SKIN was updated to state "1 cm *or more*".
13. Ambiguous Terms Clarification:
    a. Added Ambiguous Terminology Lists: References of Last Resort
14. Updated Appendices.

APPENDIX B: Site-Specific Surgery Codes

Note: The histologies specified in this section apply only to cases diagnosed in 2010 or later. Please consult *FORDS: Revised for 2009* for applicable histologies for cases diagnosed prior to that date.

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

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 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 surgical events 10–14.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Wide excision, NOS

Code 30 includes:

Hemiglossectomy
Partial glossectomy

40 Radical excision of tumor, NOS
- 41 Radical excision of tumor ONLY
- 42 Combination of 41 WITH resection in continuity with mandible (marginal, segmental, hemi-, or total resection)
- 43 Combination of 41 WITH resection in continuity with maxilla (partial, subtotal, or total resection)

Codes 40–43 include:

Total glossectomy
Radical glossectomy

Specimen sent to pathology from surgical events 20–43.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 12/4/02, 01/10, 02/10, 01/16)

PAROTID AND OTHER UNSPECIFIED GLANDS

Parotid Gland C07.9, Major Salivary Glands C08.0–C08.9

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 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 surgical events 10–14.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy
- Any combination of 20 or 26–27 WITH
  - 21 Photodynamic therapy (PDT)
  - 22 Electrocautery
  - 23 Cryosurgery
  - 24 Laser ablation
- 25 Laser excision

30 Less than total parotidectomy, NOS; less than total removal of major salivary gland, NOS
- 31 Facial nerve spared
- 32 Facial nerve sacrificed
- 33 Superficial lobe ONLY
  - 34 Facial nerve spared
  - 35 Facial nerve sacrificed
- 36 Deep lobe (Total)
  - 37 Facial nerve spared
  - 38 Facial nerve sacrificed

40 Total parotidectomy, NOS; total removal of major salivary gland, NOS
- 41 Facial nerve spared
- 42 Facial nerve sacrificed

50 Radical parotidectomy, NOS; radical removal of major salivary gland, NOS
- 51 WITHOUT removal of temporal bone
- 52 WITH removal of temporal bone
- 53 WITH removal of overlying skin (requires graft or flap coverage)

80 Parotidectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 01/10, 02/10, 01/16)

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

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

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 Stripping

No specimen sent to pathology from surgical events 10–15.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

- 25 Laser excision
- 28 Stripping

30 Pharyngectomy, NOS
- 31 Limited/partial pharyngectomy; tonsillectomy, bilateral tonsillectomy
- 32 Total pharyngectomy

40 Pharyngectomy WITH laryngectomy OR removal of contiguous bone tissue, NOS (does NOT include total mandibular resection)
- 41 WITH Laryngectomy (laryngopharyngectomy)
- 42 WITH bone
- 43 WITH both 41 and 42

50 Radical pharyngectomy (includes total mandibular resection), NOS
- 51 WITHOUT laryngectomy
- 52 WITH laryngectomy

Specimen sent to pathology from surgical events 20–52.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 01/10, 02/10, 01/16)

ESOPHAGUS

C15.0–C15.9

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 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 surgical events 10–14.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Partial esophagectomy

40 Total esophagectomy, NOS

50 Esophagectomy, NOS 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

80 Esophagectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 01/10, 02/10, 01/16)

STOMACH

C16.0–C16.9

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 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 surgical events 10–14.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Gastrectomy, NOS (partial, subtotal, hemi-)
- 31 Antrectomy, lower (distal-less than 40% of stomach)***
- 32 Lower (distal) gastrectomy (partial, subtotal, hemi-)
- 33 Upper (proximal) gastrectomy (partial, subtotal, hemi-)

Code 30 includes:

Partial gastrectomy, including a sleeve resection of the stomach
Billroth I: anastomosis to duodenum (duodenostomy)
Billroth II: anastomosis to jejunum (jejunostomy)

40 Near-total or total gastrectomy, NOS
- 41 Near-total gastrectomy
- 42 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

Codes 50–52 are used for gastrectomy resection when only portions of esophagus are included in procedure.

60 Gastrectomy with a resection in continuity with the resection of other organs, NOS***

61 Partial or subtotal gastrectomy, in continuity with the resection of other organs***

62 Near total or total gastrectomy, in continuity with the resection of other organs***

63 Radical gastrectomy, in continuity with the resection of other organs***

Codes 60–63 are used for gastrectomy resections with organs other than esophagus. Portions of esophagus may or may not be included in the resection.

80 Gastrectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

_____

*** Incidental splenectomy NOT included

(Revised 01/10, 02/10, 01/16)

COLON

C18.0–C18.9

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 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 surgical events 10–14.

20 Local tumor excision, NOS
- 27 Excisional biopsy
- 26 Polypectomy, NOS
- 28 Polypectomy-endoscopic
- 29 Polypectomy-surgical excision

Any combination of 20 or 26–29 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Partial colectomy, segmental resection
- 32 Plus resection of contiguous organ; example: small bowel, bladder

40 Subtotal colectomy/hemicolectomy (total right or left colon and a portion of transverse colon)
- 41 Plus resection of contiguous organ; example: small bowel, bladder

50 Total colectomy (removal of colon from cecum to the rectosigmoid junction; may include a portion of the rectum)
- 51 Plus resection of contiguous organ; example: small bowel, bladder

60 Total proctocolectomy (removal of colon from cecum to the rectosigmoid junction, including the entire rectum)
- 61 Plus resection of contiguous organ; example: small bowel, bladder

70 Colectomy or coloproctotectomy with resection of contiguous organ(s), NOS (where there is not enough information to code 32, 41, 51, or 61)

Code 70 includes: Any colectomy (partial, hemicolectomy, or total) WITH a resection of any other organs in continuity with the primary site. Other organs may be partially or totally removed. Other organs may include, but are not limited to, oophorectomy, partial proctectomy, rectal mucosectomy, or pelvic exenteration.

80 Colectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 01/10, 02/10, 01/16)

RECTOSIGMOID

C19.9

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 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 surgical events 10–14.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Wedge or segmental resection; partial proctosigmoidectomy, NOS
- 31 Plus resection of contiguous organs; example: small bowel, bladder

Procedures coded 30 include, but are not limited to:

Anterior resection
Hartmann operation
Low anterior resection (LAR)
Partial colectomy, NOS
Rectosigmoidectomy, NOS
Sigmoidectomy

40 Pull through WITH sphincter preservation (colo-anal anastomosis)

50 Total proctectomy

51 Total colectomy

55 Total colectomy WITH ileostomy, NOS
- 56 Ileorectal reconstruction
- 57 Total colectomy WITH other pouch; example: Koch pouch

60 Total proctocolectomy, NOS
- 65 Total proctocolectomy WITH ileostomy, NOS
- 66 Total proctocolectomy WITH ileostomy and pouch

Removal of the colon from cecum to the rectosigmoid or a portion of the rectum.

70 Colectomy or proctocolectomy resection in continuity with other organs; pelvic exenteration

80 Colectomy, NOS; Proctectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 01/10, 02/10, 01/16)

RECTUM

C20.9

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Code removal/surgical ablation of single or multiple liver metastases under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294).

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 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 surgical events 10-14.

20 Local tumor excision, NOS
- 27 Excisional biopsy
- 26 Polypectomy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

- 25 Laser excision
- 28 Curette and fulguration

30 Wedge or segmental resection; partial proctectomy, NOS

Procedures coded 30 include, but are not limited to:

Anterior resection
Hartmann's operation
Low anterior resection (LAR)
Transsacral rectosigmoidectomy
Total mesorectal excision (TME)

40 Pull through WITH sphincter preservation (coloanal anastomosis)

50 Total proctectomy

Procedure coded 50 includes, but is not limited to:

Abdominoperineal resection (Miles Procedure)

60 Total proctocolectomy, NOS

70 Proctectomy or proctocolectomy with resection in continuity with other organs; pelvic exenteration

80 Proctectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 01/10, 02/10, 05/10, 01/16)

ANUS

C21.0–C21.8

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

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 Thermal Ablation

No specimen sent to pathology from surgical events 10–15.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

60 Abdominal perineal resection, NOS (APR; Miles procedure)
- 61 APR and sentinel node excision
- 62 APR and unilateral inguinal lymph node dissection
- 63 APR and bilateral inguinal lymph node dissection

The lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292) or *Scope of Regional Lymph Node Surgery at This Facility* (NAACCR Item #672).

Specimen sent to pathology from surgical events 20–63.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 01/04, 01/10, 02/10, 01/16)

LIVER AND INTRAHEPATIC BILE DUCTS

C22.0–C22.1

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

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 (Percutaneous Ethanol Injection-PEI)
- 16 Heat-Radio-frequency ablation (RFA)
- 17 Other (ultrasound, acetic acid)

No specimen sent to pathology from surgical events 10–17.

20 Wedge or segmental resection, NOS
- 21 Wedge resection
- 22 Segmental resection, NOS
  - 23 One
  - 24 Two
  - 25 Three
  - 26 Segmental resection AND local tumor destruction

30 Lobectomy, NOS
- 36 Right lobectomy
- 37 Left lobectomy
- 38 Lobectomy AND local tumor destruction

50 Extended lobectomy, NOS (extended: resection of a single lobe plus a segment of another lobe)
- 51 Right lobectomy
- 52 Left lobectomy
- 59 Extended lobectomy AND local tumor destruction

60 Hepatectomy, NOS
- 61 Total hepatectomy and transplant

65 Excision of a bile duct (for an intra-hepatic bile duct primary only)
- 66 Excision of an intrahepatic bile duct PLUS partial hepatectomy

75 Extrahepatic bile duct and hepatectomy WITH transplant

Specimen sent to pathology from surgical events 20–75.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

Revised 01/10, 02/10, 01/11, 01/16)

PANCREAS

C25.0–C25.9

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

25 Local excision of tumor, NOS

30 Partial pancreatectomy, NOS; example: distal

35 Local or partial pancreatectomy and duodenectomy
- 36 WITHOUT distal/partial gastrectomy
- 37 WITH partial gastrectomy (Whipple)

40 Total pancreatectomy

60 Total pancreatectomy and subtotal gastrectomy or duodenectomy

70 Extended pancreatoduodenectomy

80 Pancreatectomy, NOS

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 01/10, 02/10, 01/16)

LARYNX

C32.0–C32.9

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

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 Stripping

No specimen sent to pathology from surgical events 10–15.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

- 25 Laser excision
- 28 Stripping

30 Partial excision of the primary site, NOS; subtotal/partial laryngectomy NOS; hemilaryngectomy NOS
- 31 Vertical laryngectomy
- 32 Anterior commissure laryngectomy
- 33 Supraglottic laryngectomy

40 Total or radical laryngectomy, NOS
- 41 Total laryngectomy ONLY
- 42 Radical laryngectomy ONLY

50 Pharyngolaryngectomy

80 Laryngectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 01/10, 02/10, 01/16)

LUNG

C34.0–C34.9

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS

Unknown whether a specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).

15 Local tumor destruction, NOS

- 12 Laser ablation or cryosurgery
- 13 Electrocautery; fulguration (includes use of hot forceps for tumor destruction)

No specimen sent to pathology from surgical events 12–13 and 15.

20 Excision or resection of less than one lobe, NOS

- 23 Excision, NOS
- 24 Laser excision
- 25 Bronchial sleeve resection ONLY
- 21 Wedge resection
- 22 Segmental resection, including lingulectomy

30 Resection of lobe or bilobectomy, but less than the whole lung (partial pneumonectomy, NOS)

- 33 Lobectomy WITH mediastinal lymph node dissection

The lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292) or *Scope of Regional Lymph Node Surgery at This Facility* (NAACCR Item #672).

45 Lobe or bilobectomy extended, NOS

- 46 WITH chest wall
- 47 WITH pericardium
- 48 WITH diaphragm

55 Pneumonectomy, NOS

- 56 WITH mediastinal lymph node dissection (radical pneumonectomy)

The lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292) or *Scope of Regional Lymph Node Surgery at This Facility* (NAACCR Item #672).

65 Extended pneumonectomy

- 66 Extended pneumonectomy plus pleura or diaphragm

70 Extended radical pneumonectomy

The lymph node dissection should also be coded under *Scope of Regional Lymph Node Surgery* (NAACCR Item #1292) or *Scope of Regional Lymph Node Surgery at This Facility* (NAACCR Item #672).

80 Resection of lung, NOS
Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 01/04, 01/10, 02/10, 01/16)

HEMATOPOIETIC/RETICULOENDOTHELIAL/

IMMUNOPROLIFERATIVE/MYELOPROLIFERATIVE DISEASE

C42.0, C42.1, C42.3, C42.4 (with any histology)

or

M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992 **(with any site)**

Code

98 All hematopoietic/reticuloendothelial/immunoproliferative/myeloproliferative disease sites and/or histologies, WITH or WITHOUT surgical treatment.

Surgical procedures for hematopoietic/reticuloendothelial/immunoproliferative/ myeloproliferative primaries are to be recorded using the data item *Surgical Procedure/Other Site* (NAACCR Item #1294) or *Surgical Procedure/Other Site at This Facility* (NAACCR Item #674).

(Revised 01/04, 01/10, 02/10, 01/16)

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

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS

Unknown whether a specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).

15 Local tumor destruction

No specimen sent to pathology from surgical event 15.

25 Local excision

26 Partial resection

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, NOS
- 54 Internal hemipelvectomy

Specimen sent to pathology from surgical events 25–54.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 8/17/02, 01/10, 02/10, 01/16)

SPLEEN

C42.2

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS

Unknown whether a specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).

21 Partial splenectomy

22 Total splenectomy

80 Splenectomy, NOS

Specimen sent to pathology for surgical events 21-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 01/04, 01/10, 02/10, 01/16)

SKIN

C44.0–C44.9

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 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 surgical events 10–14.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Biopsy of primary tumor followed by a gross excision of the lesion (does not have to be done under the same anesthesia)
- 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
- 34 Mohs surgery, NOS
- 35 Mohs with 1-cm margin or less
- 36 Mohs with more than 1-cm margin

45 Wide excision or reexcision of lesion or minor (local) amputation with margins more than 1 cm, NOS. **Margins MUST be microscopically negative.**
- 46 WITH margins more than 1 cm and less than or equal to 2 cm
- 47 WITH margins greater than 2 cm

If the excision or reexcision has microscopically confirmed negative margins less than 1 cm OR the margins are 1cm or more but are <u>not</u> microscopically confirmed; use the appropriate code, 20–36.

60 Major amputation

Specimen sent to pathology from surgical events 20–60.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 01/04, 01/10, 02/10, 01/15, 01/16)

BREAST

C50.0–C50.9

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction, NOS

No specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).

20 Partial mastectomy, NOS; less than total mastectomy, NOS
- 21 Partial mastectomy WITH nipple resection
- 22 Lumpectomy or excisional biopsy
- 23 Reexcision of the biopsy site for gross or microscopic residual disease
- 24 Segmental mastectomy (including wedge resection, quadrantectomy, tylectomy)

Procedures coded 20–24 remove the gross primary tumor and some of the breast tissue (breast-conserving or preserving). There may be microscopic residual tumor.

30 Subcutaneous mastectomy

A subcutaneous mastectomy, also called a nipple sparing mastectomy, is the removal of breast tissue without the nipple and areolar complex or overlying skin. It is performed to facilitate immediate breast reconstruction. Cases coded 30 may be considered to have undergone breast reconstruction.

40 Total (simple) mastectomy
- 41 WITHOUT removal of uninvolved contralateral breast
  - 43 With reconstruction NOS
    - 44 Tissue
    - 45 Implant
    - 46 Combined (Tissue and Implant)
- 42 WITH removal of uninvolved contralateral breast
  - 47 With reconstruction NOS
    - 48 Tissue
    - 49 Implant
    - 75 Combined (Tissue and Implant)

A total (simple) mastectomy removes all breast tissue, the nipple, and areolar complex. An axillary dissection is not done, but sentinel lymph nodes may be removed.

For single primaries only, code removal of the contralateral breast under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294) and/or *Surgical Procedure/Other Site at This Facility* (NAACCR Item #674).

If the contralateral breast reveals a second primary, each breast is abstracted separately. The surgical procedure is coded 41 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed on that site.

Reconstruction that is planned as part of first course treatment is coded 43-49 or 75, whether it is done at the time of mastectomy or later.

76 Bilateral mastectomy for a single tumor involving both breasts, as for bilateral inflammatory carcinoma.

50 Modified radical mastectomy
- 51 WITHOUT removal of uninvolved contralateral breast
  - 53 Reconstruction, NOS
    - 54 Tissue
    - 55 Implant
    - 56 Combined (Tissue and Implant)
- 52 WITH removal of uninvolved contralateral breast
  - 57 Reconstruction, NOS
    - 58 Tissue
    - 59 Implant
    - 63 Combined (Tissue and Implant)

Removal of all breast tissue, the nipple, the areolar complex, and variable amounts of breast skin in continuity with the axilla. The specimen may or may not include a portion of the pectoralis major muscle

If contralateral breast reveals a second primary, it is abstracted separately. The surgical procedure is coded 51 for the first primary. The surgical code for the contralateral breast is coded to the procedure performed on that site.

For single primaries only, code removal of involved contralateral breast under the data item *Surgical Procedure/Other Site* (NAACCR Item #1294) or *Surgical Procedure/Other Site at This Facility* (NAACCR Item #674).

60 Radical mastectomy, NOS
- 61 WITHOUT removal of uninvolved contralateral breast
  - 64 Reconstruction, NOS
    - 65 Tissue
    - 66 Implant
    - 67 Combined (Tissue and Implant)
- 62 WITH removal of uninvolved contralateral breast
  - 68 Reconstruction, NOS
    - 69 Tissue
    - 73 Implant
    - 74 Combined (Tissue and Implant)

70 Extended radical mastectomy

71 WITHOUT removal of uninvolved contralateral breast
72 WITH removal of uninvolved contralateral breast

80 Mastectomy, NOS

Specimen sent to pathology for surgical events coded 20-80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 01/04, 01/10, 02/10, 05/10, 01/11, 01/13, 01/16)

CERVIX UTERI

C53.0–C53.9

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

For invasive cancers, dilation and curettage is coded as an incisional biopsy (02) under the data item *Surgical Diagnostic and Staging Procedure* (NAACCR Item #1350).

Codes

00 None; no surgery of primary site; autopsy ONLY

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 Loop Electrocautery Excision Procedure (LEEP)
- 16 Laser ablation
- 17 Thermal ablation

No specimen sent to pathology from surgical events 10–17.

20 Local tumor excision, NOS
- 26 Excisional biopsy, NOS
- 27 Cone biopsy
- 24 Cone biopsy WITH gross excision of lesion
- 29 Trachelectomy; removal of cervical stump; cervicectomy

Any combination of 20, 24, 26, 27 or 29 WITH
- 21 Electrocautery
- 22 Cryosurgery
- 23 Laser ablation or excision

- 25 Dilatation and curettage; endocervical curettage (for in situ only)
- 28 Loop electrocautery excision procedure (LEEP)

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 and/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 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.

72 Posterior exenteration
Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.

73 Total exenteration
Includes removal of all pelvic contents and pelvic lymph nodes.

74 Extended exenteration
Includes pelvic blood vessels or bony pelvis.

Specimen sent to pathology from surgical events 20–74.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 01/04, 01/10, 02/10, 01/16)

CORPUS UTERI

C54.0–C55.9

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

For invasive cancers, dilation and curettage is coded as an incisional biopsy (02) under the data item *Surgical Diagnostic and Staging Procedure* (NAACCR Item #1350).

Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS

Unknown whether a specimen was sent to pathology for surgical events coded 19 (principally for cases diagnosed prior to January 1, 2003).

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 Loop Electocautery Excision Procedure (LEEP)
- 16 Thermal ablation

No specimen sent to pathology from surgical events 10–16.

20 Local tumor excision, NOS; simple excision, NOS
- 24 Excisional biopsy
- 25 Polypectomy
- 26 Myomectomy

Any combination of 20 or 24–26 WITH
- 21 Electrocautery
- 22 Cryosurgery
- 23 Laser ablation or excision

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)

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) and/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 procedure

64 Extended radical hysterectomy

65 Hysterectomy, NOS, WITH or WITHOUT removal of tube(s) and ovary(ies)

66 WITHOUT removal of tube(s) and ovary(ies)

67 WITH removal of tube(s) and ovary(ies)

75 Pelvic exenteration

76 Anterior exenteration

Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.

77 Posterior exenteration

Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.

78 Total exenteration

Includes removal of all pelvic contents and pelvic lymph nodes.

79 Extended exenteration

Includes pelvic blood vessels or bony pelvis.

Specimen sent to pathology from surgical events 20–79.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 01/04, 01/10, 02/10, 01/16)

OVARY

C56.9

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

17 Local tumor destruction, NOS

No specimen sent to pathology from surgical event 17.

25 Total removal of tumor or (single) ovary, NOS
- 26 Resection of ovary (wedge, subtotal, or partial) ONLY, NOS; unknown if hysterectomy done
- 27 WITHOUT hysterectomy
- 28 WITH hysterectomy

35 Unilateral (salpingo-)oophorectomy; unknown if hysterectomy done
- 36 WITHOUT hysterectomy
- 37 WITH hysterectomy

50 Bilateral (salpingo-)oophorectomy; unknown if hysterectomy done
- 51 WITHOUT hysterectomy
- 52 WITH hysterectomy

55 Unilateral or bilateral (salpingo-)oophorectomy WITH OMENTECTOMY, NOS; partial or total; unknown if hysterectomy done
- 56 WITHOUT hysterectomy
- 57 WITH hysterectomy

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 or total 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 exenteration

Includes bladder, distal ureters, and genital organs WITH their ligamentous attachments and pelvic lymph nodes.

- 72 Posterior exenteration

Includes rectum and rectosigmoid WITH ligamentous attachments and pelvic lymph nodes.

73 Total exenteration
Includes removal of all pelvic contents and pelvic lymph nodes.

74 Extended exenteration
Includes pelvic blood vessels or bony pelvis.

80 (Salpingo-)oophorectomy, NOS

Specimen sent to pathology from surgical events 25–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 01/04, 01/10, 02/10, 01/16)

PROSTATE

C61.9

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Do not code an orchiectomy in this field. For prostate primaries, orchiectomies are coded in the data item *Hematologic Transplant and Endocrine Procedures* (NAACCR Item #3250).

Codes

00 None; no surgery of primary site; autopsy ONLY

18 Local tumor destruction or excision, NOS

19 Transurethral resection (TURP), NOS, and no specimen sent to pathology or unknown if sent

Unknown whether a specimen was sent to pathology for surgical events coded 18 or 19 (principally for cases diagnosed prior to January 1, 2003).

10 Local tumor destruction, NOS
- 14 Cryoprostatectomy
- 15 Laser ablation
- 16 Hyperthermia
- 17 Other method of local tumor destruction

No specimen sent to pathology from surgical events 10–17.

20 Local tumor excision, NOS
- 21 Transurethral resection (TURP), NOS, with specimen sent to pathology
- 22 TURP–cancer is incidental finding during surgery for benign disease
- 23 TURP–patient has suspected/known cancer

Any combination of 20–23 WITH
- 24 Cryosurgery
- 25 Laser
- 26 Hyperthermia

30 Subtotal, segmental, or simple prostatectomy, which may leave all or part of the capsule intact

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 resection in continuity with other organs; pelvic exenteration

Surgeries coded 70 are any prostatectomy WITH resection in continuity with any other organs. The other organs may be partially or totally removed. Procedures may include, but are not limited to, cystoprostatectomy, radical cystectomy, and prostatectomy.

80 Prostatectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 12/4/02, 01/10, 02/10, 1/11, 01/16)

TESTIS

C62.0–C62.9

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

12 Local tumor destruction, NOS

No specimen sent to pathology from surgical event 12.

20 Local or partial excision of testicle

30 Excision of testicle WITHOUT cord

40 Excision of testicle WITH cord or cord not mentioned (radical orchiectomy)

80 Orchiectomy, NOS (unspecified whether partial or total testicle removed)

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 01/04, 01/10, 02/10, 01/16)

KIDNEY, RENAL PELVIS, AND URETER

Kidney C64.9, Renal Pelvis C65.9, Ureter C66.9

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-99922)

Codes

00 None; no surgery of primary site; autopsy ONLY

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 Thermal ablation

No specimen sent to pathology from this surgical event 10–15.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Partial or subtotal nephrectomy (kidney or renal pelvis) or partial ureterectomy (ureter)

Procedures coded 30 include, but are not limited to:

Segmental resection
Wedge resection

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) in continuity with the 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

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 01/10, 02/10, 01/16)

BLADDER

C67.0–C67.9

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

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 Intravesical therapy
- 16 Bacillus Calmette-Guerin (BCG) or other immunotherapy

Also code the introduction of immunotherapy in the immunotherapy items. If immunotherapy is followed by surgery of the type coded 20-80 code that surgery instead and code the immunotherapy only as immunotherapy.

No specimen sent to pathology from surgical events 10–16.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Partial cystectomy

50 Simple/total/complete cystectomy

60 Complete cystectomy with reconstruction
- 61 Radical cystectomy PLUS ileal conduit
- 62 Radical cystectomy PLUS continent reservoir or pouch, NOS
- 63 Radical cystectomy PLUS abdominal pouch (cutaneous)
- 64 Radical cystectomy PLUS in situ pouch (orthotopic)

When the procedure is described as a pelvic exenteration for males, but the prostate is not removed, the surgery should be coded as a cystectomy (code 60-64).

70 Pelvic exenteration, NOS
- 71 Radical cystectomy including anterior exenteration

For females, includes removal of bladder, uterus, ovaries, entire vaginal wall, and entire urethra. For males, includes removal of the prostate. When a procedure is described as a pelvic exenteration for males, but the prostate is not removed, the surgery should be coded as a cystectomy (code 60-64).

72 Posterior exenteration

For females, also includes removal of vagina, rectum and anus. For males, also includes prostate, rectum and anus.

73 Total exenteration

Includes all tissue and organs removed for an anterior and posterior exenteration.

74 Extended exenteration

Includes pelvic blood vessels or bony pelvis.

80 Cystectomy, NOS

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 01/04, 01/10, 02/10, 01/12, 01/16)

BRAIN

Meninges C70.0–C70.9, Brain C71.0–C71.9,

Spinal Cord, Cranial Nerves and Other Parts of Central Nervous System C72.0–C72.9

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Do not code laminectomies for spinal cord primaries.

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Tumor destruction, NOS

No specimen sent to pathology from surgical event 10.

Do not record stereotactic radiosurgery (SRS), Gamma knife, Cyber knife, or Linac radiosurgery as surgical tumor destruction. All of these modalities are recorded in the radiation treatment fields.

20 Local excision of tumor, lesion or mass; excisional biopsy

21 Subtotal resection of tumor, lesion or mass in brain

22 Resection of tumor of spinal cord or nerve

30 Radical, total, gross resection of tumor, lesion or mass in brain

40 Partial resection of lobe of brain, when the surgery cannot be coded as 20-30.

55 Gross total resection of lobe of brain (lobectomy)

Codes 30 - 55 are not applicable for spinal cord or spinal nerve primary sites.

Specimen sent to pathology from surgical events 20–55.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 01/04, 01/10, 02/10, 01/16)

THYROID GLAND

C73.9

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

13 Local tumor destruction, NOS

No specimen sent to pathology from surgical event 13.

25 Removal of less than a lobe, NOS
- 26 Local surgical excision
- 27 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

Specimen sent to pathology from surgical events 20–80.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 01/10, 02/10, 01/15, 01/16)

LYMPH NODES

C77.0–C77.9

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

19 Local tumor destruction or excision, NOS

Unknown whether a specimen was sent to pathology for surgical events coded to 19 (principally for cases diagnosed prior to January 1, 2003).

15 Local tumor destruction, NOS

No specimen sent to pathology from surgical event 15.

25 Local tumor excision, NOS

Less than a full chain, includes an excisional biopsy of a single lymph node.

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 (Includes staging laparotomy for lymphoma.)

- 61 One chain
- 62 Two or more chains

Specimen sent to pathology for surgical events 25-62.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 09/04, 01/10, 02/10, 01/16)

ALL OTHER SITES

C14.2–C14.8, C17.0–C17.9, C23.9, C24.0–C24.9, C26.0–C26.9, C30.0–C 30.1, C31.0–C31.9, C33.9, C37.9, C38.0–C38.8, C39.0–C39.9, C48.0–C48.8, C51.0–C51.9, C52.9, C57.0–C57.9, C58.9, C60.0–C60.9, C63.0–C63.9, C68.0–C68.9, C69.0–C69.9, C74.0–C74.9, C75.0–C75.9

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Codes

00 None; no surgery of primary site; autopsy ONLY

10 Local tumor destruction, NOS
- 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 surgical events 10–14.

20 Local tumor excision, NOS
- 26 Polypectomy
- 27 Excisional biopsy

Any combination of 20 or 26–27 WITH
- 21 Photodynamic therapy (PDT)
- 22 Electrocautery
- 23 Cryosurgery
- 24 Laser ablation

25 Laser excision

30 Simple/partial surgical removal of primary site

40 Total surgical removal of primary site; enucleation
- 41 Total enucleation (for eye surgery only)

50 Surgery stated to be “debulking”

60 Radical surgery

Partial or total removal of the primary site WITH a resection in continuity (partial or total removal) with other organs.

Specimen sent to pathology from surgical events 20–60.

90 Surgery, NOS

99 Unknown if surgery performed; death certificate ONLY

(Revised 01/04, 01/10, 02/10, 01/16

UNKNOWN AND ILL-DEFINED PRIMARY SITES

C76.0–C76.8, C80.9

(Except for M-9727, 9732, 9741-9742, 9762-9809, 9832, 9840-9931, 9945-9946, 9950-9967, and 9975-9992)

Code

98 All unknown and ill-defined disease sites, WITH or WITHOUT surgical treatment.

Surgical procedures for unknown and ill-defined primaries are to be recorded using the data item *Surgical Procedure/Other Site* (NAACCR Item #1294) or *Surgical Procedure/Other Site at This Facility* (NAACCR Item #674).

(Revised 01/04, 01/10, 02/10, 01/16)

APPENDIX C: *Date Case Completed – CoC*

STORE Items Required to Be Complete to Enter Date Case Completed – CoC for Cases Diagnosed in 2018

See *Date Case Completed–CoC* [2092] for instructions.

Category	STORE Items	NAACCR Item #
Identification **Class of Case 00-22**	Addr at DX–City	70
	Addr at DX–State	80
	Addr at DX–Postal Code	100
	County at DX	90
	Addr at DX--Country	102
	Date of 1st Contact	580
	Date of 1st Contact Flag	581
	Class of Case	610
	Primary Payer at DX	630
	NPI Archive FIN	3105
	Archive FIN	3100
	Accession Number	500
	Sequence Number	560
	Abstracted By	570
	Secondary Diagnosis #1	3780
	Secondary Diagnosis #2	3782
	Secondary Diagnosis #3	3784
	Secondary Diagnosis #4	3786
	Secondary Diagnosis #5	3788
	Secondary Diagnosis #6	3790
	Secondary Diagnosis #7	3792
	Secondary Diagnosis #8	3794
	Secondary Diagnosis #9	3796
	Secondary Diagnosis #10	3798
	Override Acsn/Class/Seq	1985
	CoC Coding System - Current	2140
	CoC Coding System - Original	2150
	Vendor Name	2170
	ICD-O-3 Conversion Flag	2116
	Date of Last Contact or Death	1750
	Date of Last Contact Flag	1751
	City/Town – Current	1810

Category	STORE Items	NAACCR Item #
	State – Current	1820
	Postal Code – Current	1830
	Address Current--Country	1832
	Last Name	2230
	First Name	2240
	Middle Name	2250
	Medical Record Number	2300
	Social Security Number	2320
	Patient Address (Number and Street) at Diagnosis	2330
	Patient Address at Diagnosis – Supplemental	2335
	Patient Address (Number and Street) – Current	2350
	Patient Address–Current - Supplemental	2335
	Telephone	2360
Demographic Class of Case 00-22	Race 1	160
	Race 2	161
	Race 3	162
	Race 4	163
	Race 5	164
	Spanish/Hispanic Origin	190
	Sex	220
	Age at Diagnosis	230
	Date of Birth	240
	Date of Birth Flag	241
	Birthplace--State	252
	Birthplace--Country	254
	Race Coding System – Current	170
	Race Coding System – Original	180
Diagnostic Class of Case 00-22	Date of Diagnosis	390
	Primary Site	400
	Laterality	410
	Histologic Type ICD-O-3	522
	Behavior Code ICD-O-3	523
	Grade Clinical	3843
	Grade Pathological	3844
	Grade Post Therapy	3845
	Diagnostic Confirmation	490
	Sequence Number - Hosp	560
	RX Hosp–DX/Stg Proc	740
	Site Coding System – Current	450

Category	STORE Items	NAACCR Item #
	Site Coding System – Original	460
	Morph Coding System – Current	470
	Morph Coding System – Original	480
	Override HospSeq/DxConf	1986
	Override CoC Site/Type	1987
	Override HospSeq/Site	1988
	Override Site/TNM-StgGrp	1989
	Override Age/Site/Morph	1990
	Override SeqNo/DxConf	2000
	Override Site/Lat/SeqNo	2010
	Override Surg/DxConf	2020
	Override Site/Type	2030
	Override Histology	2040
	Override Leuk, Lymphoma	2070
	Override Site/Behavior	2071
	Override Site/Lat/Morph	2074
Staging **Class of Case 10-22**	TNM Edition Number	1060
	AJCC TNM Clin T	1001
	AJCC TNM Clin T Suffix	1031
	AJCC TNM Clin N	1002
	AJCC TNM Clin N Suffix	1034
	AJCC TNM Clin M	1003
	AJCC TNM Clin Stage Group	1004
	AJCC TNM Path T	1011
	AJCC TNM Path T Suffix	1032
	AJCC TNM Path N	1012
	AJCC TNM Path N Suffix	1035
	AJCC TNM Path M	1013
	AJCC TNM Path Stage Group	1014
	AJCC TNM Post Therapy T	1021
	AJCC TNM Post Therapy T Suffix	1033
	AJCC TNM Post Therapy N	1022
	AJCC TNM Post Therapy N Suffix	1036
	AJCC TNM Post Therapy M	1023
	AJCC TNM Post Therapy Stage Group	1024
	Lymphovascular Invasion	1182
	Tumor Size Summary	756
	Regional Nodes Positive	820
	Regional Nodes Examined	830

Category	STORE Items	NAACCR Item #
	Date Regional Lymph Node Dissection	682
	Date Regional Lymph Node Dissection Flag	683
	Sentinel Lymph Nodes Positive	835
	Sentinel Lymph Nodes Examined	834
	Date of Sentinel Lymph Node Biopsy	832
	Date of Sentinel Lymph Node Biopsy Flag	833
	SSDI if required for case	-----
	Tumor Size Summary	756
	Mets at DX-Bone	1112
	Mets at DX-Brain	1113
	Mets at Dx-Distant LN	1114
	Mets at DX-Liver	1115
	Mets at DX-Lung	1116
	Mets at DX-Other	1117
	Summary Stage 2018	764
Hospital-Specific Treatment Class of Case 10-22	RX Hosp–Surg App 2010	668
	Surgical Procedure of Primary Site at This Facility	670
	Scope of Regional Lymph Node Surgery at This Facility	672
	Surgical Procedure / Other Site at This Facility	674
	Chemotherapy at This Facility	700
	Hormone Therapy at This Facility	710
	Immunotherapy at This Facility	720
	Other Treatment at This Facility	730
	Palliative Care at This Facility	3280
	Date of First Course of Treatment	1270
	Date of 1st Crs Flag	1271
	Date of First Surgical Procedure	1200
	RX Date–Surgery Flag	1201
	Date of the Most Definitive Resection of the Primary Site	3170
	RX Date–Mst Defin Srg Flag	3171
	Date of Surgical Discharge	3180
	RX Date–Surg Disch Flag	3181
	Date Radiation Started	1210
	RX Date–Radiation Flag	1211
	Date Radiation Ended	3220
	RX Date–Rad Ended Flag	3221
	Date Systemic Therapy Started	3230
	Date Chemotherapy Started	1220

Category	STORE Items	NAACCR Item #
	RX Date–Chemo Flag	1221
	Date Hormone Therapy Started	1230
	RX Date–Hormone Flag	1231
	Date Immunotherapy Started	1240
	RX Date–BRM Flag	1241
	Date Other Treatment Started	1250
	RX Date–Other Flag	1251
	RX Summ–Treatment Status	1285
	NPI- Managing Physician	2465
	NPI-Following Physician	2475
	NPI-Primary Surgeon	2485
	NPI-Physician #3	2495
	NPI-Physician #4	2505
	Surgical Procedure of Primary Site	1290
Summary Treatment Class of Case 10, 12, 14, 20, 22	Scope of Regional Lymph Node Surgery	1292
	Surgical Procedure / Other Site	1294
	Surgical Margins of the Primary Site	1320
	Reason for No Surgery of Primary Site	1340
	Surgical Diagnostic and Staging Procedure	1350
	Palliative Care	3270
	Radiation / Surgery Sequence	1380
	Hematological Transplant and Endocrine Procedures	3250
	Chemotherapy	1390
	Hormone Therapy	1400
	Immunotherapy	1410
	Other Treatment	1420
	Reason for No Radiation	1430
	Rx Coding System–Current	1460
	Regional Dose: cGy	1510
	Phase I Radiation Primary Treatment Volume	1504
	Phase I Radiation to Draining Lymph Nodes	1505
	Phase I Radiation Treatment Modality	1506
	Phase I Radiation External Beam Planning Tech	1502
	Phase I Dose per Fraction	1501
	Phase I Number of Fractions	1503
	Phase I Total Dose	1507
	Phase II Radiation Primary Treatment Volume	1514
	Phase II Radiation to Draining Lymph Nodes	1515
	Phase II Radiation Treatment Modality	1516

Category	STORE Items	NAACCR Item #
	Phase II Radiation External Beam Planning Tech	1512
	Phase II Dose per Fraction	1511
	Phase II Number of Fractions	1513
	Phase II Total Dose	1517
	Phase III Radiation Primary Treatment Volume	1524
	Phase III Radiation to Draining Lymph Nodes	1525
	Phase III Radiation Treatment Modality	1526
	Phase III Radiation External Beam Planning Tech	1522
	Phase III Dose per Fraction	1521
	Phase III Number of Fractions	1523
	Phase III Total Dose	1527
	Number of Phases of Rad Treatment to this Volume	1532
	Radiation Treatment Discontinued Early	1531
	Total Dose	1533
	Location of Radiation Treatment	1550
	Systemic / Surgery Sequence	1639
	NPI-Inst Referred To	2425
Referred To **Class of Case 00** **[Must have a facility OR at least one Physician]**	NPI-Primary Surgeon	2485
	NPI-Physician #3	2495
	NPI-Physician #4	2505
	NPI-Inst Referred From	2415
Referred To or From **Class of Case 11-13, 20-22** **[Must have at least one facility OR at least one Physician]**	NPI-Inst Referred To	2425
	NPI-Managing Physician (if that person diagnosed the patient and the other options do not apply)	2465
	NPI-Primary Surgeon	2485
	NPI-Physician #3	2495
	NPI-Physician #4	2505

(Revised 01/12, 01/14, 01/15, 01/16, 01/18)

APPENDIX D: Country and State Codes

Geographic Area	Country Code	State or Province Code
Preferred: Specific Codes for Use Where the Detail is Known		
United States (state and armed forces codes)		
Alabama	USA	AL
Alaska	USA	AK
Arizona	USA	AZ
Arkansas	USA	AR
Armed Forces Americas	USA	AA
Armed Forces Canada, Europe, Middle East, Africa	USA	AE
Armed Forces Pacific	USA	AP
California	USA	CA
Colorado	USA	CO
Connecticut	USA	CT
Delaware	USA	DE
District of Columbia	USA	DC
Florida	USA	FL
Georgia	USA	GA
Hawaii	USA	HI
Idaho	USA	ID
Illinois	USA	IL
Indiana	USA	IN
Iowa	USA	IA
Kansas	USA	KS
Kentucky	USA	KY
Louisiana	USA	LA
Maine	USA	ME
Maryland	USA	MD
Massachusetts	USA	MA
Michigan	USA	MI
Minnesota	USA	MN
Mississippi	USA	MS
Missouri	USA	MO
Montana	USA	MT
Nebraska	USA	NE
Nevada	USA	NV
New Hampshire	USA	NH

Geographic Area	Country Code	State or Province Code
Preferred: Specific Codes for Use Where the Detail is Known		
New Jersey	USA	NJ
New Mexico	USA	NM
New York	USA	NY
North Carolina	USA	NC
North Dakota	USA	ND
Ohio	USA	OH
Oklahoma	USA	OK
Oregon	USA	OR
Pennsylvania	USA	PA
Rhode Island	USA	RI
South Carolina	USA	SC
South Dakota	USA	SD
Tennessee	USA	TN
Texas	USA	TX
Utah	USA	UT
Vermont	USA	VT
Virginia	USA	VA
Washington	USA	WA
West Virginia	USA	WV
Wisconsin	USA	WI
Wyoming	USA	WY
Canada (province and territory codes)		
Alberta	CAN	AB
British Columbia	CAN	BC
Manitoba	CAN	MB
New Brunswick	CAN	NB
Newfoundland and Labrador	CAN	NL
Northwest Territories	CAN	NT
Nova Scotia	CAN	NS
Nunavut	CAN	NU
Ontario	CAN	ON
Prince Edward Island	CAN	PE
Quebec	CAN	QC
Saskatchewan	CAN	SK
Yukon Territory	CAN	YT
Afghanistan	AFG	XX

Geographic Area	Country Code	State or Province Code
Preferred: Specific Codes for Use Where the Detail is Known		
Aland Islands	ALA	XX
Albania	ALB	XX
Algeria	DZA	XX
American Samoa	ASM	AS
Andorra	AND	XX
Angola (Sao Tome, Principe, Cabinda)	AGO	XX
Anguilla	AIA	XX
Antarctica	ATA	XX
Antigua and Barbuda	ATG	XX
Argentina	ARG	XX
Armenia	ARM	XX
Aruba	ABW	XX
Australia	AUS	XX
Australia and Australian New Guinea	AUS	XX
Austria	AUT	XX
Azerbaijan	AZE	XX
Bahamas	BHS	XX
Bahrain	BHR	XX
Bangladesh (East Pakistan)	BGD	XX
Barbados	BRB	XX
Belgium	BEL	XX
Belize (British Honduras)	BLZ	XX
Benin	BEN	XX
Bermuda	BMU	XX
Bhutan	BTN	XX
Bolivia, Plurinational State of	BOL	XX
Bonaire, Saint Eustatius and Saba	BES	XX
Bosnia and Herzogovina	BIH	XX
Botswana	BWA	XX
Bouvet Island	BVT	XX
Brazil	BRA	XX
British Indian Ocean Territory	IOT	XX
Virgin Islands, British	VGB	XX
Brunei	BRN	XX
Bulgaria	BGR	XX
Burkina Faso	BFA	XX
Burma (Myanmar)	MMR	XX
Burundi (Urundi)	BDI	XX

Geographic Area	Country Code	State or Province Code
Preferred: Specific Codes for Use Where the Detail is Known		
Byelorus (Byelorussian SSR, White Russia)	BLR	XX
Cambodia	KHM	XX
Cameroon	CMR	XX
Panama (Canal Zone)	PAN	XX
Cape Verde	CPV	XX
Cayman Islands	CYM	XX
Central African Republic	CAF	XX
Ceylon (Sri Lanka)	LKA	XX
Chad	TCD	XX
Chile	CHL	XX
China (Peoples Republic of China)	CHN	XX
Christmas Island	CXR	XX
Cocos (Keeling) Islands	CCK	XX
Colombia	COL	XX
Comoros	COM	XX
Congo	COG	XX
Congo, Democratic Republic of	COD	XX
Cook Islands	COK	XX
Costa Rica	CRI	XX
Cote d'Ivoire	CIV	XX
Croatia	HRV	XX
Cuba	CUB	XX
Curacao	CUW	XX
Cyprus	CYP	XX
Czech Republic	CZE	XX
Denmark, Faroe Islands	DNK	XX
Djibouti	DJI	XX
Dominica	DMA	XX
Dominican Republic	DOM	XX
Ecuador	ECU	XX
Egypt (United Arab Republic)	EGY	XX
El Salvador	SLV	XX
England	ENG	XX
Equatorial Guinea	GNQ	XX
Eritrea	ERI	XX
Estonian SSR (Estonia)	EST	XX
Ethiopia	ETH	XX
Falkland Islands (Malvinas)	FLK	XX

Geographic Area	Country Code	State or Province Code
Preferred: Specific Codes for Use Where the Detail is Known		
Faroe Islands	FRO	XX
Fiji	FJI	XX
Finland	FIN	XX
France, Corsica, Monaco	FRA	XX
French Guiana	GUF	XX
French Polynesia	PYF	XX
French Southern Territories	ATF	XX
Gabon	GAB	XX
Gambia	GMB	XX
Georgia	GEO	XX
Germany (East and West)	DEU	XX
Ghana	GHA	XX
Gibraltar	GIB	XX
Greece	GRC	XX
Greenland	GRL	XX
Grenada	GRD	XX
Guadeloupe	GLP	XX
Guam	GUM	GU
Guatemala	GTM	XX
Guernsey	GGY	XX
Guinea	GIN	XX
Guinea Bissau	GNB	XX
Guyana (British Guiana)	GUY	XX
Haiti	HTI	XX
Heard Island and McDonald Islands	HMD	XX
Honduras	HND	XX
Hong Kong	HKG	XX
Hungary	HUN	XX
Iceland	ISL	XX
India	IND	XX
Indonesia (Dutch East Indies)	IDN	XX
Iran (Persia)	IRN	XX
Iraq	IRQ	XX
Ireland (Eire) (Ireland NOS, Republic of Ireland)	IRL	XX
Isle of Man	IMN	XX
Israel	ISR	XX
Italy (Sardinia, Sicily), San Marino, Vatican City	ITA	XX
Jamaica	JAM	XX

Geographic Area	Country Code	State or Province Code
Preferred: Specific Codes for Use Where the Detail is Known		
Japan	JPN	XX
Jersey	JEY	XX
Johnston Atoll	UMI	UM
Jordan (Transjordan) and former Arab Palestine	JOR	XX
Kazakhstan	KAZ	XX
Kenya	KEN	XX
Kiribati (Canton, Enderbury, Gilbert, S Lines, Phoenix)	KIR	XX
Kuwait	KWT	XX
Kyrgyzstan	KGZ	XX
Laos, Lao People's Democratic Republic	LAO	XX
Latvian SSR (Latvia)	LVA	XX
Lebanon	LBN	XX
Lesotho	LSO	XX
Liberia	LBR	XX
Libya (Tripoli, Tripolitania, Cyrenaica), Libyan Arab Jamahiriya	LBY	XX
Liechtenstein	LIE	XX
Lithuania (Lithuanian SSR)	LTU	XX
Luxembourg	LUX	XX
Macao (Macau)	MAC	XX
Macedonia	MKD	XX
Madagascar (Malagasy Republic)	MDG	XX
Malawi (Nyasaland)	MWI	XX
Malaysia	MYS	XX
Mali	MLI	XX
Malta	MLT	XX
Mariana Islands (Trust Territory of Pacific Islands)	MNP	MP
Marshall Islands (Trust Territory Pacific Islands)	MHL	MH
Martinique	MTQ	XX
Mauritania	MRT	XX
Mauritius	MUS	XX
Mayotte	MYT	XX
Mexico	MEX	XX
Micronesia (Fed States of) (Caroline, Trust Terr of Pacific)	FSM	FM
Mid-East Asia NOS, Maldives	MDV	XX
Midway Islands, U.S. Minor Outlying Islands	UMI	UM
Moldova	MDA	XX
Monaco	MCO	XX
Mongolia	MNG	XX

Geographic Area	Country Code	State or Province Code
Preferred: Specific Codes for Use Where the Detail is Known		
Montenegro	MNE	XX
Montserrat	MSR	XX
Morocco	MAR	XX
Mozambique	MOZ	XX
Namibia	NAM	XX
Nampo-Shoto, Southern (Japan)	JPN	XX
Nauru	NRU	XX
Nepal, Bhutan, Sikkim	NPL	XX
Netherlands	NLD	XX
New Caledonia	NCL	XX
New Zealand	NZL	XX
Nicaragua	NIC	XX
Niger	NER	XX
Nigeria	NGA	XX
Niue	NIU	XX
Norfolk Island	NFK	XX
North Korea	PRK	XX
Northern Ireland	NIR	XX
Norway (Svalbard, Jan Mayen)	NOR	XX
Oman	OMN	XX
Pakistan (West Pakistan)	PAK	XX
Palau	PLW	PW
Palestine Territory, Occupied	PSE	XX
Panama	PAN	XX
Papua New Guinea	PNG	XX
Paraguay	PRY	XX
Peru	PER	XX
Philippines (Philippine Islands)	PHL	XX
Pitcairn Islands	PCN	XX
Poland	POL	XX
Portugal (Madeira Islands, Azores, Cape Verde Islands)	PRT	XX
Puerto Rico	PRI	PR
Qatar	QAT	XX
Republic of South Africa	ZAF	XX
Réunion	REU	XX
Romania	ROU	XX
Russian SFSR (Russia)	RUS	XX
Rwanda (Ruanda)	RWA	XX

Geographic Area	Country Code	State or Province Code
Preferred: Specific Codes for Use Where the Detail is Known		
Ryukyu Islands (Japan)	JPN	XX
Samoa	ASM	XX
San Marino	SMR	XX
Sao Tome & Principe	STP	XX
Saudi Arabia	SAU	XX
Scotland	SCT	XX
Senegal	SEN	XX
Serbia	SRB	XX
Seychelles	SYC	XX
Sierra Leone	SLE	XX
Singapore	SGP	XX
Sint-Maarten	SXM	XX
Slovakia	SVK	XX
Slovenia	SVN	XX
Solomon Islands	SLB	XX
Somalia (Somali Republic, Somaliland)	SOM	XX
South Georgia and the South Sandwich Islands	SGS	XX
South Sudan	SSD	XX
Spain (Canary Islands, Balearic Islands), Andorra	ESP	XX
St Pierre and Miquelon	SPM	XX
St. Barthelemy	BLM	XX
St. Helena, Ascension and Tristan da Cunha	SHN	XX
St. Kitts and Nevis	KNA	XX
St. Lucia	LCA	XX
St. Martin	MAF	XX
St. Vincent and the Grenadines	VCT	XX
Sudan	SDN	XX
Suriname (Dutch Guiana)	SUR	XX
Svalbard and Jan Mayen	SJM	XX
Swan Islands	UMI	UM
Swaziland	SWZ	XX
Sweden	SWE	XX
Switzerland	CHE	XX
Syria	SYR	XX
Taiwan (Formosa) (Republic of China)	TWN	XX
Tajikistan	TJK	XX
Tanzania (Tanganyika, Zanzibar)	TZA	XX
Thailand (Siam)	THA	XX

Geographic Area	Country Code	State or Province Code
Preferred: Specific Codes for Use Where the Detail is Known		
Tibet	CHN	XX
Timor-Leste	TLS	XX
Togo	TGO	XX
Tokelau	TKL	XX
Tonga	TON	XX
Trinidad and Tobago	TTO	XX
Tunisia	TUN	XX
Turkey	TUR	XX
Turkmenistan	TKM	XX
Turks and Caicos	TCA	XX
Tuvalu (Ellice Islands)	TUV	XX
U.S. Virgin Islands	VIR	VI
Uganda	UGA	XX
Ukraine	UKR	XX
United Arab Emirates	ARE	XX
Uruguay	URY	XX
Uzbekistan	UZB	XX
Vanuatu	VUT	XX
Holy See (Vatican City State)	VAT	XX
Venezuela, Bolivarian Republic of	VEN	XX
Vietnam (Tonkin, Annam, Cochin China)	VNM	XX
Wake Island	UMI	UM
Wales	WLS	XX
Wallis and Fotuna	WLF	XX
Western Sahara	ESH	XX
Yemen	YEM	XX
Zambia (Northern Rhodesia)	ZMB	XX
Zimbabwe (Rhodesia, Southern Rhodesia)	ZWE	XX

General

Geographic Area	Country Code	State or Province Code
General: Codes to Use In the Absence of More Specific Information		
United States, NOS	USA	US
Canada, NOS	CAN	CD
Africa, NOS (Central, Equatorial)	ZZF	YY
Asia, NOS	ZZA	YY
Asian and Arab Countries	ZZA	YY
Atlantic/Caribbean Area	ZZN	YY
Baltic Republic(s), NOS (Baltic States, NOS)	ZZE	YY
Central America	ZZC	YY
Czechoslovakia	CSK	YY
East Asia	ZZA	YY
Europe, NOS (Central, Eastern, Northern, Southern, Western)	ZZE	YY
Latin America, NOS	ZZU	YY
Near East	ZZA	YY
North America, NOS	ZZN	YY
Other Atlantic/Caribbean Area (not on detailed list)	ZZN	YY
Other Mainland Europe (not on detailed list)	ZZE	YY
Other Mediterranean Isles (not on detailed list)	ZZE	YY
Other Pacific Area (not on first list)	ZZP	YY
Pacific Area, NOS	ZZP	YY
Pacific Islands, NOS	ZZP	YY
Romance-Language Countries	ZZE	YY
South America, NOS	ZZS	YY
South American Islands	ZZS	YY
United Kingdom, NOS	GBR	XX
Yugoslavia	YUG	YY
Not U.S., but no other information	ZZX	YY
Unknown, no mention in patient record	ZZU	ZZ

Obsolete

Geographic Area	Country Code	State or Province Code
Obsolete: State/Province or Country Codes That Must Not Be Used for Current Coding (May have been assigned during conversion, so may be present in pre-2013 data)		
New England and New Jersey	USA	NN
Maritime Provinces (New Brunswick, Newfound, Nova Scotia, PE)	CAN	MM
Northwest Territories, Yukon Territory	CAN	YN
Prairie Provinces (Alberta, Manitoba, Saskatchewan)	CAN	PP
African Coastal Islands (previously in South Africa, NOS)	XIF	YY
Arabian Peninsula	XAP	YY
Caucasian Republics of the USSR	XCR	YY
China, NOS	XCH	YY
East Africa	XEF	YY
England, Channel Islands, Isle of Man	XEN	XX
Ethiopia (Abyssinia), Eritrea	XET	YY
Germanic Countries	XGR	YY
Indochina	XSE	YY
Israel and former Jewish Palestine	XIS	YY
Korea (Not Specified whether North or South)	KOR	XX
Malaysia, Singapore, Brunei	XMS	YY
Melanesian Islands, Solomon Islands	XML	YY
Micronesian Islands	XMC	YY
North Africa	XNF	YY
North American Islands	XNI	YY
Other Asian Republics of the USSR	XOR	YY
Other Caribbean Islands	XCB	YY
Other West African Countries	XWF	YY
Polynesian Islands	XPL	YY
Republic of South Africa, Botswana, Lesotho, Namibia, Swaziland	XSF	YY
Scandinavia	XSC	YY
Slavic Countries	XSL	XX
South Africa, NOS	XSF	YY
Southeast Asia	XSE	YY
Sudanese Countries	XSD	YY
Ukraine and Moldavia	XUM	YY
West Africa, NOS (French Africa, NOS)	XWF	YY